THE COORDINATING CENTER

INSPIRED SOLUTIONS

Prepared for HSCRC
Care Coordination Subcommittee
Dec. 12, 2014

Readmission Reduction Programs at The Coordinating Center

GET WELL

Coaching from Hospital to Home

West Baltimore Readmission Reduction Collaborative (WBRRC)

The Coordinating Center

WBRRC the "How"

- Based on RCA done by hospitals
  - University of Maryland Main Campus
  - University of Maryland Midtown
  - Bon Secours
- Application process for CCTP contributed to relationship building
- Model implemented to bridge transitions
  - Embedded Liaisons in each hospital
    - Target and enroll those at high risk in Get Well Program
    - Use reports developed by the hospitals to assist in identifying the high risk population
  - 30 Day Intervention based on a hybrid of the Coleman and Boost Models
    - Pre and post discharge site visit (within 3 days) by transition coach
    - 3 follow up calls over 30 days
    - Interactions are focused on personal motivators and four pillars of Coleman
    - Coaches use all organization knowledge to identify community based resources, services and programs to meet a person's needs

Measuring Results

- Technology used
  - CARMA care management information system
  - CRISP
  - CMS data based on claims (6 month lag time)
  - Care at Hand (mobile technology for coaches)
- Results to date for WBRRC
- Results using CRISP data

Results using CRISP data August 1 – Oct. 31, 2014

- Of those targeted at high risk for readmission and enrolled (N=912) in Get Well across 3 hospitals had an average 12% readmitted (N = 107)
- Variation in numbers of readmissions by coach
  - Range from 0% for one coach to 16%
  - Removing the outliers, average readmits by coach is 8%
  - 1 of 3 hospitals had 0 readmissions for those enrolled
    - Also had 58% rate of visit in first 3 days
    - Coach had less patients that others (due to a combined role of coach/ liaison)

Challenges Overcome

- Embedding staff in hospitals
  - Variations in orientation, access to patient information and badging processes at hospitals
  - Physical space to optimize the relationship between hospital and community organization
  - Integrating CCTP program with existing or emerging hospital care transition initiatives
- Balancing hiring, training and set up costs of staff prior to revenue generation
- Inefficient processes
  - Targeting and enrollment
  - Low 3 day visit rate post discharge
- Achieving a large enough footprint to move needle
  - Initially used a condition based targeting method
  - Expanded to a risk based tool (Based on 8Ps Boost and social determinants)

Ongoing Challenges

- No one size fits all model
- Optimal delivery of the intervention
  - Rapid cycle improvement
- Addressing the needs of the highest cost users
  - Behavioral Health
  - Supportive Housing
  - Homelessness
- Data and data Systems
  - Claims data
  - CRISP Data
  - Care at Hand system
  - How a readmission is measured
    - All Cause? Does ER Count? What about observation beds? What about a person transferring from medical admission to mental health admission?
- Choosing the best technology to support the work
- Relationship growth between hospitals and community based organizations
  - Adopting a collective impact approach to address complex cross sector challenges

For Additional Information

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