Care Coordination at Frederick Regional Health System

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About the Health System

- 258 Licensed acute beds
- Approximately 70,000 ED visits annually
- Single acute provider in the county – strong community support
- Physician Practice Organization – including PCMH practice
- MSSP ACO Application approved, start date of January 1, 2015
- 3 Immediate Care locations
- Home Health Service
- Hospice and Palliative Care Services
  - Residential Hospice House
- Several Ambulatory services in geographically diverse areas of the county
- Hospitals provide inpatient care for approximately 90% of hospitalized patients
- Numerous large unaffiliated/employed provider groups in the county

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The Journey to Redefine Care Management

- FMH Project Discharge – Multi-Agency/Disciplinary Team formed in July 2010
  - Project RED
  - Project BOOST
  - Care Transitions – Coleman Model
- Conducted data analysis to understand readmission opportunities
  - Diagnosis
  - Physician
  - Discharge location
  - Payer type
- Launched Heart Failure pilot in May 2011
  - 25% improvement in heart failure readmissions
- Signed ARR agreement in November 2011
- Launched Care Transitions program in August 2012

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Care Coordination Team

- Hospital Based
  - Medical Director
  - RNs
  - Social Work
  - Support Staff
- Plan for the Day, The Stay, and beyond
- Comprehensive Screen and Assessment of 100% of patients placed in a bed (regardless of status/behavioral interviewing)
- Resource utilization/management
- Discharge planning and coordination with post acute services
  - Length of stay
  - Avoidable utilization

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Care Transitions Program

- Dedicated team focused on improving patient outcomes across the continuum, focused on:
  - Patient Engagement
  - Health Literacy
  - Medication management
  - Access to care
  - Community Support post discharge
  - Patient Centered Goals of Care
- Focused on the high/rising risk population at the point of entry into the system; or *before*
- Initial patient touch point may be at the bedside, however the majority of interaction happens in the community
  - Home visits
  - Facility visits
  - Physician/provider visits

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Hospital Based Care Management Process

- Pre-Hospital:
  - Proactive monthly meetings with community partners to collaborate on patient care plans
- Emergency Department Intervention:
  - Identification of "high utilizer" population
  - ED Care Plans
  - Revisit/Readmission Interview
  - Preliminary discharge planning assessment
- Day 1 of hospitalization:
  - Use modified LACE tool imbedded in Meditech to screen for care coordination needs, including risk for readmission (completed on all in, obs and SDSS pts)
  - Engage Care Transitions team on high risk patients

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Care Management Process

- Ongoing throughout hospitalization:
  - Comprehensive education re. chronic disease
  - Identification of barriers to compliance
  - Development of Personal Health Record with patient
- Prior to discharge:
  - Ensure patient has a medical home/PCP, if not assist with securing one, or alternative for post discharge follow up:
  - Mission of Mercy, Immediate Care, Primary Care Practices, FMH Bridge Clinic
- Care Transitions team conducts a series of:
  - Follow up phone calls (1 per week for 4 weeks)
  - Home visits
  - Tele monitoring for non-home care patients
  - Support during PCP/Specialist appointments
  - Engagement 30 + days

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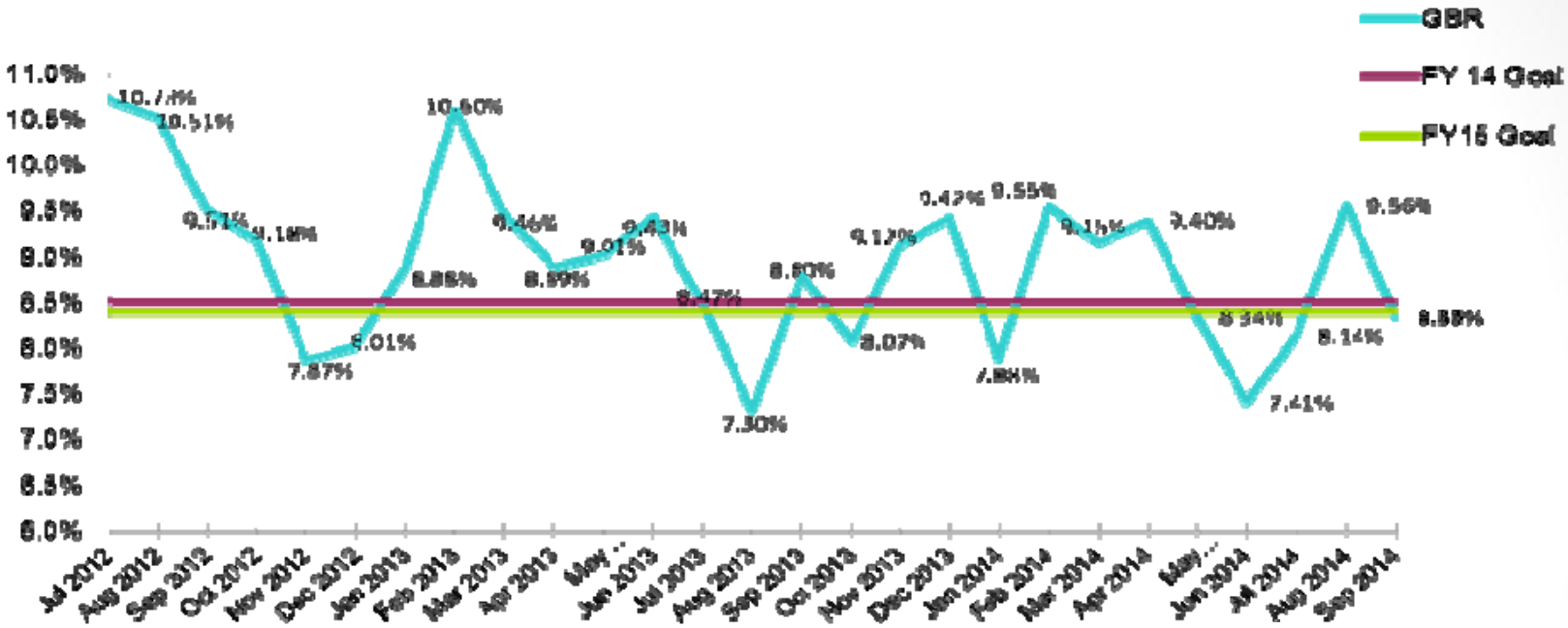
Readmission Trend



- Year to Date .. 8.42% versus a goal of **8.40%**
- Readmissions have dropped 20% overall since the start of the program
- Denominator has changed
  - Absolute #
  - Demographic
- Early efforts provided easier "wins"

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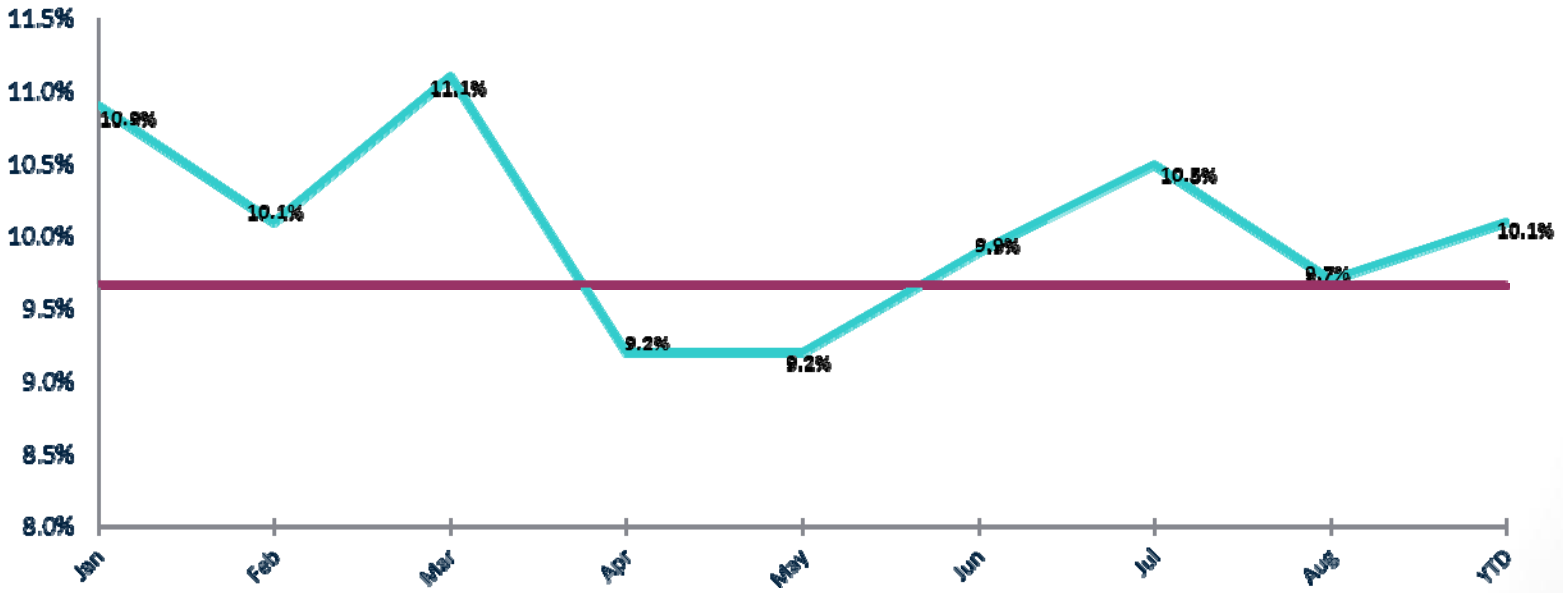
Inter Hospital Readmission Trend

ALL	Jan	Feb	Mar	Apr	May	Jun	July	Aug	YTD	Target
Rate	10.9%	10.1%	11.1%	9.2%	9.3%	9.9%	10.5%	9.7%	10.1%	9.67%



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Mr. G.

- 60 year old male
  - Heart Failure, COPD, End-Stage Renal Disease on dialysis, complicated medication plan
  - Homeless, unemployed, uninsured, poor health literacy, unable to receive dialysis locally due to > $55k in unpaid treatments
- September 2013 – May 2014:
  - 17 ED/ inpatient hospitalizations; > $125,000
- Care Transitions began working with Mr. G in January 2014
  - Met with Care Transitions Pharmacist and Nurse Practitioner in the Bridge Clinic
  - Social work began assisting with applications for housing, insurance options and completing the process to finalize his Green Card application
  - Negotiated with Dialysis to resume treatment; back in care with insurance coverage for treatments
  - Secured primary care provider
- He is still living in and out of homelessness, however:
  - Receives his dialysis treatments regularly
  - Is self managing his meds
  - Is engaged in self management and taking ownership for his choices
  - 2 ED visits since May 2014 and no hospitalizations

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Understanding why patients are readmitted

FY 2015 (July 2014-June 2015)	Jul	#	Aug	#	Sep	#	Oct	#	Nov	#	Dec	#	Jan	#	Feb	#	Mar	#	Apr	#	May	#	Jun	#	FY2015	#
Got Sicker	79.31%	23	92.86%	13	65.85%	27																			**75.00%**	**63**
New Illness	13.79%	4	7.14%	1	24.39%	10																			**17.86%**	**15**
Sent by Home Health Nurse	0.00%	0	0.00%	0	2.44%	1																			**1.19%**	**1**
Couldn't afford care	0.00%	0	0.00%	0	0.00%	0																			**0.00%**	**0**
Unable to follow instructions	0.00%	0	0.00%	0	0.00%	0																			**0.00%**	**0**
Not able to care for self	6.90%	2	0.00%	0	4.88%	2																			**4.76%**	**4**
Did not fill Rxs	0.00%	0	0.00%	0	2.44%	1																			**1.19%**	**1**
Did not go to F/U appt	0.00%	0	0.00%	0	0.00%	0																			**0.00%**	**0**
Need NH/AL placement	0.00%	0	0.00%	0	0.00%	0																			**0.00%**	**0**
Total		29		14		41																				**84**

- Social Determinates of Health
  - Environment
  - Housing
  - Marital status
  - Biology and Genetics (gender, race, ethnicity)
  - Employment / income
  - Personal Choices/Preferences
  - Access and affordability of quality healthcare

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Ongoing Identification of Priorities

- Monthly Care Transitions Operations Meeting
  - Multidisciplinary and Multi Agency
    - Hospital EMR Data
    - CRISP Reports
      - Prevention Quality Indicators
      - Potentially Avoidable Utilization
    - Readmission RCA's
    - Utilization by zip code to identify undeserved areas
- Creation of Task Force type groups
- Frederick Integrated Healthcare Network Care Management partnership

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Collaboration with Skilled Facilities

- Post Acute/Skilled Facilities:
  - Disease specific programs – development of consistent treatment protocols and education materials
  - Facility based providers; SNFist
    - Admission assessment
    - Triage prior to transfer to Ed
  - Post Acute Hi Value Dashboard and preferred provider partnerships
  - Care Transitions team engagement at the facility and at the time of discharge home
  - Care Transition Pharmacist ensures med reconciliation is complete across settings
  - Direct admission to SNF from home – hospital contract
  - Discharge Checklist
    - Medications
    - Appointments
    - Home care

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Community and Provider Partnerships

- Collaboration with practice based care managers
- Breathing Clinic – partnership with Pulmonology Group
- Way Station Inc.
  - CNS Notifications thru CRISP
  - ED High Utilizer Care Plans
  - Health Home Pilot partnership
  - Monthly operations meeting
- Davita Dialysis Center
- Walgreens (healthsystem and SNF)
- Department of Aging/Health Department - transportation
- Home Care agencies
- Private Duty/Personal Care Agencies
- Assisted Living Communities
- Colleges and Universities
- Bridges Program
- Chamber of Commerce

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Short-term Focused Priorities

- Care Transitions RN dedicated to post dc follow up:
  - Medicare patients
  - High Opportunity PCPs
  - Heart Failure and COPD
  - Surgical practice education and collaboration re. alternatives to ED
  - Increased tele-monitoring use (non-home care)
  - High risk/high utilizer employees
  - Peds ED high utilizers
- Community based behavioral health follow up:
  - LCSW-C follow up, coordination, intervention, removal of barriers to patient engagement
- Follow all Acute to Acute Transfers for follow up post discharge
- Heart Failure Task Force – Back to Basics

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Next Steps for the Program

- Ensure teams are working at the top of licensure
- Development of a "Community Health Workers" workforce
- Advance Care Planning:
  - The Conversation Project Kick of on April 16, 2015
- Post Acute Preferred Provider Agreements
- Feasibility of a multidisciplinary, chronic disease, primary care clinic
- Integration with PCP offices without care management
- ACO Care Management, expanded integration with provider practices
- Strategy to address underserved areas in the county (based on ED utilization)
- Bridges Program – Building Medical Religious Partnerships
- Engagement with Latino community, particularly blood pressure screening events – connection to a medical home
- Exploration of "risk-sharing" type partnerships

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Challenges/Barriers

- Health System:
  - Taking on role outside of traditional healthcare "Social Determinates of Health"
  - Paradigm shift
  - Access to data / needs assessment outside of the health system
  - Maintaining clear focus on priorities
  - Lack of integrated IT system with post acute/ community providers
- Community Partners
  - Competing priorities for resources
  - SNF Consolidated Billing
  - 3 Day hospitalization requirement
  - Medicare coverage for SNF – 20 Days at 100%
- Providers
  - Malpractice concerns/defensive medicine
  - Payment misaligned with hospital
  - Alignment of goals and priorities
- Patient/Support networks:
  - ACA and Medicaid expansion has increased the number of insured individuals, however insurance does not = access
  - Engagement of consumers/patients/support systems
  - End of life/Advanced care planning

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Commitment, Cooperation and Partnership

- Investment and commitment from Health System Board of Directors
- Executive Commitment
- Engagement of the community to improve overall health status and access to high quality services
- Spirit of partnership and collaboration
- Earnest participation on focused projects
- Patient stories
- Enthusiasm

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