Care Coordination

Presented by: Afryea L. Brown, RN, MSW

Director of Outcomes Management and Social Work

Care Coordination: A Vital Component

- Prior to the Admission Readmission Revenue (ARR) and Global Budget Revenue (GBR) models, acute care and Emergency Room visits served as the cornerstones of our healthcare continuum.
- Currently, they are just two components of the entire continuum of care.
- An emphasis on pre and post-acute care has made ***effective*** Care Coordination a top priority.

Current State of Care Coordination

- Multiple initiatives within the organization.
  - Peer Recovery Coaches in the ED
  - Health Enterprise Zone
  - Outcomes Management and Social Work
  - Behavioral Health Programs and Services
- Established relationships with internal and external care providers throughout the area.
  - The Coordinating Center
  - Bon Secours Homeless Outreach Program
  - Transitional Housing Providers
  - Home Health Agencies
  - Skilled Nursing Facilities
  - Baltimore City's Area Agency on Aging

Current State of Care Coordination

- Ambulatory Care Collaboration
  - Our Good Help ACO patients are flagged in EPIC.
  - Our clinics will provide follow up care for uninsured patients and patients whose PCPs are not available within 7-10 days of discharge.
  - Educate unaffiliated clinics about our programs and services and vice versa.
- University of Maryland Midtown Collaboration
  - CRISP alerts
  - Care Transition Teams were introduced.
  - Information sharing among both groups as needed.

Ongoing Challenges

- Addressing frequent users of hospital services with behavioral health and/or substance abuse issues.
- Finding cost effective ways to address social determinants of health.
  - Barriers identified but now what?
- Length of stay reduction.
  - To keep or not to keep?
- Doing more with less!
  - Is it feasible for us to cross train select disciplines to fill care coordination gaps?

Identified Areas of Opportunity

- Providing continuous physician, staff, and community education.
- Educating patients/families on services available; and, most importantly, explaining how they can benefit from those services.
- Focusing on unnecessary utilization and appropriateness of admissions.
- Improving our effective handoff and communication internally.

Desired Future State of Care Coordination

- To identify and establish a care coordination model to monitor and manage the care of our high risk patients.
  - Examine the current structures and processes that will allow the organization to address current healthcare demands.
- Improve overall cost of care, outcomes, and patient experience.
  - Allocate resources to identified areas of focus to build a sustainable infrastructure.
- Create Care Plans in EPIC for high utilizers.
  - At Bon Secours, it starts in the Emergency Room.
- Expansion and integration of the EMR to include key service lines (e.g. Behavioral Health) for increased continuity and coordination.
- Continue to develop non traditional pathways to address the needs of our patients.

Thank you!