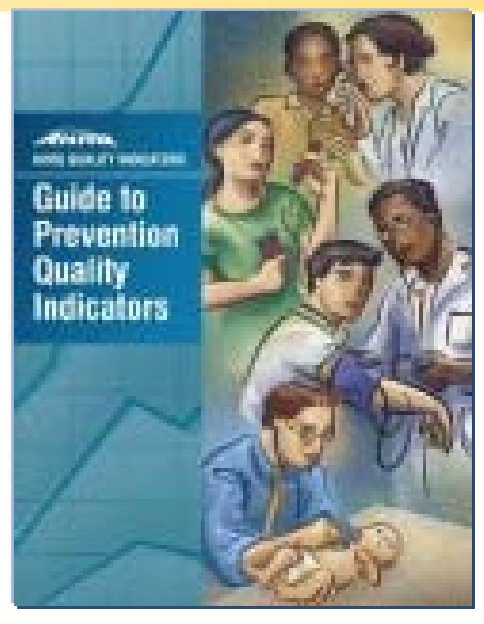


Care Coordination Across the Healthcare Continuum: Journey to Integration

CMS Support

- *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.*
- *Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.*

Patient Care Management Transition: 2014

Old Approach

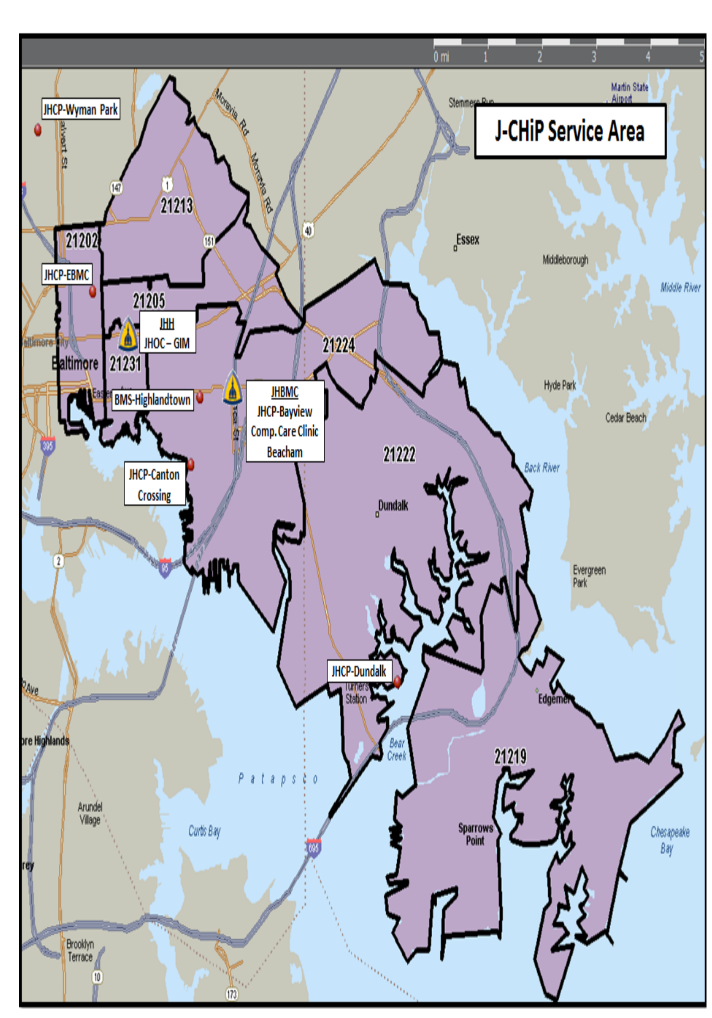
- Focus is on the high risk patient
- Episodic acute care is the priority
- Health care professionals work in isolation
- Care planning is conceptual and siloed
- Provider infrastructure is fragmented and information systems are not integrated
- Patient and families minimally included in decision making

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

Community Health Partnership

- 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

Acute care delivery redesign:
- 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

Seamless transitions of care:
- 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)

Deployment of community care teams:
- 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."

ED Management

Risk Screens

Interdisciplinary Care Planning

Patient/Family Education

Medication Management

Primary Provider Handoff

Transitions of Care

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

ED
Outpatient

In Depth
Risk Screen

Moderate Intense Intervention
- Follow Up Phone Call
- Follow-up Appt
- Post Acute Referrals

High Intense Intervention
- Transition Guide
- Post Acute Referrals
- Follow-up Appt

Fails Screen or ↑ LOS

Early Risk
Screen

Interdis.
Care
Planning

Education: AHDP
- Red Flags
- Self-Care
- Medications
- Who to call

DC Risk
Assessment

Provider Handoff:
- DC Sum
- FU appt

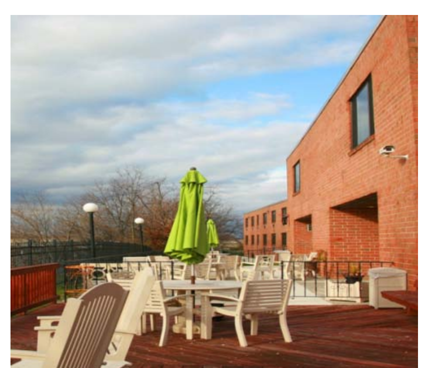
Hospitalization

Adult
Admission

Personal Coach

Access ***Transition***

Community Health Partnership
SNF Component


Genesis Heritage

FutureCare Canton Harbor

FutureCare Northpoint

Clinical Protocols-
- CHF, COPD, Discharge

Brintonwoods Post-acute Care Center

Riverview
Skilled Nursing Facility

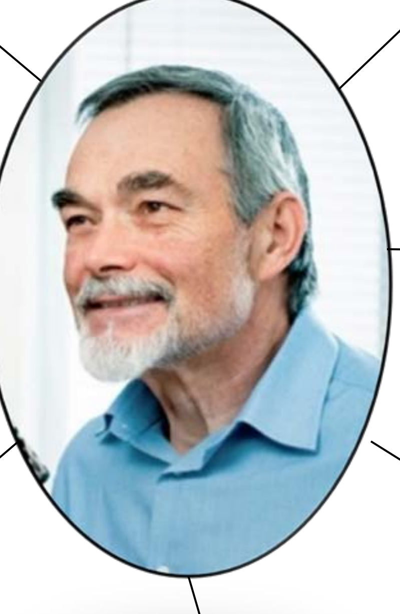
Transition Assessments-
- Admission Nursing & Medicine
- Planned and Unplanned discharge
- Staff Attitudes Surveys

Community Health Partnership
Community Intervention

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

GOALS

1. Improved Health care
2. Improved Experience with Healthcare system
3. Reduced Costs of Care



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

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

Complex Episode Across Continuum of Care

Episode Clinical Pathway

Acute Illness Case Management

Care Coordination

Community & Health System

Integrated Health System

Pre-Hospital to Post-Acute Hospital

Hospital

Primary Prevention

Acute Illness Management

Health Maintenance End of Life Care/Palliative Care

Health Risk Screening

Risk Reduction

Preventive Care

Tertiary Prevention

Appropriate Utilization Length of Stay

Transitional Care

Secondary Prevention

Self-Management Support

Quality of Life

Specialty Care

Improved outcomes

Health · *Experience* · *Cost*

JHM Care Management Continuum: Structure, Roles, Processes

Structure/Roles	Acute Illness	Transitional / In home Care	Community-based Care: Population Health Management
Scope/ Population (Who: includes the breadth of the population and the time frame or episode for intervention)	• Time limited, • Episodic care management • ED/Admission through discharge and post-acute handoffs	• Time limited intense episodic care management • Home setting • post-acute period (30-60 days)	• No time limit • Continuous case management for high risk • On-going surveillance
Goals (for episode and context)	• Return to clinical baseline • Utilization (LOS) • Pt/Fam Satisfaction • Safe transitions & handoffs	• Self-care mgmt. and patient activation • Complications prevention and mgmt. • Transition to community	• Primary, secondary and tertiary prevention • Risk reduction • Self-care mgmt. knowledge and support • QOL maintenance
Site (Where)	• Hospital, ED, Pre-op clinics	• Home • Hotel/shelter, etc. • Acute rehab/SNF	• Medical Home • Specialty care • Home and Community

JHM Care Management Continuum: Structure, Roles, Processes

Structure/Roles	Acute Illness	Transitional / In home Care	Community-based Care: Population Health Management
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).

JHM Care Management Continuum: Structure, Roles, Processes

Processes	Acute Illness	Transitional / In home Care	Community-based Care: Population Health Management
Complex Case Mgmt. • Pt. identification/ • Screening • In-depth assessment • Individualized interdisciplinary care/transitions planning • Communication and collaboration • Care coordination	• All hospitalized and ED pts. Screened (tools and population characteristics • Identification based on screening • Individual assessments with patients/family • Care Planning and Goals/Collaboration	• Pts. identified during acute/or newly identified post acute • Screening by post-acute team • Collaboration with Medical Home/PCPs • Receipt of patients from SNF/Acute Rehab	• Population risk screens and/or referrals • In-depth assessment of patient needs • Individualized, interdisciplinary care plan • Self care mgmt. support • Community health interventions (social determinants of health)
Evidenced –based care • Disease, health behavior protocols • Risk Stratification • Decision support tools	• Structured Care Methodologies (orders, protocols, pathways, etc.). • Screening tools • Triage protocols • Outcomes mgmt.	• Continuation of Care plans/guidelines • SNF, HF and COPD protocols • Outcomes mgmt. related to transitions	• Use of population evidenced based guidelines • Analysis of population data for targeted interventions • Decision support tools

JHM Care Management Continuum: Structure, Roles, Processes

Processes	Acute Illness	Transitional / In home Care	Community-based Care: Population Health Management
Patient/Family Engagement • Self-Care Mgmt. assess • Education/ Communication • Collaboration in care plan • Support for pt./family/ care giver	• 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	• 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.	• 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

JHM Care Management Continuum Structure, Roles, Processes

JOHNS HOPKINS MEDICINE

Processes	Acute Illness	Transitional / In home Care	Community-based Care: Population Health Management
Care Coordination • Specialty referrals, dx studies and follow-up • 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