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
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

- **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

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

<table>
<thead>
<tr>
<th>Baltimore City</th>
<th>Baltimore Suburbs</th>
<th>DC Suburbs</th>
<th>Chesapeake</th>
<th>Northern Border</th>
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<tbody>
<tr>
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<tr>
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<td>BWMC</td>
<td>Doctors</td>
<td>Anne Arundel</td>
<td>Carroll Hospital</td>
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<tr>
<td>Good Samaritan</td>
<td>Franklin Square</td>
<td>Ft. Washington</td>
<td>Atlantic General</td>
<td>Frederick Memorial</td>
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<td>GBMC</td>
<td>Holy Cross</td>
<td>Calvert Memorial</td>
<td>Garrett County Memorial</td>
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<td>Laurel Regional</td>
<td>Chester River</td>
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<td>MedStar</td>
<td>Civista</td>
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<td>UMMC</td>
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<td>Adventist</td>
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</tbody>
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Source: CRISP
MHA Care Transitions
Sub-Committees

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

Aims

- Engaging the ED in care transitions
- Reengineering hospital discharge
- Communication and linkages to primary care
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

1. Revisit Hospital Discharge Process
2. Comprehensive Primary Care
3. Optimal Emergency Department Utilization

Patient Centered Care Transitions supported by HIT and Care Coordination