Maryland’s Hospitals & Care Coordination

Carmela Coyle
President & CEO
Maryland Hospital Association
• Not well defined
• In Medicare, mixed results
• Maryland is different
  – Testing in all payer environment
  – Significantly greater incentives
• Maryland hospitals focused on waiver success
MHA Initiatives

- Learn – TPR Experience
- Partner – Dr. Amy Boutwell
- Convene – State care continuum partners
- Collectively Strategize – Portfolio approach/Best practices
Learn – TPR Experience

Participating Hospitals

- Calvert Memorial Hospital
- Carroll Hospital Center
- Chester River Hospital Center
- Garrett County Memorial Hospital
- The McCready Foundation
- Meritus Medical Center
- Shore Health System (Easton) (Memorial and Dorchester General)
- Union Hospital
- Western Maryland Health System

- All participating hospitals are sole providers with three members being part of a larger health system
- Together, we have a combined net revenue of $1.4 billion and serve a combined population of 727,000, many of them residents or rural Maryland
- Maryland’s TPR Collaborative is unique. We learn from each other’s challenges and successes, improving care as a group despite geographic diversity.
Learn – TPR Experience

- Pre-Acute Care
  - Added primary care practices
  - Created PCMHs
  - Developed high risk clinics
  - Partnered with urgent care centers

- Acute Care
  - Targeted high utilizers
  - Reviewed readmissions daily
  - Expanded care coordination: behavioral health and ED
  - “Discharge” redefined to 1st primary care visit
  - Discharge with meds

- Post-Acute Care
  - Care coordination teams
  - Expand home care resources
  - Community health workers
  - SNF transition care
Partner – Dr. Amy Boutwell

- Co-designer IHI STAAR Initiative, first state/community based approach to reducing readmissions
- Advisor, national coordinating center for the CMS Care Transitions Aim
- Advisor, CMS Learning Systems for ACOs and Bundled Payments
- Co-Principal Investigator, AHRQ Reducing Medicaid Readmissions Project
Convene – State Continuum Partners
Focus on readmission reduction

“Rehospitalization is a system issue and the problem does not lie with one organization or one provider, but with the community and the local health care system. Addressing this issue will require organizations and providers to work together.”

- Anne-Marie Audet, VP, The Commonwealth Fund
Who is High Risk?
MHA’s Initiatives

- Launched *Transitions: Handle with Care* campaign in January 2013
- Multi-stakeholder, statewide initiative to reduce readmissions by:
  - Fostering collaboration within state and across settings
  - Using data strategically
  - Implementing evidence based strategies at the local level
Cross-Continuum Team Representation

Jan-13
n=16 hosp.

May-14
n=34 hosp.

- Hospice
- Mental Health
- PCMH
- FQHC
- Physician Offices
- Home Health/VNA
- Post-Acute
- Other
Points of Education and Collaboration
March 2013-May 2014

Training / Education
*Cumulative

- Joint Commission Hand-off Webinars
- MHA Bi-Monthly Newsletter
- Trainings
- Regional Cross-Continuum Team Meetings
- Monthly Webinars
Post Acute Interventions

- MHA sponsored training conducted by INTERACT founders for 86 post acute facilities and 10 hospitals
Calendar of Events

Transitions: Handle With Care
Shared Calendar of Events

February 2013
26 Materials: Pre-work for March 19 meeting, including data analysis, readmission interviews, cross-continuum team composition, sample invitation letters, and sample agenda.

March 2013
19 Transitions: Handle with Care Statewide Launch Meeting

April 2013
23 Steering Committee Meeting (3rd)
23 Using Data to Improve Care Transitions Webinar

May 2013
9 Lifespan Leadership Summit on the Role of Post Acute Services in Health Reform
22 How HIE Can Help You Improve Transitions Webinar
22 Issue Brief: Using HIE to Improve Transitions & Reduce Readmissions

June 2013
4 Senior Care Provider Roundtable, Williamsport
19 Improving Care Transitions for Patients with Behavioral Health Needs Webinar
26 INTERACT Training
27 INTERACT Training
27 Steering Committee Meeting (2nd)

July 2013
17 Frederick Memorial & Borwell: Medicaid Readmissions

August 2013
6 Multi-payer PCMH Learning Collaborative (keynote and 3-hospital panel)
13 University of Maryland Baltimore Washington Medical Center Site Visit
13 Senior Care Provider Roundtable, Southern Maryland
20 Frederick Memorial & Meritus Cross-Continuum Team Regional Meeting
20 Frederick Memorial & Borwell: Behavioral Health Transitions
21 Involving Patients and Families in Reducing Avoidable Readmissions Webinar

September 2013
18 The Role of Pharmacists and Local Pharmacies in Reducing Avoidable Readmissions Webinar
18 Maryland National Capital Homecare Association Annual Meeting
18 Maryland National Capital Homecare Association - Breakout Session
19 Steering Committee Meeting (3rd)
23 MHA, MedStar Health and Genesys presenting to the Maryland Health Care Reform Coordinating Council’s Healthcare Delivery Reform Subcommittee
23-26 LifeSpan/HFAM 2013 Art of Caring Conference: Together We Can
Collectively Strategize

- Portfolio Approach
- Sepsis

Percent of Total Deaths by APR-DRGs FY2013

<table>
<thead>
<tr>
<th>DRG</th>
<th>Description</th>
<th>% Total Deaths</th>
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<tbody>
<tr>
<td>720</td>
<td>Septicemia &amp; disseminated infections</td>
<td>29.69</td>
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<tr>
<td>133</td>
<td>Pulmonary edema &amp; respiratory failure</td>
<td>6.03</td>
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<tr>
<td>194</td>
<td>Heart failure</td>
<td></td>
</tr>
<tr>
<td>710</td>
<td>Chronic obstructive pulmonary disease</td>
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</tbody>
</table>

Distribution of Top 50 APR-DRG Categories at Index Admission (First Hospitalization) of All-Cause, All Hospital Readmissions, Maryland CMS Methodology All-Payer FY2013

<table>
<thead>
<tr>
<th>APR DRG</th>
<th>Descriptions</th>
<th># Index Admissions w/ Readmission</th>
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</thead>
<tbody>
<tr>
<td>194</td>
<td>Heart failure</td>
<td>4,007</td>
</tr>
<tr>
<td>720</td>
<td>Septicemia &amp; disseminated infections</td>
<td>3,440</td>
</tr>
<tr>
<td>140</td>
<td>Chronic obstructive pulmonary disease</td>
<td>3,079</td>
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</table>

### All Payer PPC Description

<table>
<thead>
<tr>
<th>PPC</th>
<th>PPC Description</th>
<th>PPCs Expected</th>
<th>PPCs Actual</th>
<th>PPC Weighted Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPC 4</td>
<td>Acute Pulmonary Edema and Respiratory Failure with Ventilation</td>
<td>1,069.72</td>
<td>1,209</td>
<td>$39,634,647</td>
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<tr>
<td>PPC 65</td>
<td>Urinary Tract Infection without Catheter</td>
<td>2,388.77</td>
<td>2,048</td>
<td>$29,313,024</td>
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<tr>
<td>PPC 14</td>
<td>Ventricular Fibrillation/Cardiac Arrest</td>
<td>1,250.11</td>
<td>1,375</td>
<td>$27,780,500</td>
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<tr>
<td>PPC 24</td>
<td>Renal Failure without Dialysis</td>
<td>3,660.69</td>
<td>3,355</td>
<td>$27,672,040</td>
</tr>
<tr>
<td>PPC 5</td>
<td>Pneumonia &amp; Other Lung Infections</td>
<td>1,288.80</td>
<td>1,169</td>
<td>$24,418,072</td>
</tr>
<tr>
<td>PPC 3</td>
<td>Acute Pulmonary Edema and Respiratory Failure without Ventilation</td>
<td>2,326.32</td>
<td>2,209</td>
<td>$21,665,872</td>
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<tr>
<td>PPC 9</td>
<td>Shock</td>
<td>1,141.40</td>
<td>1,063</td>
<td>$20,538,223</td>
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<tr>
<td>PPC 35</td>
<td>Septicemia &amp; Severe Infections</td>
<td>1,052.88</td>
<td>1,060</td>
<td>$19,984,180</td>
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<tr>
<td>PPC 21</td>
<td>Clostridium Difficile Colitis</td>
<td>1,028.00</td>
<td>1,030</td>
<td>$17,934,360</td>
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<tr>
<td>PPC 40</td>
<td>Post-Operative Hemorrhage &amp; Hematoma without Hemorrhage Control</td>
<td>1,515.83</td>
<td>1,512</td>
<td>$14,846,328</td>
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Collectively Strategize

• Portfolio Approach

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Rate</th>
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<tbody>
<tr>
<td># Medicare admissions/year</td>
<td>5,000 admissions</td>
<td></td>
</tr>
<tr>
<td>Medicare readmissions rate</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td># Medicare readmissions/year</td>
<td>1,000 readmissions</td>
<td></td>
</tr>
<tr>
<td>1. Improve standard care</td>
<td>5,000 admissions</td>
<td>20% readmissions rate</td>
</tr>
<tr>
<td>Expected effect</td>
<td></td>
<td>10%</td>
</tr>
<tr>
<td># Expected readmissions reduction</td>
<td>100 readmissions avoided</td>
<td></td>
</tr>
<tr>
<td>2. Collaborate with receivers</td>
<td>1,650 admissions (1/3 total)</td>
<td>30% readmissions rate</td>
</tr>
<tr>
<td>Expected effect</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td># Expected readmissions reduction</td>
<td>99 readmissions avoided</td>
<td></td>
</tr>
<tr>
<td>3. Enhanced service for pilot</td>
<td>200 admissions</td>
<td>25% readmissions rate</td>
</tr>
<tr>
<td>Expected effect</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td># Expected readmissions reduction</td>
<td>10 readmissions avoided</td>
<td></td>
</tr>
<tr>
<td>Hospital-wide readmissions impact</td>
<td>209 readmissions avoided</td>
<td>209/1000=20% overall</td>
</tr>
</tbody>
</table>
Collectively Strategize

• Share best practice

Webinars
(all presentations and recordings are available online)

• Knowing Your Readmissions Data: The First Step to Effective Change
• Improving Care Transitions for Mental Illness and Substance Use Disorder
• Involving Patients and Families in Reducing Avoidable Readmissions
• The Role of Pharmacists and Local Pharmacies in Reducing Avoidable Readmissions
• Partnering with Medicaid Managed Care
• Nursing Homes – Reducing Unnecessary Hospital Transfers, Admissions and Readmissions
• Improving Care Transitions between Hospital and Home Health
• Addressing Health Care Disparities and Health Literacy to Reduce Hospital Readmissions
• Partnering at the Local Level to Reduce Behavioral Health Readmissions
• Strategies for Success Under New Medicare Waiver: Part 1
• Strategies for Success Under New Medicare Waiver: Part 2
Collectively Strategize

• Examples from the Field
  – Patient & Family Engagement
    ➢ Anne Arundel Medical Center’s SMART Discharge Tool
  – Care Preferences
    ➢ Meritus Medical Center
  – Community Partnerships
    ➢ Sinai Hospital and Health Care Access Maryland
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