Care Coordination Across the Healthcare Continuum: Journey to Integration
The project described was supported by Funding Opportunity Number CMS-1C1-12-0001 from Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation.

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Old Approach

• Focus is on the high risk patient
• Episodic acute care is the priority
• Health care professionals work in isolation
• Care planning is conceptual and siloed
• Provider infrastructure is fragmented and information systems are not integrated
• Patient and families minimally included in decision making

New Approach

• Focus is on care coordination for all patients
• **Continuity and transitions** of care across the continuum is the priority
• Collaboration among health care team members is required
• Care planning is aggressive, results oriented & prevention is important
• Provider infrastructure is fully integrated
• Emphasis on Patient/Family centered care
• Build on existing programs. Over 200 people involved.
• Will transform patient care across continuum: clinics, SNFs hospitals, home, and EDs.
• Catalyzed by a three-year CMS grant of $19.9M.
• East Baltimore Community – 7 zip codes.
Who will J-CHiP “Touch”?  

- Up to **40,000 adult annual discharges** from JHH/JHBMC by year 3. **1000s** of ED visits.

- About **7000 adult Medicaid** and **10-14,000 Medicare** patients receiving local community care will be monitored and **3000 targeted**.
  - Mental illness, substance abuse and chronic illness.
**AIMS**

- JHM will improve care coordination for:
  - (a) > 8,000 M/M acute care patients and 1,600 M/M high risk community residents by the end of year 1, and
  - (b) >15,000 M/M acute care patients and 3,000 M/M high risk community residents by the end of year 3.
- JHM will recruit, train, and deploy 25-30 new workers by the end of year 1 and 75-80 new workers by the end of year 3 (along with many additional in-kind hires).
- JHM will reduce direct costs per inpatient by 3-5% for the year post-hospitalization, and will reduce total cost of care for M/M high risk community residents by 8-10% per year and by 15-18% over 3 years.

**PRIMARY DRIVERS**

- Acute care delivery redesign
- Seamless transitions of care
- Deployment of community care teams

**SECONDARY DRIVERS**

- Early and frequent risk screening for complex needs
- Transdisciplinary care planning through daily rounds
- Pharmacist-driven medication management
- Preparation for self-care management through targeted patient/family education
- ED care coordination and use of protocols for common conditions
- Creation of after-hospital personal health plan
- Primary provider handoff and early follow-up
- Moderate and high intense post-acute interventions (Transition Guides, Home Care, Skilled Nursing/Rehab Facilities)
- Patient Access Line (PAL)
- Establish community partnerships
- Predictive modeling to identify patients at high risk for utilization
- Care coordination teams with embedded case managers and behavioral specialists, and community-based community health workers, and volunteers
- Frequent surveillance of patients’ self-management, adherence, barriers to care, and engagement
- Integrated behavioral care based on risk
Community Health Partnership
Hospital/Transitions/ED Component

• Readmission and transition efforts began through JHHS Readmissions Task Force efforts in 2009.
• HSCRC ARR program ➔ New Waiver
• “All Payer.”
Care Coordination “Bundle”

- **ED Care Management**
  - ED Care Protocols
  - Assess Risk and Ease Transition Back to Community

- **Risk screening—Early and periodic**

- **Patient family education**
  - Self-care management
  - Condition-Specific Education Modules
  - “Teach-back”

- **Interdisciplinary care planning**
  - Multidisciplinary team-based rounds: every day, every patient
  - **Mobility initiative**
  - Projected discharge date on every patient
Care Coordination “Bundle”

- **Provider handoffs**
  - Provider communication on admission and DC--iPIPE
  - Discharge summary within 5 days
  - PCP follow-up within 7-14 days

- **Medication Management**
  - “Medications in hand” before discharge
  - Medication reconciliation
  - Pharmacist Education

- **Transitions of Care**
  - Phone calls
  - Home visits (Transition Guide/Pharmacy)

- **PAL Line: Patient “Anytime” Line**
  - Post-discharge phone calls
  - After hours triage system
Community Health Partnership
Care Coordination

Adult Admission

ED Outpatient

Early Risk Screen

Fails Screen or ↑ LOS

In Depth Risk Screen

Follow Up Phone Call
Follow-up Appt
Post Acute Referrals

Moderate Intense Intervention

High Intense Intervention

Transition Guide
Post Acute Referrals
Follow-up Appt

ED Outpatient

Interdis. Care Planning

Education: AHDP

• Red Flags
• Self-Care
• Medications
• Who to call

DC Risk Assessment

Provider Handoff:

• DC Sum
• FU appt

Hospitalization

Personal Coach
Access
Transition
Community Health Partnership

SNF Component

Genesis Heritage
FutureCare Canton Harbor
FutureCare Northpoint
Brintonwoods Post-acute Care Center
Riverview Skilled Nursing Facility

Clinical Protocols-
- CHF, COPD, Discharge

Transition Assessments-
- Admission Nursing & Medicine
- Planned and Unplanned discharge
- Staff Attitudes Surveys
Community Health Partnership
Community Intervention

Target Population
Attend one of the participating clinics within 7 zip codes

1. Member identified to be in the top 20% of people with a high risk of inpatient admission or ED Visit

2. A Clinical Screener will verify eligibility and complete Demographics and Health Status sections of assessment. Assigns to team.

3. Community Health Worker outreaches to identify barriers to getting Healthcare services and schedules follow up with Case Manager.

4. Nurse Case Manager Visit at clinic to complete survey of health and behavioral needs.

5. Visit with PCP and team at clinic to work on a Care Plan to identify goals and health care services needs.

6. Referral to members of the JCHiP Team for self-management education, behavioral support, or specialty care.

7. Ongoing relationship with team members in the clinic and community

GOALS
1. Improved Health care
2. Improved Experience with Healthcare system
3. Reduced Costs of Care
4. Nurse Case Manager
5. Visit with PCP and team at clinic to work on a Care Plan to identify goals and health care services needs.
6. Referral to members of the JCHiP Team for self-management education, behavioral support, or specialty care.
7. Ongoing relationship with team members in the clinic and community
Community Health Partnership

Community Patient Characteristics

High Risk Group = 1000 PPMCO patients

Patient characteristics: Medical and Behavioral Conditions

36% have 6 or more chronic conditions.

Heart disease: 98%
- Conditions
  » Coronary Artery Disease (condition leading to heart attack): 58%
  » Heart Failure: 32%
- Modifiable risk factors
  » Hypertension: 84%
  » Smoking: 71%
  » High Levels of Cholesterol: 52%

Lung disease
- Asthma: 42%
- Emphysema: 29%

Kidney disease: 28%

Substance use
- Smoking: 71%
- Substance abuse: 45%
- Alcohol Abuse: 29%

Diabetes: 49%
JHM Care Management Continuum

Population Health Management

Community & Health System

Complex Episode Across Continuum of Care

Integrated Health System

Episode Clinical Pathway

Pre-Hospital to Post-Acute Hospital

Acute Illness Case Management

Hospital

Primary Prevention

Health Risk Screening • Risk Reduction • Preventive Care

Acute Illness Management

Tertiary Prevention • Appropriate Utilization • Length of Stay • Transitional Care

Health Maintenance

End of Life Care/Palliative Care

Secondary Prevention • Self-Management Support • Quality of Life • Specialty Care

Improved outcomes

Health • Experience • Cost
## JHM Care Management Continuum: Structure, Roles, Processes

<table>
<thead>
<tr>
<th>Structure/Roles</th>
<th>Acute Illness</th>
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<tbody>
<tr>
<td><strong>Scope/ Population</strong> <em>(Who: includes the breadth of the population and the time frame or episode for intervention)</em></td>
<td>• Time limited, • Episodic care management • ED/Admission through discharge and post-acute handoffs</td>
<td>• Time limited intense episodic care management • Home setting • post-acute period (30-60 days)</td>
<td>• No time limit • Continuous case management for high risk • On-going surveillance</td>
</tr>
<tr>
<td><strong>Goals</strong> <em>(for episode and context)</em></td>
<td>• Return to clinical baseline • Utilization (LOS) • Pt/Fam Satisfaction • Safe transitions &amp; handoffs</td>
<td>• Self-care mgmt. and patient activation • Complications prevention and mgmt. • Transition to community</td>
<td>• Primary, secondary and tertiary prevention • Risk reduction • Self-care mgmt. knowledge and support • QOL maintenance</td>
</tr>
<tr>
<td><strong>Site (Where)</strong></td>
<td>• Hospital, ED, Pre-op clinics</td>
<td>• Home • Hotel/shelter, etc. • Acute rehab/SNF</td>
<td>• Medical Home • Specialty care • Home and Community</td>
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*ED = Emergency Department, SNF = Skilled Nursing Facility"
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| **Intensity (What)** | • Clinical Case Mgmt.  
  • Psycho-social, behavioral, economic resources  
  • Protocols/Pathways  
  • Telephonic contact | • Coordination of all post-acute services  
  • Transitions coaching  
  • Skilled home/Hospice care  
  • Acute/Sub Acute rehab | • Monitoring health status changes  
  • High risk Care Mgmt.  
  • Chronic disease mgmt.  
  • Health coaching, lifestyle mgmt. |
| **Roles (Who)** | • Nurse Case Managers (CMs)  
  • PAL CMs  
  • Social Workers  
  • Multi-Disciplinary Team | • Transitions Coaches  
  • Home Care CMs/Field nurses  
  • PT CMs  
  • Community Social Workers  
  • Community CMs | • Community CMs  
  • Health Behaviors Specs  
  • Health Educators  
  • Community Health Workers (CHWs). |
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<td><strong>Complex Case Mgmt.</strong></td>
<td>• All hospitalized and ED pts. Screened (tools and population characteristics</td>
<td>• Pts. identified during acute/or newly identified post acute</td>
<td>• Population risk screens and/or referrals</td>
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<tr>
<td>• Pt. identification/</td>
<td>• Identification based on screening</td>
<td>• Screening by post-acute team</td>
<td>• In-depth assessment of patient needs</td>
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<tr>
<td>• Screening</td>
<td>• Individual assessments with patients/family</td>
<td>• Collaboration with Medical Home/PCPs</td>
<td>• Individualized, interdisciplinary care plan</td>
</tr>
<tr>
<td>• In-depth assessment</td>
<td>• Care Planning and Goals/Collaboration</td>
<td>• Receipt of patients from SNF/Acute Rehab</td>
<td>• Self care mgmt. support</td>
</tr>
<tr>
<td>• Individualized interdisciplinary</td>
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<td></td>
<td>• Community health interventions (social determinants of health)</td>
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<tr>
<td>care/transitions planning</td>
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<tr>
<td>• Communication and collaboration</td>
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<tr>
<td>• Care coordination</td>
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<tr>
<td><strong>Evidenced –based care</strong></td>
<td>• Structured Care Methodologies (orders, protocols, pathways, etc.).</td>
<td>• Continuation of Care plans/guidelines</td>
<td>• Use of population evidenced based guidelines</td>
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<td>• Disease, health behavior protocols</td>
<td>• Screening tools</td>
<td>• SNF, HF and COPD protocols</td>
<td>• Analysis of population data for targeted interventions</td>
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<td>• Risk Stratification</td>
<td>• Triage protocols</td>
<td>• Outcomes mgmt. related to transitions</td>
<td>• Decision support tools</td>
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<td><strong>Patient/Family Engagement</strong></td>
<td>• Assessment: - Healthcare literacy/Activation - Learning needs - Education based on AHRQ pillars - Patients beliefs, values, preferences - Multi-media approaches - Personal Coach support - Modification of care plan based on feedback - HCAHPS, Press Gainey</td>
<td>• Continuous patient/family support through transitions - Facilitation of education plan post-acute (in home environment) - Reevaluation and reprioritization of after-hospital plan - Mitigation of barriers to self-care mgmt.</td>
<td>• Patient access to web-based portal - Medical records access - Principles of Health Literacy Universal Precautions in all communications - CAHPS Surveys - Surveys for patient engagement and care experience (ex. PAM) - Enlistment of “support person” for identified patients (to enact care plan) - Timely response to urgent issues</td>
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| **Care Coordination**  
- Specialty referrals, dx  
- Monitoring of provision of services and barriers  
- Appropriate handoffs to next provider |  
- Communication with provider from source of admission  
- Monitoring of progress toward outcomes  
- Mitigation of barriers  
- Referrals for inpatient services and therapies  
- Enlistment of pt/family preferences for care/transitions plan  
- Resource utilization  
- Development of transitions plan  
- Implement Care Coordination bundle  
- Post-Acute referrals (Community CM, etc.)  
- Communication to post-acute team (EMR) |  
- Transitions teams daily communication with acute care teams for intake  
- Follow-up on post-discharge plan and modifications based on pt. environment  
- Post-acute referrals as indicated (PCP, Community CM, pharmacists, etc.).  
- Plans for return to community based care  
- Documentation in EMR |  
- Population based approach  
- Individualized care plans for at risk patients  
- Interdisciplinary care teams and collaborative processes for resource deployment  
- Use of local HIE, CRISP, real time alerts for admissions, ED visits  
- Collaboration with acute and post acute care teams.  
- Follow up after acute episode (PCP appts.) |


Journey Towards Integration

- Analytic/cost evaluation/data/IT and QI
- Patient and staff education/communication
- Care management efforts/workflows
- Behavioral health integration in inpatient/outpatient settings
- Meaningful community partnerships
- Community and physician advisory boards
- Workforce: pharmacy extenders, CHW, NN, etc.
- Direct referrals/transitions