Envisioning Better Care, Better Health, a Better You!

A Team of Care Coordinator Nurses, Social Worker & Educator

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PeaceHealth Ketchikan Medical Center

Ketchikan Population: 12,000

Prince of Wales Population: 4,000
CMS Demonstration Project

- 2010 Affordable Care Act: Healthcare Innovation Awards
  - 3 Year, $3.1 million award
  - Functionally started in January 2013
  - Over 3300 Unique/Individual Encounters

CMS SAVINGS

POPULATION HEALTH CONFIDENCE
Demonstration Project

**Goal:** Explore primary care redesign model of Patient Centered Medical Home, particularly care coordination to work toward the Triple Aim.

Reduce cost of care per beneficiary per encounter:
1. Reduce Readmission Rates
2. Reduce Unnecessary Utilization
3. Increase Chronic Disease Care
4. Increase Community Literacy
5. Increase Access
Outcomes
(Some examples)

Diabetes A1c Poor Control

Emergency Room Clinic Referrals

Discharged Patient Follow-Up

Hypertension patients on active management plan has risen from 84% to 89%
ADULT 30 DAY READMISSION RATES

QUEST Predictive Rate
ADULT 30 DAY READMISSION RATES

QUEST Predictive Rate

- Readmission

Linear (Readmission)
Adult Readmission Rate: 5.93% (n=1821)

- 33% reduction compared to expected 8.87%
- Historically we were a bit higher

Six Month Periods

- Jul-Dec 13: 7.42%
- Jan-June 14: 5.73%
- July-Dec 14: 4.86%
## Per Beneficiary Per Encounter Cost Reduction

<table>
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<tr>
<th>Payer</th>
<th>FY12</th>
<th>FY13</th>
<th>Net Change</th>
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<tbody>
<tr>
<td>Medicare/Medicaid</td>
<td>$536/encounter</td>
<td>$457/encounter</td>
<td>-15%</td>
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<tr>
<td>All Payers</td>
<td>$630/encounter</td>
<td>$545/encounter</td>
<td>-14%</td>
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</table>

<table>
<thead>
<tr>
<th>Payer</th>
<th>Clinic PBPE</th>
<th>Hospital PBPE</th>
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<tbody>
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<tr>
<td>Medicare/Medicaid</td>
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<tr>
<td>All Payers</td>
<td>$203</td>
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</table>
Example: Transitional Care

Patient

Discharge Report

Next Course of Treatment

Medication Reconciliation

Hurdles to Care: Medical & Non-Medical
Example: Transitional Care

- Patient
- Social Worker
- PCP
- Others: Financial, Education, Community assistance

Discharge Report
TRANSITION OF CARE CALL TEMPLATE
(Daily Discharge Report is Mailed to CC)

ADMITTED on: [Date]
DISCHARGED from: [ER, In-Patient, Observation, etc.]
First call attempted within: [Within 2 business days]
Face to face within: [Protocol for visit in clinic]
DISCHARGE DIAGNOSIS:
PRE CALL PREPERATION/BACKGROUND
(gathered from chart review):

Education Resources/Red Flag Conditions:
Specific symptoms to watch for include:

Medication review:
Medications discontinued:
Medications changed:
Medications added:

Follow Up Appointment(S) Scheduled:

Home Health:
Other Community Support:
Supplies and Equipment:
PHONE CALL/ASSESSMENT:

Next Steps for Care
   Confirm Follow-up Appointments
   Confirm further follow-up tests, etc.

**Education of red flag symptoms:** is able to verbalize instructions for care and concerning symptoms to report, with cues.

**Medication Reconciliation**

**Psychosocial assessment/support needs**
   Motivation Interviewing/active listening
   Barriers/Other: List services/referrals

RECOMMENDATION:
Psychological and Social (Non-Medical) Hurdles to Follow-Up Care:

- Financial
  - No insurance/Under insured
  - Fear of non-coverage (ignorance of plan benefits)
  - Lack of pricing transparency for follow-up care
- Housing (homeless, marginal housing, boats)
- Family/social support
- Transportation challenges (cost, knowledge of bus routes, etc.)
- Access to food and basic needs
- Disabilities
- General medical literacy challenges
QUESTIONS AND DISCUSSION

- Tough Math: $700,000 in operational costs results in about a $1.5 million in lost revenue. Where is the incentive to change?
- Key ingredient currently missing in most facilities is **capital** and **confidence**.
- Care Coordination requires local knowledge by care-givers.