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
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
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
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
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
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
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”
# Inter Hospital Readmission Trend

<table>
<thead>
<tr>
<th>ALL</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>July</th>
<th>Aug</th>
<th>YTD</th>
<th>Target</th>
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<tbody>
<tr>
<td>Rate</td>
<td>10.9%</td>
<td>10.1%</td>
<td>11.1%</td>
<td>9.2%</td>
<td>9.3%</td>
<td>9.9%</td>
<td>10.5%</td>
<td>9.7%</td>
<td>10.1%</td>
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![Inter Hospital Readmission Trend Chart](chart.png)
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
Understanding why patients are readmitted

- 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

<table>
<thead>
<tr>
<th>FY 2015 (July 2014-June 2015)</th>
<th>Jul #</th>
<th>Aug #</th>
<th>Sep #</th>
<th>Oct #</th>
<th>Nov #</th>
<th>Dec #</th>
<th>Jan #</th>
<th>Feb #</th>
<th>Mar #</th>
<th>Apr #</th>
<th>May #</th>
<th>Jun #</th>
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<td>79.31%</td>
<td>13</td>
<td>92.86%</td>
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<td>New Illness</td>
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<td>Sent by Home Health Nurse</td>
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<td>0</td>
<td>0.00%</td>
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<td>0.00%</td>
<td>0</td>
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<td>Couldn't afford care</td>
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<td>Not able to care for self</td>
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<td>4.88%</td>
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<td>0</td>
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<td>1</td>
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<td>0.00%</td>
<td>0</td>
<td>2.44%</td>
<td>1</td>
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<tr>
<td>Did not go to F/U appt</td>
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<td>0.00%</td>
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<td>Need NH/AL placement</td>
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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
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
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
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
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
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
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