



DSRIP (Delivery System Reform Incentive Payment Program)
Learning Collaborative Presentation

July 9th, 2015

- The only level 1 Trauma in Southern NJ
- 100 outpatient offices throughout the region including Surgical Centers and Urgent Care Centers
- Cooper Health Sciences Campus includes Cooper University Hospital, MD Anderson Cancer Center and Cooper Medical School of Rowan University
- 10 institutes including the Adult Health Institute, Cooper Bone and Joint Institute, Center for Critical Care Services, MD Anderson Cancer Center, Cooper Heart Institute, Cooper Neurological Institute, Center for Population Health, Urban Health Institute, Women' and Children's Institute, and Surgical Specialties Institute



Cooper University Health Care Mission

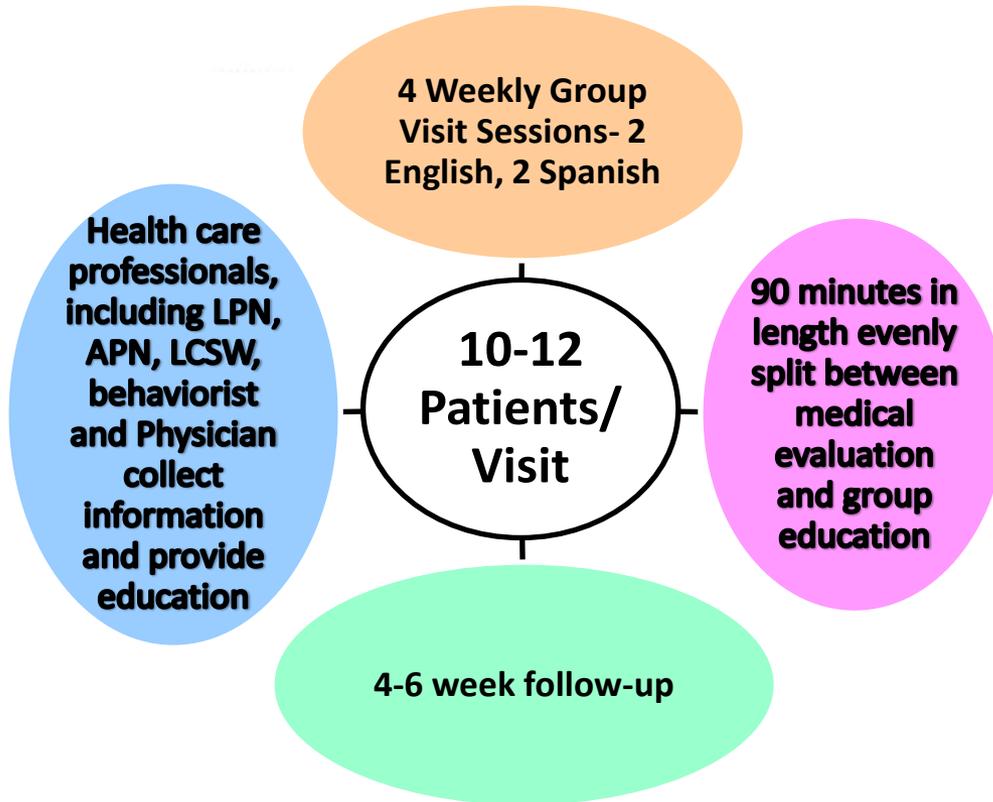
Our mission is to serve, to heal and to educate. We accomplish our mission through innovative and effective systems of care and by bringing people and resources together, creating value for our patients and the community



Cooper's DSRIP Team

- Kathy Stillo, MBA, Executive Director, Urban Health Institute
- Adrienne Elberfeld, MS-OEDC, PMP, Senior Vice President, Quality and Operational Excellence
- Cory Angelini, MBA- Director, Operational Excellence and DSRIP
- Steven Kaufman, MD- Physician Lead
- Stephanie McBeth, MBA- DSRIP Project Manager
- Adam Brooks- Senior Analyst- Informatics
- Kathy Motter- RN, PI Outcomes Manager
- Jill Palmer- BSN, RN, PI Outcomes Manager
- Kathy Zublic- LPN, Care Coordinator
- Partnership with Population Health

Group Visit Pilot Design- August 2014



Group education program

How to manage glucose levels?

Importance of diet and exercise

Impact of consistency on health

Team based approach to diabetic care

Medical team including – physician, nurse practitioner, behavioralist, LPN and medical assistants

Facilitation of peer support

Promote patient-led discussion

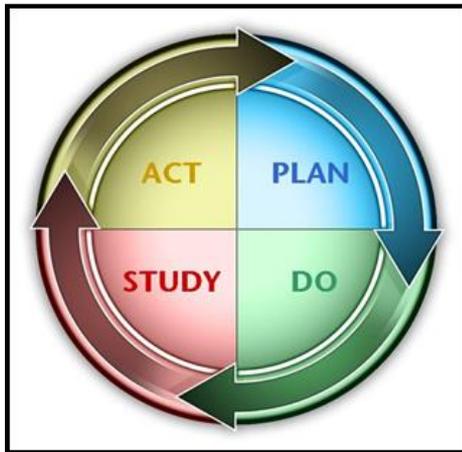
Identify patients that model success

Highlight the challenges group members experience

Group Visit Program Re-Design

Barrier to Care

1. Lack of Patient Engagement (ongoing since DY3Q3)
2. Duration too long (DY3Q2)
3. Group Visit Work Flow

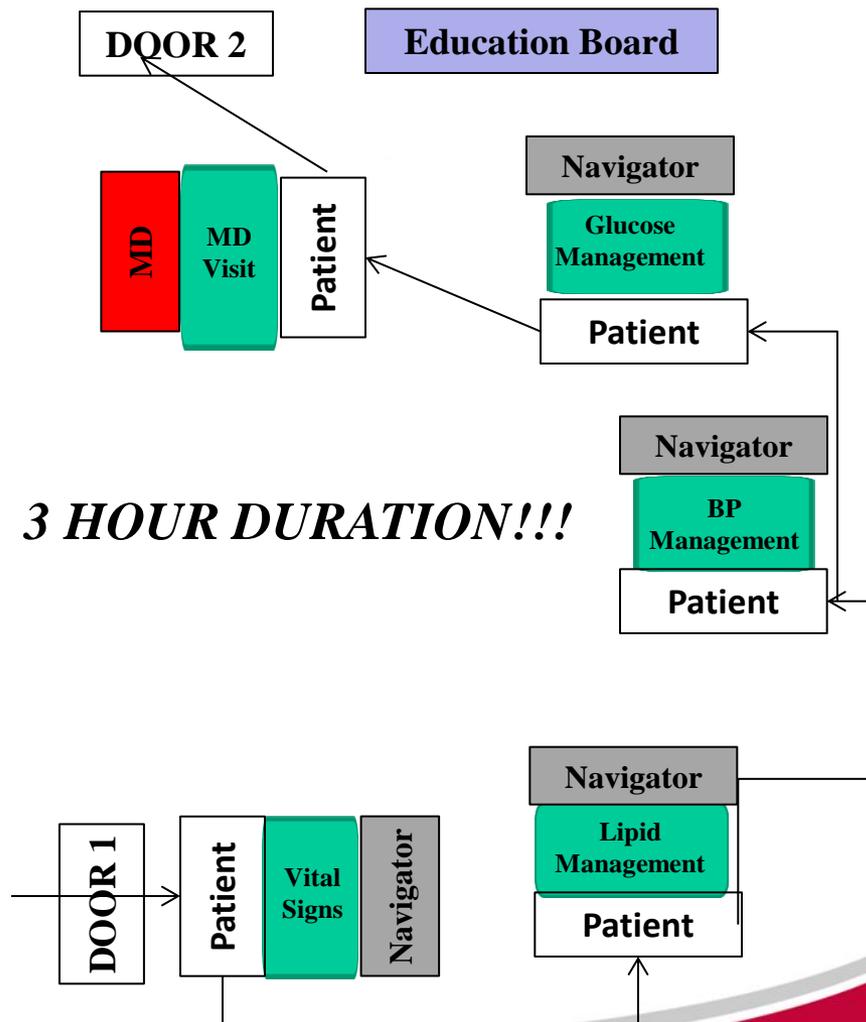


Process Improvement

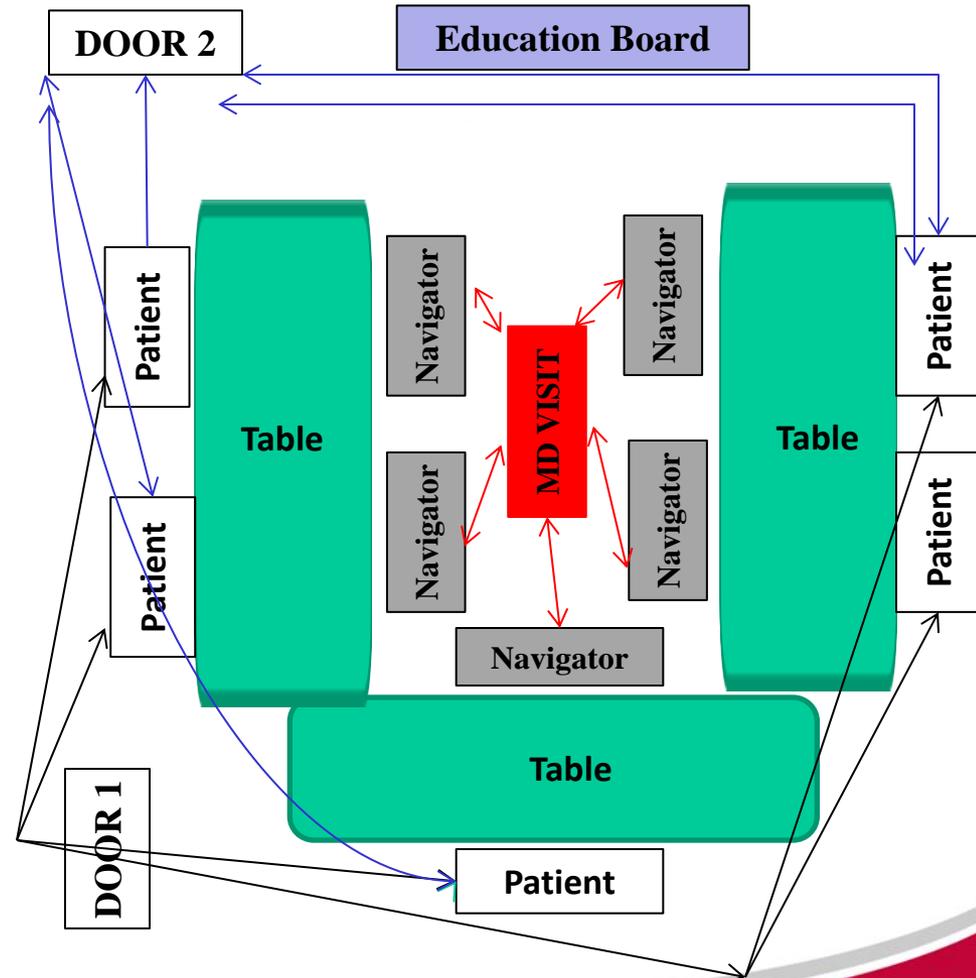
1. Attribution panel received early 2015. Marketing and Care Coordination strategies continue to be discussed to engage DSRIP population. No-show rate 30% at present
2. “Fast-Tracking” process implemented. Patient Satisfaction Survey collection removed from visit process. Current average duration is 91minutes.
3. Patient station model amended to navigation model for workflow improvement

*****Bi-Weekly Group Visit meeting held to discuss barriers and perform PDSA cycles for program improvements*****

Patient Station Model



Navigator Model



- Main focus is now on care coordination.
- Without effective care coordination there will be poor outcomes.
- Where do we begin?



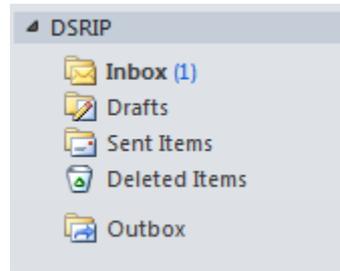
Goals

- To meet the patient's needs while providing quality health care.
- Organize care and share information with all of the patient's care providers to achieve more effective care.
- Decrease ED and in patient visits.
- Patient's care becomes self managed.



Patient Flag

- Attributed diabetic patients that are high utilizers of ED and admissions were flagged within EPIC.
- DSRIP email was set up and a notification is sent to the inbox when the patient is admitted.



 donotreply@cooperhealth.edu 10:31 AM
DSRIP Patient Patient Name: [REDACTED]

Yesterday

 donotreply@cooperhealth.edu Wed 9:34...
DSRIP Patient Patient Name: [REDACTED]

 donotreply@cooperhealth.edu Wed 5:08...
DSRIP Patient Patient Name: [REDACTED]

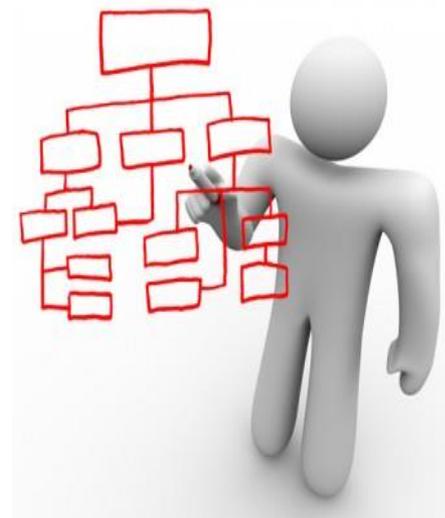
High Touch

- We can meet patient face to face once we receive notification.
- Set up an appointment for the patient to attend the group visit.
- Follow patient once discharged.



Collaboration

- Held a table top discussion with inpatient and outpatient care coordinators, case managers, physicians, etc. from within Cooper to establish a Care Management Process.
- Multiple flow and process issues were identified.
 - No consistent way to notify or track our patients.
 - No consistent soft handoff/transfer of patient or identification of who owns the patient.
 - No standard documentation of notes.
 - Care Coordination templates differ between in/out patient.
 - Epic view for in/out patient – information is different
- Next Steps / Ideas
 - Develop work flows and identify barriers to achieving the work flows.
 - Need work flows for non-Cooper PCP's and Community physicians.
 - Develop and initiate a pilot workflow.
 - Banner or system within Epic to identify patients and owners of those patients.





- Met with Cooper's Center for Population Health and established an AIDET script.

A : Acknowledge

I : Introduce

D : Duration

E : Explain

T : Thank You

- This will be used by Care Coordinators when meeting patients for the first time.

Collaboration

- Cooper hosted a SJLC meeting with the main topic of discussion being care coordination.
- Meeting was attended by: Virtua Health System, Kennedy Health System, Atlanticare, Cape Regional, Lourdes Health System.
- Camden Coalition presented an overview of the HIE.
- Two main actions were initiated :
 - Update list of DSRIP contacts from each health system.
 - Update list of resources- collaboration with South Jersey Learning Collaborative members to identify reliable resources within the community to be utilized for care coordination.

