Maryland Care Transitions Steering Committee

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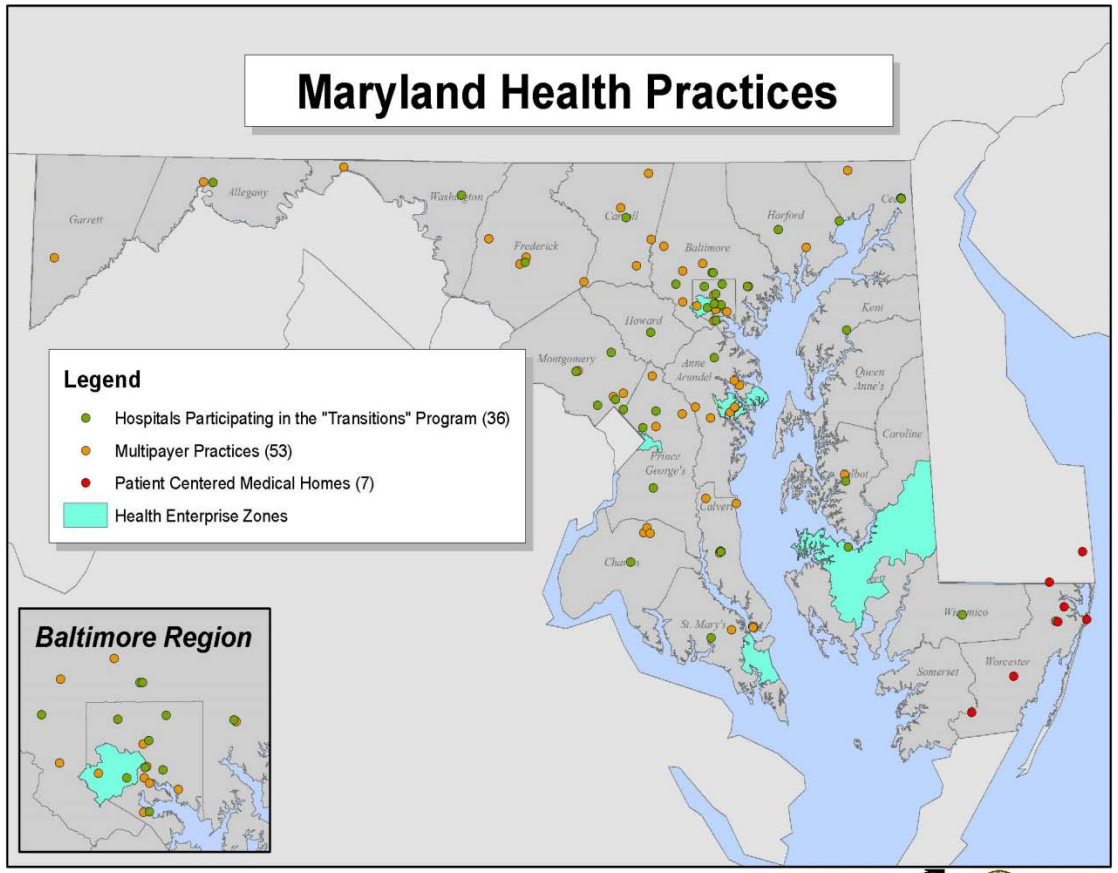
Collaboration at Two Levels

- Local Level
  - ➢Hospitals work with cross continuum teams to improve care transitions and reduce readmissions
- State Level
  - ➢Steering Committee to provide visibility and mobilize solutions to common systemic challenges

Reducing readmissions and improving care across settings involves

IMPROVING CARE

- Within settings
- Between settings
- Across numerous settings, over time
- Within disciplines
- Among disciplines
- Across clinical and non-clinical boundaries



Source: Maryland Hospital Association
June 2013

CHRC

Partners Preventing Avoidable Readmissions

Steering Committee Representation

Care Transitions Steering Committee Goals

Reduce Readmissions (10 percent, across payers, across hospitals)

Increase:

- Cross-continuum partnerships at local level
- Association and organizational partnerships at state level
- Education and training opportunities for clinical and service providers
- Use of the health information exchange

Steering Committee Dashboard

Care Transitions Steering Committee Goals

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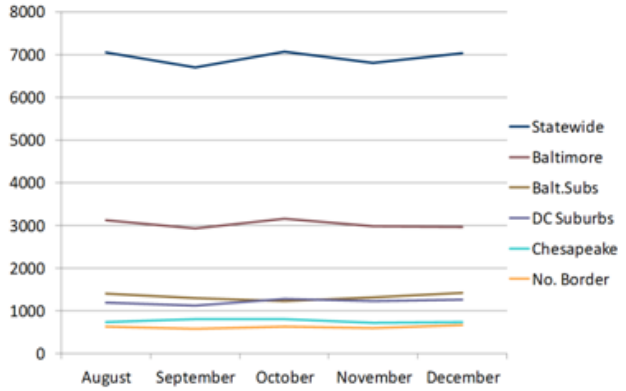
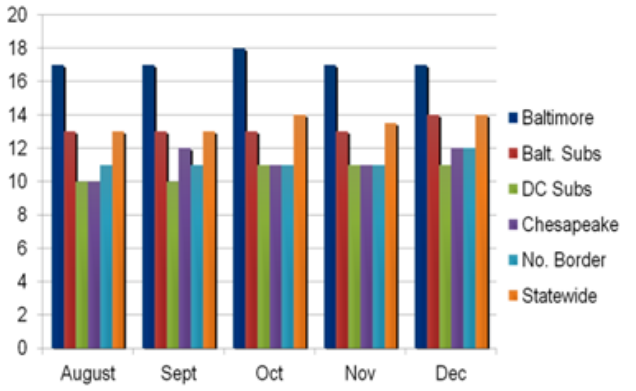
Number of Readmissions by Region

August – December 2013



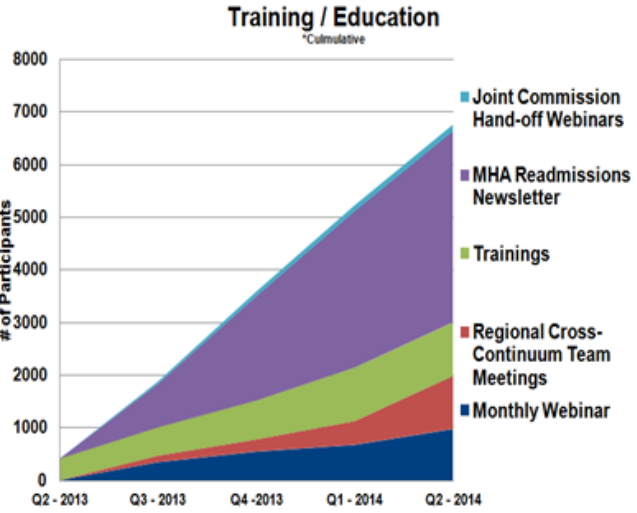
Readmission Rates by Region

August – December 2013

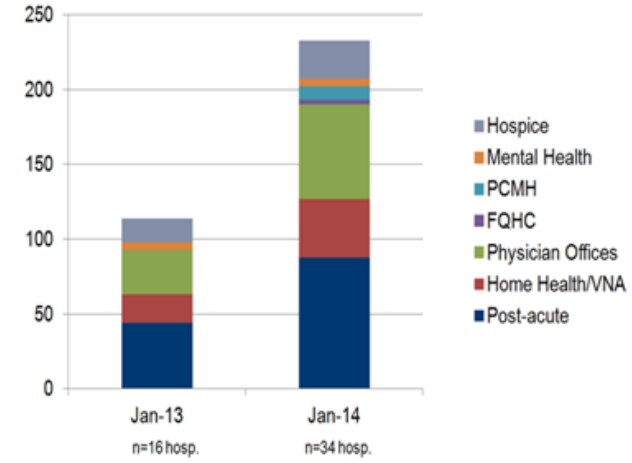


Points of Education and Collaboration

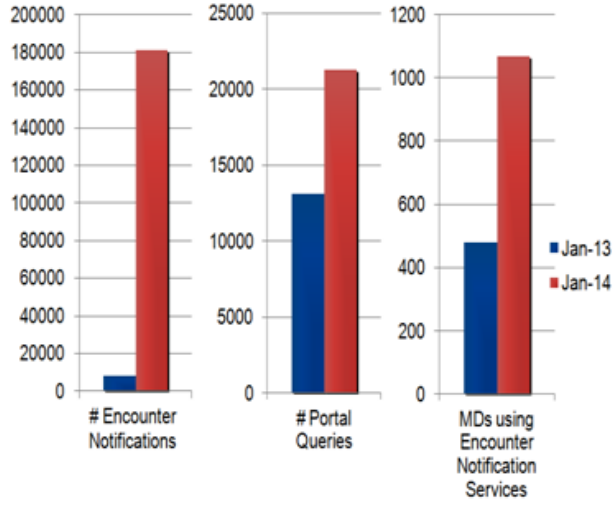
March 2013 – March 2014



Cross-Continuum Team Representation



CRISP Utilization



Readmission Calculation Source: CRISP.

Note: Includes all-cause readmissions to any Maryland Hospital.

Hospitals by Region

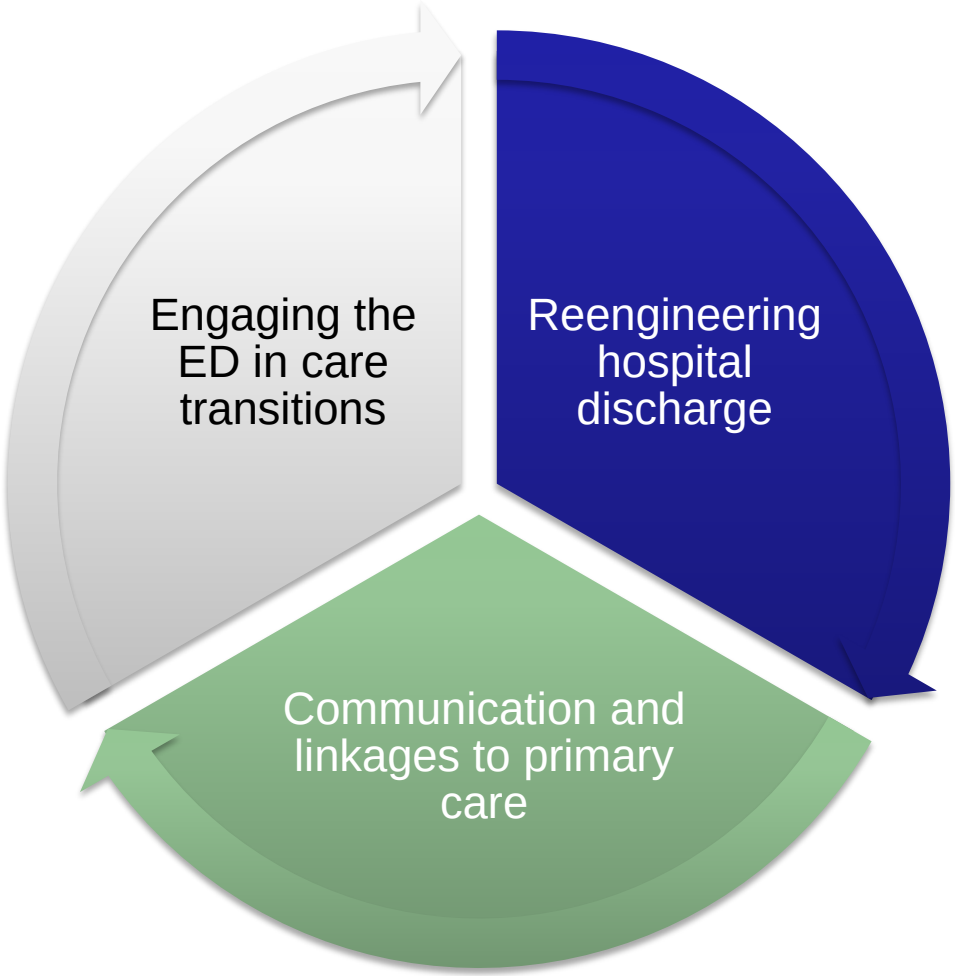
Baltimore City	Baltimore Suburbs	DC Suburbs	Chesapeake	Northern Border
HOSPITALS	HOSPITALs	HOSPITALS	HOSPITALS:	HOSPITALs
Bon Secours Good Samaritan Harbor Hospital Kernan Hospital Bayview Johns Hopkins Maryland General Mercy Saint Agnes Sinai Union Memorial UMMC	BWMC Franklin Square GBMC Harford Memorial Howard County Northwest St. Joseph's Upper Chesapeake	Doctors Ft. Washington Holy Cross Laurel Regional MedStar Montgomery Prince George's Shady Grove Southern Maryland Suburban Washington Adventist	Anne Arundel Atlantic General Calvert Memorial Chester River Civista Dorchester General McCready Easton PRMC St.Mary's	Carroll Hospital Frederick Memorial Garrett County Meritus Union Hosp. of Cecil Western Maryland

Source: CRISP

MHA Care Transitions Sub-Committees

- Hospital Post-Acute Readmissions
- Clinical Leadership
- Regional Cross Continuum Engagement
- Consumer Engagement & Outreach

Clinical Leadership Subcommittee Aims



Partners Preventing Avoidable Readmissions

Reengineering Discharge process

- Identification of High Utilizers
- Care transitions teams are multi-disciplinary and follow patients 30–45 days
- Warm handoffs ‘ideal’ to primary care
- High Utilizers have patterns of behavior that are difficult to change

Primary Care

- ENS inform primary care practices about Admissions/Discharge/Transfer
- Care Coordination CMS codes 99495/99496, reimbursement $160/210
- Open access is essential for high utilizers
- 40-50% no show rates for scheduled follow up visits 7-14 days after discharge

Engaging ED in Care Transitions

- 1st visit after Hospital Discharge is a critical visit for another level of intervention
- VHR/CRISP Portal availability to all EDs
- Availability of open access in nearby primary care for patients without PCP
- Easy communication with patients' PCP
- Ambulatory sensitive conditions

Summary Goals: Seamless Care Transitions

Revisit Hospital Discharge Process

Comprehensive Primary Care

Optimal Emergency Department Utilization

Patient Centered Care Transitions supported by HIT and Care Coordination