B2: Patient Navigation & ED Diversion/B1: Care Transitions & Readmissions

Instructions (30 minutes):

1. **20 minutes:**
    a. **DISCUSSION QUESTIONS:** Using the materials attached pick one or two of the measures and go through these questions:
        i. What have you found to be the most effective strategies to achieve these performance measures?
        ii. What challenges have you encountered in working to achieve these performance measures?
        iii. Are there any opportunities to collaborate with other providers serving the same patients to achieve common performance measures?
2. **10 minutes**: Volunteers from groups will report key thoughts or questions to larger group.

- **Materials:**
    - Discussion Questions
    - List of Measures in the Bundle and Which DSRIP providers have those measures
    - List of activities providers are implementing to achieve their measures (not all inclusive)
- **Note Taker:** Record thoughts and comments on post it paper:
    - Identify the measure(s) discussed
    - Key notes
    - Questions
    - Unique Ideas
- **Introductions (very quick):** Name, Organization, Your Role, Overall approach to achieving measure selected (in two sentences or less)

B2: RHP 9, 10, & 18 Patient Navigation & ED Diversion Measure Bundle Discussions

Measure ID	Patient Navigation & ED Diversion Measure Bundle Discussions	Providers
B2-242	Reduce emergency department visits for chronic ambulatory care sensitive conditions (ACSC)	Methodist Charlton Medical Center Methodist Dallas Medical Center Methodist Richardson Medical Center Methodist Mansfield Medical Center JPS Health Network Wise Regional Health System
B2-387	Reduce emergency department visits for behavioral health and substance abuse	Wise Regional Health System
B2-392	Reduce emergency department visits for acute ambulatory care sensitive conditions (ACSC)	Methodist Charlton Medical Center Methodist Dallas Medical Center Methodist Richardson Medical Center Methodist Mansfield Medical Center JPS Health Network Wise Regional Health System
B2-393	Reduce emergency department visits for dental conditions.	Wise Regional Health System

B1/K2: RHP 9, 10, & 18 Care Transitions & Readmissions/Rural Emergency Care

Measure ID	Patient Navigation & ED Diversion Measure Bundle Discussions	Providers
B1-124	Medication Reconciliation Post-Discharge	UT Southwestern Medical Center Children's Medical Center City Hospital at White Rock
B1-141	Risk Adjusted All-Cause 30-Day Readmission for Targeted Conditions: heart failure hospitalization, coronary artery bypass graft (CABG) surgery, CHF, Diabetes, AMI, Stroke, COPD, Behavioral Health, Substance Use	
B1-217	Risk Adjusted All-Cause 30-Day Readmission	
B1-252	Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges)	
B1-253	Transition Record with Specified Elements Received by Discharged Patients (Discharges from Inpatient Facility)	
B1-287	Documentation of Current Medications in the Medical Record	
B1-352	Post-Discharge Appointment	
K2-287	Documentation of Current Medications in the Medical Record	Ennis Regional Medical Center

Measure ID	Patient Navigation & ED Diversion Measure Bundle Discussions	Providers
		Glen Rose Medical Center
K2-355	Admit Decision Time to ED Departure Time for Admitted Patients	Ennis Regional Medical Center Glen Rose Medical Center
K2-359	Emergency Transfer Communication Measure	Ennis Regional Medical Center Glen Rose Medical Center

RHP 9, 10, & 18 Activities Providers are Implementing to Achieve B1 & B2 Measures

Common Themes	Activity	Provider
Enhancement in coordination between primary care, urgent care, and Emergency Departments to increase communication and improve care transitions for patients	Coordination of care and communication of patient information for safe and effective transition of care Review our current status of coordination of care for our patients, will identify any areas for improvement and will then implement any changes necessary to ensure coordination between our emergency department, primary care providers, transferring hospitals and inpatient facilities.	Ennis Regional Medical Center Glen Rose Medical Center
Expansion of access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions.	Education for both staff and patients will guide the patient to internal and external services and programs that may be available that can lead to better health outcomes.	JPS Health Network
Implementation of a care transition and/or a discharge planning program and post discharge support program. This could include a development of a cross-continuum team comprised of clinical and administrative representatives from acute care, skilled nursing, ambulatory care, health centers, and home care providers.	UTSW will expand and/or enhance the use of discharge processes to ensure patients are appropriately transitioned to the next level of care. A care transition program, including a discharge planning and post discharge support will be developed and applied across the continuum of care at Children's Health. Clinical and administrative leadership from emergency care, acute care, ambulatory care, primary care, home health, physical medicine and rehabilitation (Our Children's House), care management (accountable care, case management, care coordination, and patient education will develop the program to facilitate a supportive, consistent approach to transition.	UT Southwestern Medical Children's Health

Common Themes	Activity	Provider
Provision of navigation services to targeted patients (e.g., patients with multiple chronic conditions, cognitive impairments and disabilities, Limited English Proficient patients, the uninsured, those with low health literacy, frequent visitors to the ED, and others)	continue to utilize at least two highly skilled, case management professionals (RNs and/or social workers), to identify frequent ED users and patients with multiple readmissions to connect them to local primary care providers The navigators will work with the patient to identify the clinical and non-clinical factors driving the patient's frequent ED visits / hospital admissions and address care barriers (i.e. social determinants of health) with the goal of improving health outcomes and patient self-efficacy Interdisciplinary care teams will be leveraged to address high risk patients with complex clinical and social needs, through the development of care plans and care coordination with external care resources. The patient navigators will be able to utilize the robust reporting and data collection capabilities of the provider's new EMR to develop targeted interventions based on the patient's individual care needs.	Methodist Hospital Charlton Methodist Hospital Dallas Methodist Hospital Richardson Methodist Hospital Mansfield
Utilization of a comprehensive, multidisciplinary intervention to address the needs of high-risk patients.	White Rock has developed and implemented a standardized care transitions model that addresses the individualize needs of patients being discharged from the hospital and identifies post-acute services that the patient requires. The patients are matched up with the resources available within the community and follow up calls are performed to ensure compliance.	City Hospital at White Rock