"We made a commitment to quality as a health system," said Phyllis Wingate, president of Carolinas Medical Center–NorthEast, in Concord, NC.

This is evident in the work of Douglas Kelling, MD, internist and pulmonologist at Concord Internal Medicine, a part of Carolinas Medical Center. Dr. Kelling’s model for chronic disease management has received national attention from medical centers and physicians.

“We are always measuring outcomes and always trying to do better,” Dr. Kelling said. “Complications of chronic illnesses are assumed to be a failure of the system, not the patient, until proven otherwise.”

Dr. Kelling describes his model for chronic disease management as a team-based approach. Kelling’s team-based approach places the patient at the center and utilizes all staff members in the clinic to provide the best care possible. This approach requires the commitment of the office staff, as well as the dedication of the patient and their caregivers.

“Patients should have an advocate, not just a doctor,” Dr. Kelling said. “That is why we have a well-dedicated staff member that is focused on just that.”

Melody Wareham, BSN, RN, serves as a medical home case manager in Dr. Kelling’s practice. She focuses on patient access, health disparities, and costs issues. Her work is funded by the Beacon Community Program, a project that provides care teams for patients with diabetes, congestive heart failure, hypertension, and other chronic diseases to help establish a seamless, integrated health care experience.

Wareham assists the patient in arranging transportation for doctor’s visits through family members and caregivers, ambulance services and through Medicaid, if they are eligible. She also serves for a resource for patients when filling out paperwork.

“We make every effort possible to ensure that the patient makes their appointment,” Wareham said.

Concord Internal has developed a process to ensure that patients are aware of doctor’s appointments and understand how to properly take medications. Staff members call the patient within 48 hours of discharge from the hospital to help them understand discharge instructions.

(Cont’d, See Team-Based Approach, page 8)
CARE TRANSITIONS

‘It Takes a Village to Optimize Safe Care Transitions’

By ANNA MARQUEZ COOK
CCME Creative Services Consultant

South Carolina’s Georgetown Hospital System places a strong significance on the word “community,” especially when it comes to talking about its Care Transitions Program.

Studies show that preventable hospital readmissions are common and expensive. In the United States, 19.6 percent of patients with Medicare are rehospitalized within the first 30 days of discharge; of these, 76 percent of readmissions could have been prevented. According to the Medicare Payment Advisory Commission, Medicare spends about $12 billion annually on avoidable rehospitalizations. The national goal is to reduce 30-day hospital readmissions by 20 percent by 2013.

“There is no single person or action that can reduce patient readmissions; care transitions encompasses the entire community and continuum of care,” said Monica Grey, MHA, BHS, RN, ACM, director of case management at Waccamaw Community Hospital, a 167-bed facility in Murrells Inlet, SC. “Our care transition community encompasses the patient, his or her family, health care providers, and community agencies. It truly takes a village—or in this case, a community—to optimize safe care transitions.”

Through the CMS QIO initiative, The Carolinas Center for Medical Excellence (CCME) has been working with the Georgetown Hospital System (GHS) to provide technical assistance for its care transition program. CCME has been providing community-level readmissions data and trend analysis, conducting community-specific root cause analysis, and helping convene meetings of community partners.

Waccamaw Community Hospital is part of GHS, which serves Georgetown, Horry, Williamsburg, and surrounding counties. Waccamaw’s Region Care Transitions Program and their partner agencies, such as the Area Agency on Aging and Waccamaw Aging and Disability Resource Center/Waccamaw Council of Governments, are sharing staff expertise, time, money, volunteer pools, and resources to increase their “collective capacity to serve the patient.” According to CBO partner, Danita Vetter with the Waccamaw Aging and Disability Resource Center, the program’s ultimate goal is “to keep patients from returning to the hospital for the same diagnoses over and over again.”

“Historically, local providers serve the same clients and patients, but have done so without communicating much with one another and without a defined, mutually agreed upon pathway designed to create more positive outcomes for patients,” Vetter said. “The process of building the Care Transitions Program has been labor intensive, and the course has, at times, been challenging as partners learn to work together, to trust one another, and to layer small successes upon one another to build the foundation of the program. The constellation of care we collectively provide for patients are strengthened as we work to build a system from the ground up. Engaged patients will receive a level of support that was previously unavailable to them as they transition from an acute

(Cont’d, See ‘It Takes a Village,’ page 8)
Kirstin Duffey, PharmD, BCPS, CACP, CPP, pharmacist at the Mission Hospital Outpatient Anticoagulation Clinic, in Asheville, NC, knew changes were needed when she discovered that a local cardiology provider was planning to transfer all of its anticoagulation patients to Mission in January 2012.

“In September, we were seeing around 200 patients,” Dr. Duffey said. “We knew we would grow to a total population of more than 1,200 around the first of the year.”

As a result of the impending influx of patients, Duffey signed Mission up to participate in the Patient Safety and Clinical Pharmacy Services Collaborative (PSPC) and added The Carolinas Center for Medical Excellence (CCME) as a partner to reduce adverse drug events (ADEs).

“We knew we needed to prepare for a patient population of more than 1,000, which is quite a large increase,” she said. “We had to figure out how we could do it without decreasing our quality of care.”

After meeting with the Mission team, Jeana Partington, MS, BSN, RN, CPHQ, CCME care improvement specialist, offered to support the PSPC work of the team and to provide additional resources and assistance such as root cause analysis, process mapping, and patient surveys to improve efficiency and health care quality effectiveness in the clinic.

The first step CCME took was to complete a baseline process map of the clinic before the influx of patients.

After CCME conducted the process mapping exercise, the Mission leadership team met to discuss the results and to determine next steps. While the team was generally happy with the existing process, they elected to make some changes. Based on the process map, CCME found that the clinic could decrease the standard patient scheduling time and still be effective. The clinic originally had 30-minute appointments but they cut them down to 15-minute slots, unless they were seeing a new patient, a patient on a new medication, or a patient with a complicated anticoagulation therapy. They also made some staffing changes. The clinic went from two pharmacists and a pharmacy technician to three full time pharmacists and two nurses.

In December 2011, CCME assisted the clinic with conducting and evaluating a patient satisfaction survey. They found there was virtually no dissatisfaction. Based on feedback about seeing too many health care providers during visits, they are working to ensure that patients see only one clinician during appointments. The clinic is also making efforts to use consistent assignment with patients so they see the same provider during each visit.

“This helps with building trust, keeping a thorough medical history, and consistent medication management,” Dr. Duffey said.

CCME conducted a second process mapping exercise in March 2012 to determine if the new model was effec-
As the national Patient Safety and Clinical Pharmacy Collaborative (PSPC), led by the Health Resources and Services Administration, enters its fifth year, many health care providers across the country have changed care processes to prevent errors and ensure patient safety. One example of such work has taken place at a community health center in Lugoff, South Carolina.

The Carolinas Center for Medical Excellence (CCME) applauds Sandhills Medical Foundation – a federally qualified health center and a member of PSPC – for developing an ideal care model for high-risk diabetic patients with multiple chronic diseases. The health center’s patient population includes residents from Chesterfield, Kershaw, Lancaster, and Sumter counties.

“As the director of pharmacy at Sandhills Medical Foundation, I am very excited about participating in PSPC and the many opportunities for growth and improvement,” said Alyssa Norwood, RPh. “Now we are able to effectively document how we are providing integrated patient care through a multidisciplinary team.”

In addition to a pharmacist, the team at Sandhills Medical Foundation includes a physician, advanced nurse practitioner, registered nurse, quality improvement coordinator, social worker, pharmacy technician, and students from South University School of Pharmacy. All team members ensure the following for high-risk diabetic patients: appointments are current, lab values are reviewed regularly, and one-on-one counseling services are provided. Pharmacy students contribute by acting as day-to-day project leaders and they receive credit from South University for participating in the effort.

“Participating in PSPC allows us to revisit how patient-centered care is delivered and it enables us to implement changes as needed,” said Laceye Parker, doctorate of pharmacy candidate, South University School of Pharmacy. “Our mission in this effort is to reduce adverse drug events, demonstrate compliance, and to effectively manage chronic disease states.”

The health center’s current data have already shown improvement in A1C results for high-risk diabetic patients. The team’s next steps are to incorporate health screenings, diabetic foot exams, and the development of specific tools (e.g., forms, flowcharts, etc.) to make it easier to track the population of focus.

“Sandhills Medical Foundation is an excellent example of how a provider has taken steps to change care processes to avoid adverse effects to patients and to better control a chronic disease,” said Marilyn Brooks, CCME care improvement specialist.

For more information, please contact Theresa Seaberg, program manager of patient safety and care transitions at CCME, at 803-212-7560, or via email at tseaberg@scqio.sbps.org.
THE CAROLINAS CENTER FOR MEDICAL EXCELLENCE (CCME) and the South Carolina Primary Health Care Association (SCPHCA) have a common goal of improving care within physician practices in South Carolina by educating the providers and their staff on quality reporting, patient-centered care, and other quality improvement initiatives. SCPHCA is the membership organization for community health centers (CHC) in South Carolina. CHCs provide care for more than 320,000 low-income, uninsured, and vulnerable patients across the state.

“SCPHCA and CCME have established an exciting partnership with the goal of optimizing our resources to better serve primary care providers across the state,” said Janet Viars, MPH, RN, clinical quality improvement manager at SCPHCA. “We are collaborating with CCME to enhance participation of CHC’s providers in the Learning and Action Network (LAN) and assisting primary care practices in the transformation to patient-centered medical homes.”

SCPHCA has worked closely with its members to prepare and equip them with the right tools to successfully submit an application to the Patient-Centered Medical Homes (PCMH) Program through the National Committee for Quality Assurance (NCQA). Viars provides technical assistance to transform practices into medical homes.

According to LaShandal Pettaway, MBA, MHA, care improvement specialist and cardiac health program lead at CCME, “The expected benefits on this collaboration are monumental. We are both working to enhance a core primary care foundation by combining access, teamwork, and technology to deliver quality care and improve health in South Carolina.”

Maureen Schwarzer, BS, RN, program manager for population and community health at CCME, said quality reporting is also a big focus area on patient-centered care. “Because so many organizations, both federal and private, have quality initiatives, it is imperative that we form strategic partnerships and bring a unified, working plan to the primary care offices we all work with,” Schwarzer said. “While we hope to help physician practices engage in quality initiatives, we do not want to take time away from the patient, because the patient is the focus of our work.”

CCME has been working with physician practices as a part of the Cardiac & Regional Extension Center (REC) LAN since August 2011. CCME provides education to LAN participants around the PCMH model.

“It is critical for physician offices to be given the tools and support they need in order to be successful at improving outcomes for their patients,” Schwarzer said. “CCME and the SCPHCA are two of many organizations throughout the state who are working diligently to posi-

(Cont’d, See Partnership, page 7)
Hospitals don’t usually share their internal data with other hospitals or health care organizations. The same goes for home health agencies and nursing homes. But what happens when health care organizations decide to work together to address the larger issues around hospital readmissions within a multi-county community? That’s where The Carolinas Center for Medical Excellence (CCME), the Medicare Quality Improvement Organization (QIO) for North and South Carolina, can help.

CCME has been charged by the Centers for Medicare & Medicaid Services (CMS) to provide technical assistance to communities within North Carolina to implement interventions that coordinate hospitals and community-based services to reduce unnecessary hospital readmissions. The national goal is to reduce 30-day hospital readmissions by 20 percent by 2013.

CCME is working with Wake Forest Baptist Medical Center, Forsyth Medical Center, and approximately 40 other health care agencies in Forsyth County and the surrounding area to improve the care patients receive as they move from the hospital to home or a nursing home.

According to CMS, approximately 2.6 million seniors are readmitted to the hospital within 30 days at a cost of more than $26 billion every year.

To assess the community as a whole, CCME completed a detailed root cause analysis (RCA) for the community to determine why their hospital readmission rates were so high. RCA is the process of identifying the factors that cause variables in outcomes. The goal of the RCA is to determine the reasons behind the high readmission rate in order to select an intervention to implement.

Karen Southard, MHA, RN, CCME project manager for patient safety and care transitions, said, “We looked at qualitative and quantitative data and mapped out where the potential at-risk population lived, as well as the hospital readmission rates for the entire community.”

The RCA included a community assessment consisting of a variety of techniques including:

• Twelve focus groups to determine current barriers in the community and to identify patterns, trends, and opportunities for improvement

• A social network analysis to depict the flow of transitions among providers in the community

• Medicare claims data analysis to determine the community definition, the population size and characteristics, health care system interactions, key outcomes, like 30-day readmission and death, and populations at risk

• Medical records reviews at the hospitals, home health agencies, and other organizations to review randomly sampled 30-day readmissions and 30-day admissions

• Readmission tracers to review discharge and admission processes

(Cont’d, See Implementing Interventions, page 9)
‘CCME Really Helped Us’  
(Continued from page 3)

making efforts to use consistent assignment with patients so they see the same provider during each visit.

“This helps with building trust, keeping a thorough medical history, and consistent medication management,” Dr. Duffey said.

CCME conducted a second process mapping exercise in March 2012 to determine if the new model was effective and if the new patient visit time slots were sufficient. Partington said, “We found that the process was stable and the patient flow was effective.”

Based on conversations during the monthly meetings with CCME, Duffey and her team discussed ways they could further improve efficiency in the clinic. They decided to create a schedule assigning one of the pharmacists to be the administrative pharmacist. The new position rotates among the three full-time pharmacists, allowing the other two to see patients without interruptions. The administrative pharmacist does not have a dedicated assignment, allowing her to respond to emails and phone calls from patients, make home health referrals, address staff issues and questions, and see walk-in patients.

“Creating the administrative pharmacist role was the real kicker. It decreased interruptions and improved our efficiency,” Dr. Duffey said. “CCME really helped us evaluate our processes. We were already monitoring adverse drug events but we had not thought about conducting an RCA or a patient survey before and we didn’t think it was something that would be useful, but it was a huge help. It helped us improve our quality and collect data differently.”

The next steps for the Mission Outpatient Clinic are to conduct a second patient satisfaction survey to measure against the baseline survey now that the transition is completed. They are also looking at ways to grow the clinic.

“Mission is doing great work,” said Partington, “They were able to strategize and reorganize to improve their model and maintain a stable and efficient process.” For more information, contact Jeana Partington at 919-461-5660 or jpartington@thecarolinascener.org.

Partnership  
(Continued from page 5)

tation South Carolina for success in improving health outcomes and building a stronger health care workforce in the outpatient setting.”

SCPHCA’s annual clinical network retreat in June kicked off the first face-to-face LAN event and provided education for approximately 150 health care professionals working in the primary care setting. The conference focused on cardiac health, care transitions, and evidence-based care. In early 2013, SCPHCA will hold a statewide conference on PCMH and meaningful use. The statewide conference will be open to federally-qualified health centers, rural health centers, and private practices, promoting an “all teach-all learn” environment.

Darius Jones, MA, NCC, LPC, care improvement specialist at CCME, said the LAN is comprised of more than REC offices located throughout South Carolina. “When I consult with our REC offices, the topic of patient-centered medical homes frequently comes up during conversations,” he said. “Working with the SCPHCA on these types of innovative initiatives is a true testament of our ongoing collaboration and partnerships that have been strategically forged to improve primary care.”

For more information about CCME’s population health program, visit www.ccmemedicare.org/PH.
‘It Takes a Village’
(Continued from page 2)

care setting to home, which ultimately results in a better control of symptoms and a greater sense of support and well-being.”

Grey said GHS has implemented the following multi-dimensional approaches to improving care transitions:

• Transitional care coordinators (TCC) identify the patients who are high risk for readmission based on diagnosis of heart failure, pneumonia, chronic obstructive pulmonary disease, and acute myocardial infarction. The coordinators visit the patient in the acute setting to provide disease-specific education using “teach-back” methodology.

• During this initial visit, the TCCs identify barriers to a successful transition; these are often related to transportation, medication costs, access to primary care providers, and caregiver support systems. Based on this assessment, the recommendation is made for post-acute services in a skilled nursing facility (SNF), home health agency (HHA), hospice, or with a health coach.

• For those patients who are eligible for SNF, HHA, or hospice services, a standardized communication tool developed though a collaboration of extended care providers will be used by these care providers to notify a TCC when a patient is subsequently discharged from their services. Upon notification that post-acute services have concluded, the TCC initiates a post-discharge phone call to the patient and, if needed, will deploy a health coach.

• When a patient does not qualify for SNF, HHA, or hospice, the TCC enrolls the patient in the health coach program and a consent form is signed. A volunteer health coach is then deployed by the Neighbor-to-Neighbor Volunteer program and the TCC coordinates an introductory visit in the hospital setting, mentoring the health coach for patient specific needs. The health coach can provide transportation, if needed, to home, pharmacy, or physician appointment and is trained to activate the patient with the use of a personal health record. Health coaches are taught a green, yellow, red zone method for identifying concerns related to a change in condition. If a medical concern is identified, the health coach contacts the TCC, who then calls the patient and/or caregiver to further assess the need and provide guidance. In some instances, this involves the TCC contacting the primary care physician or facilitating an immediate office visit.

• The health coach provides three personal visits and 13 follow-up phone calls over a period of five weeks.

• The TCC also notifies the primary care physician when a patient (identified as high risk for readmission) is discharged from the acute care setting. The physician is made aware that the patient was enrolled in the transitional care program, and a copy of the discharge summary is provided.

• All high risk patients receive a post-discharge phone call from the TCC within 72 hours.

“During a patient’s discharge, it is not enough to arrange home health or send a patient to a skilled nursing facility — we must close the loop by following and supporting the patient in the community setting,” Grey said. “Patient activation is key, but must be accompanied by adequate support systems to ensure a successful transition.”

For more information, please contact Theresa Seaberg, program manager of patient safety and care transitions at CCME, at 803-212-7560, or via email at tseaberg@scqio.sdps.org.

Team-Based Approach
(Continued from page 1)

said Wareham. “Using my knowledge to help the patient successfully navigate through the system makes me proud.”

Dr. Kelling’s commitment to quality improvement is evident in his participation in The Carolinas Center for Medical Excellence’s (CCME’s) Cardiac Learning and Action Network.

“This is a never-ending journey; we are not at the end of our process when it comes to patients,” Dr. Kelling said.
Implementing Interventions
(Continued from page 6)

“We conducted a variety of analyses to find out the processes that drive readmissions in the hospital and the community,” Southard said. “We found that the results closely aligned with the three drivers of readmission found in the national pilot project.”

The three drivers of readmission are lack of health care education of patients and families, lack of communication across providers, and lack of standard processes for transferring patients among providers.

“Based on our findings, the community will be able to pinpoint the proper interventions to improve care transitions and reduce hospital readmissions,” Southard said.

Lynn Watkins, MSPT, project coordinator for Forsyth’s Post Acute Services Program, said, “CCME was extremely helpful in guiding us through the RCA process and suggesting methods for gathering the information.”

The information that was uncovered during the RCA will be used to guide the application the community is submitting to be accepted into a formal care transitions program.

Southard said the community was impressed by the depth and breadth of the analysis CCME provided in the RCA. “We had our finger on the pulse for the chief causes of readmission in the community,” she said.

For more information, please contact Karen Southard at 800-682-2650, ext. 5663, or via email at ksouthard@ncqio.sdps.org.