Howard County Community Care Team

Maura J. Rossman, MD, Howard County Health Officer
Steven C. Snelgrove, President, Howard County General Hospital

HSCRC Care Coordination Workgroup Presentation

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Community Integrated Medical Home (CIMH)

- Collaborative relationship among The Horizon Foundation, Howard County Health Department, Healthy Howard, and Howard County General Hospital

- Utilizes population health strategies to decrease preventable hospital readmissions

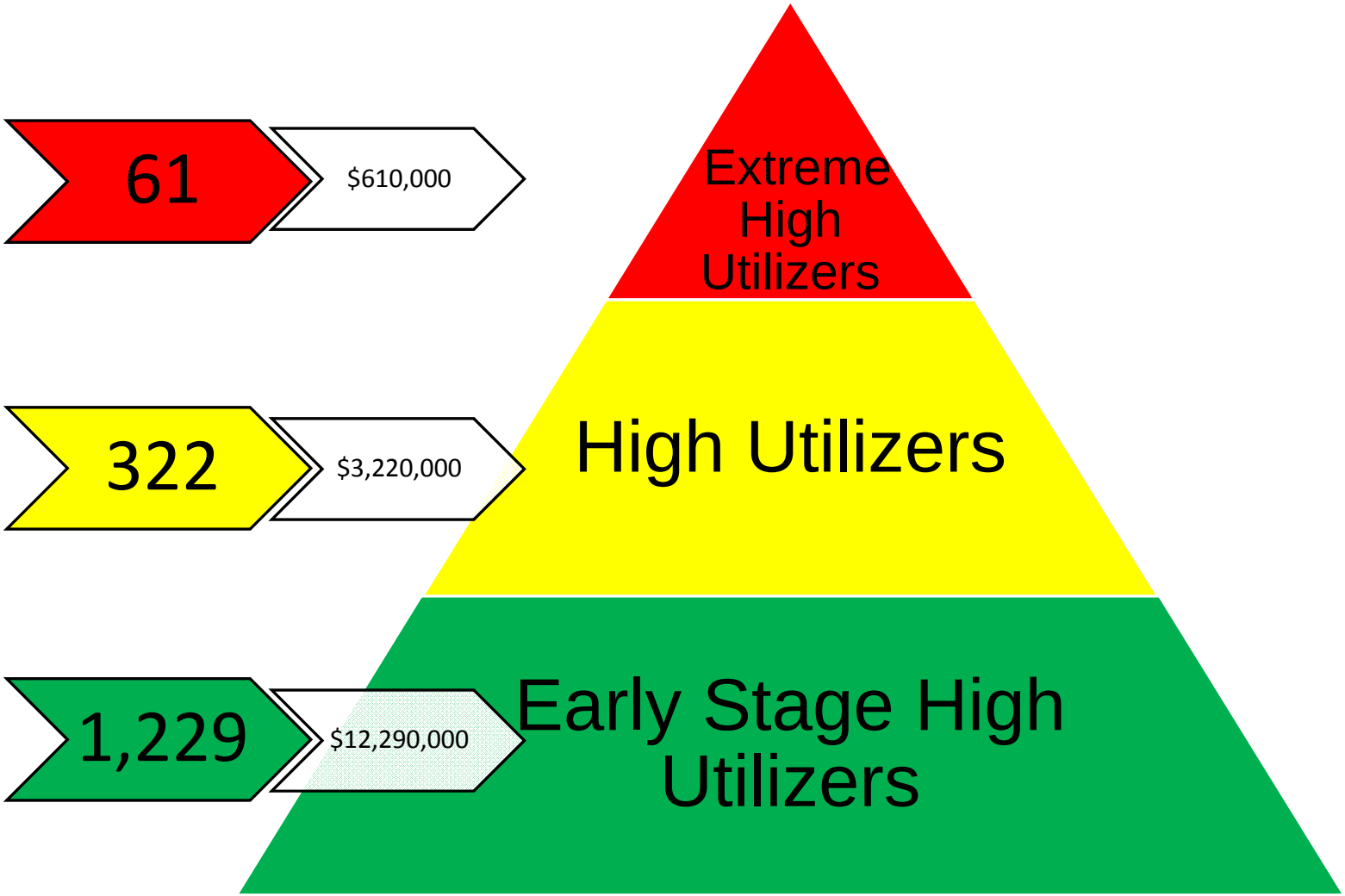
- Based on principles of the State Innovation Model (SIM) program

- Three essential components:
  1. Strategic use of data
  2. **Community Care Team**
  3. Transforming primary care practices

Hospital Utilization Analysis

	Year	Early Stage High Utilizers	High Utilizers	Extreme High Utilizers
Median IP Visits (year)	2012	2	3	6
Median ED Visits (year)	2012	1	2	4
Unique Patients	2012	1,229	322	61
Total Charges	2012	$29,330,377	$15,541,161	$4,591,567
% of Total Unique Patients	2012	3.18%	0.83%	0.16%
Charges (% Total)	2012	19.28%	10.21%	3.02%
Median Total Charges Per Patient	2012	$18,761	$38,466	$69,214
% ED Avoidable	2012	5%	6%	8%
% ED Mental Health/Substance Use	2012	23%	33%	54%
% IP 0-60 Day Readmissions	2012	29%	48%	67%

Potential Savings



Role of Community Care Team (CCT)

Goal

- To reduce unnecessary hospitalizations among Howard County's high-utilizers by delivering cost-effective community interventions

Rationale

- Costs to treat high-utilizers represent a disproportionate amount of the County's health care costs
- Patients who are connected with primary care receive better coordinated care
- Closing the communication gap between hospital and outpatient providers leads to less fragmented care

CCT Intervention

- Provide hands-on transitional care coordination at time of discharge
- Connect clients with primary care and other health care providers
- Provide in-home medication reconciliation and chronic disease management education
- Coordinate transportation to and from appointments as needed
- Connect with community services and assist with other social service needs
- Facilitate client's ability to manage their own health conditions

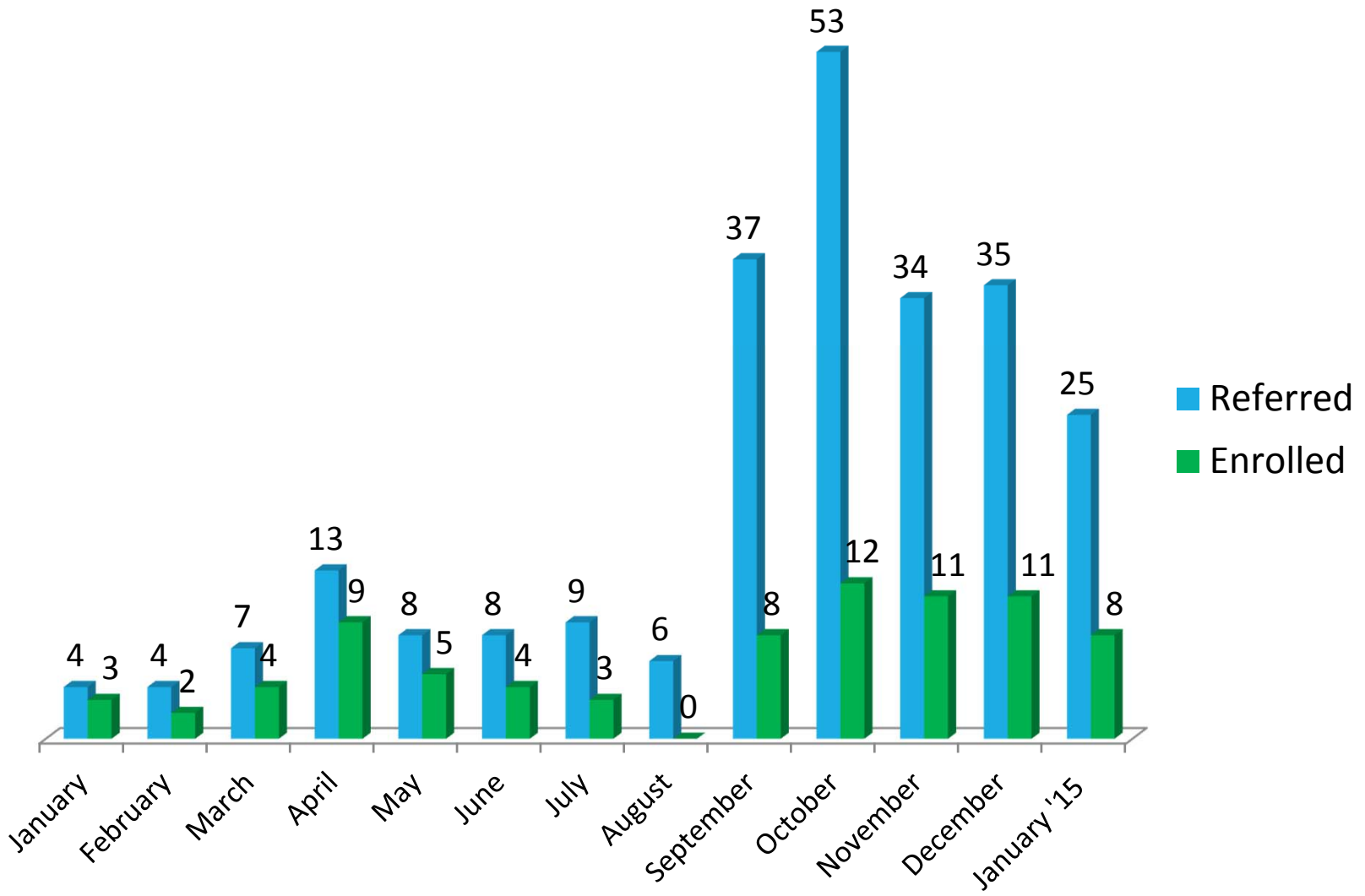
Role of Howard County General Hospital

- Provides hospital admission and discharge data to CCT.

- Generates daily reports using its electronic health record (EHR). Reports identify patients with two or more inpatient admissions / observation stays within the past year.

- Case managers are sent EHR reports and review the patient's medical record to assess and confirm patient eligibility criteria. Case managers refer eligible patients to the CCT.

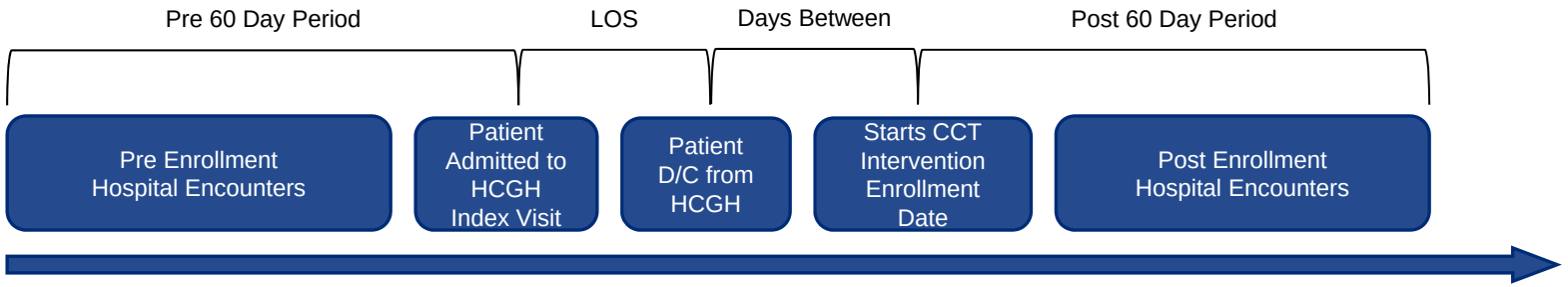
CCT Number of Referrals and Enrollees by Month



CCT Outcomes (N=83): Process Metrics

Metric	Percent	Goal
Clients with a Care Plan Created at First Home Visit	94%	100%
Clients with an Initial PCP Visit within 7 days of Hospital Discharge	39%	30%
Clients with an Initial Home Visit within Three Days Post-Discharge	45%	60%
Clients Successfully Graduating	82%	70%
Metric	**Average Time**	**Goal**
Average Number of Days until Graduation	80 days	90 days

CCT Outcomes: Pre-Post Intervention



Inpatient Admissions: Pre / Post 60 Day Analysis (N=49)

Parameter	*Pre Enrollment*	*Post Enrollment*
Number of Inpatient Admissions	33	18
Number of Inpatient Hospital Days	259	133
Average Length of Stay (days)	7.9	7.4
Observation Stays		
Number of Observation Stays	7	4
Number of Observation Days	16	12
Average Length of Stay (days)	2.3	3.0
Emergency Department (ED) Visits		
Number of ED Visits	18	9
Total Hospital Encounters		
Total Number of Hospital Encounters	58	31

CCT Successes and Lessons Learned

- Developed relationships to coordinate complex program
- Built trust and received input from community stakeholders
- Created a means to access hospital data (Epic CareLink)
- Use of technology to receive referrals and follow clients post intervention (Real-time CRISP notifications for enrolled clients); Track Via database to collect and analyze program data
- Evaluation built in from the outset
- Flexibility among partners to adapt the pilot as lessons are learned
- Data sharing is complex and report / CRISP capabilities are limited
- Culture change for hospital staff to understand the concept of population health management
- Approximately 55% of eligible patients decline CCT services

CCT-HCGH "*Continuous Improvement*"

4 South Pilot with Director of Social Work

- Patients are introduced to the CCT by HCGH Director of Social Work. Data tracking / "warm referral" to the CCT.

4 Pavilion Multidisciplinary Rounds

- Restructured clinical rounds on 4P medical-surgical unit. To reduce readmissions, the CCT will become a tool for the team when determining discharge planning.

Data Analyses

- HCGH is working with CCT members to better understand readmission patterns and to optimize CCT and Healthy Howard resources.

Care at Hands

- Use of mobile application to better assess the needs of CCT enrollees.