PeaceHealth *Innovation* Team

Envisioning Better Care, Better Health, a Better You!

A Team of Care Coordinator Nurses, Social Worker & Educator

CMS.gov
Centers for Medicare & Medicaid Services

PeaceHealth Ketchikan Medical Center
The *spirit* of healing®

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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

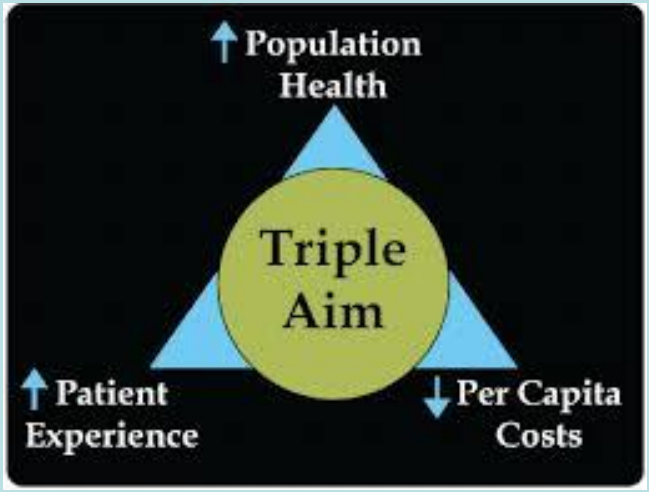
POPULATION HEALTH CONFIDENCE

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:

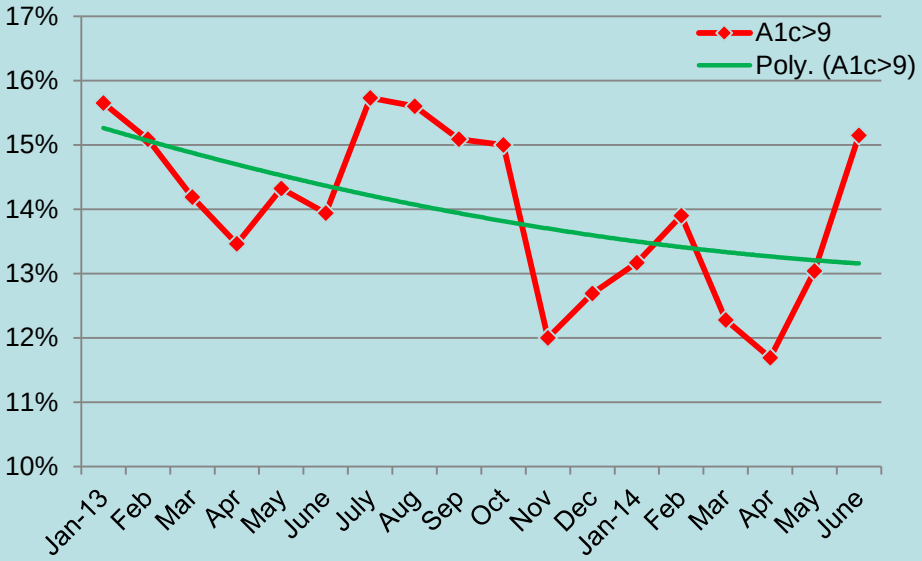
1. Reduce Readmission Rates
2. Reduce Unnecessary Utilization
3. Increase Chronic Disease Care
4. Increase Community Literacy
5. Increase Access



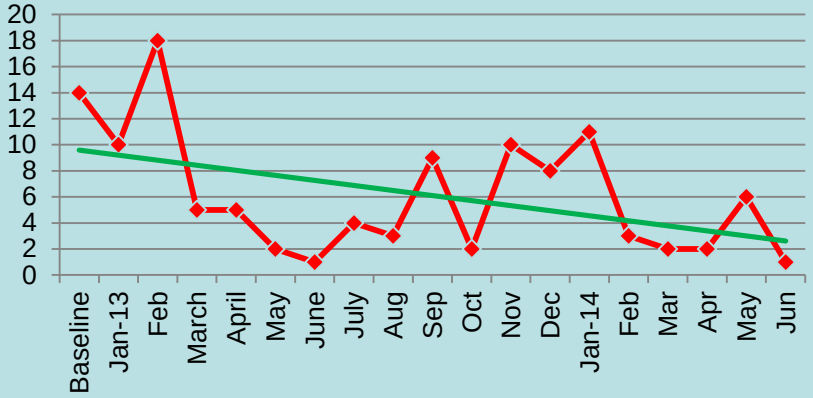
Outcomes

(Some examples)

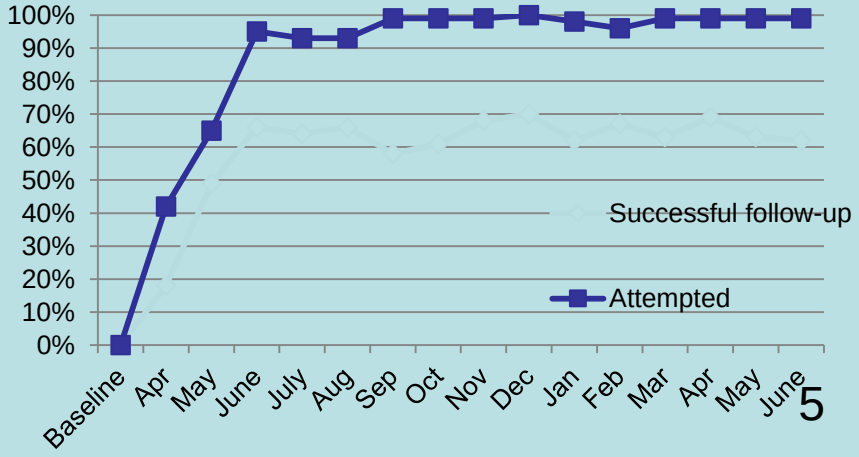
Diabetes A1c Poor Control



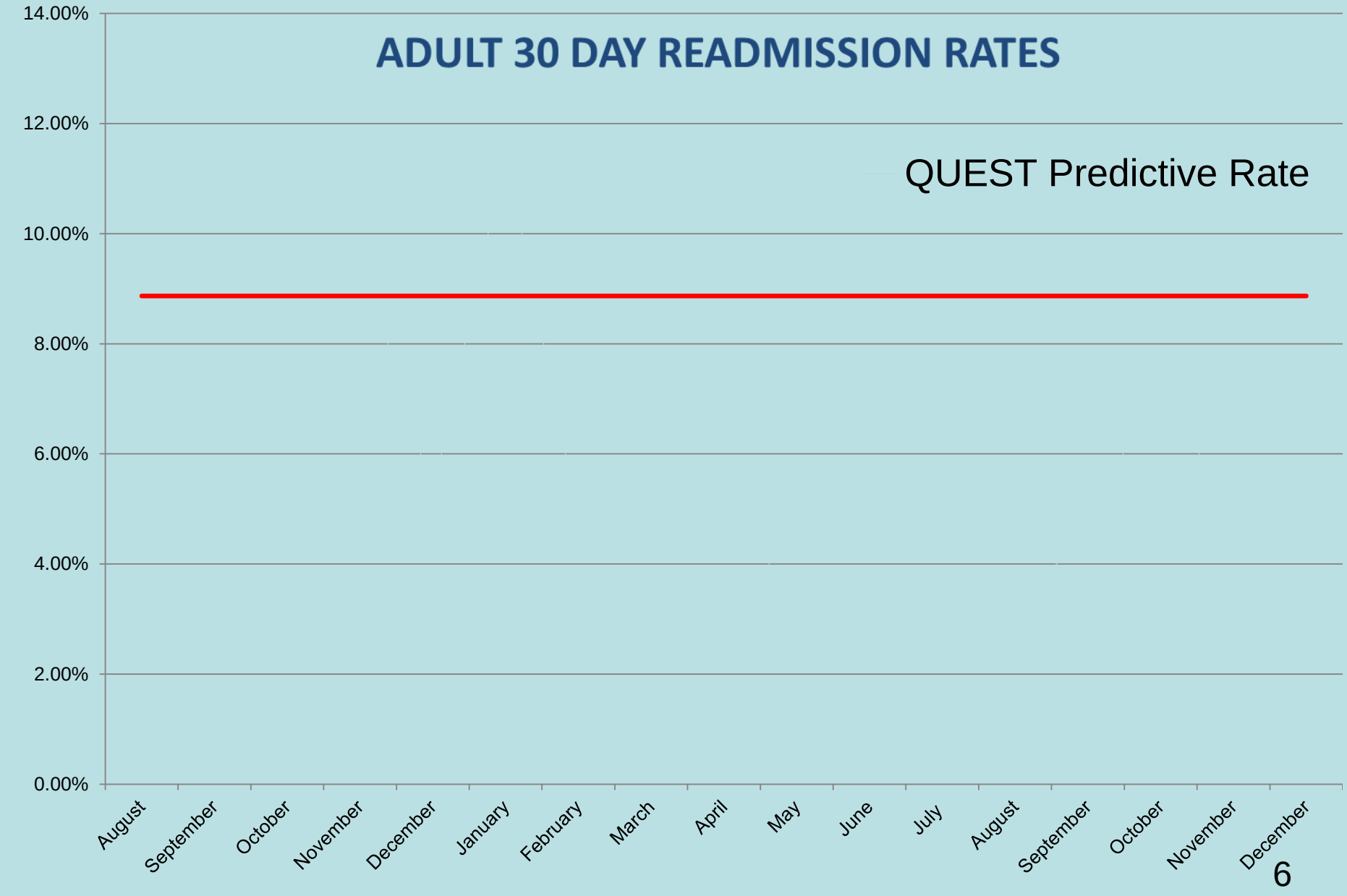
Emergency Room Clinic Referrals

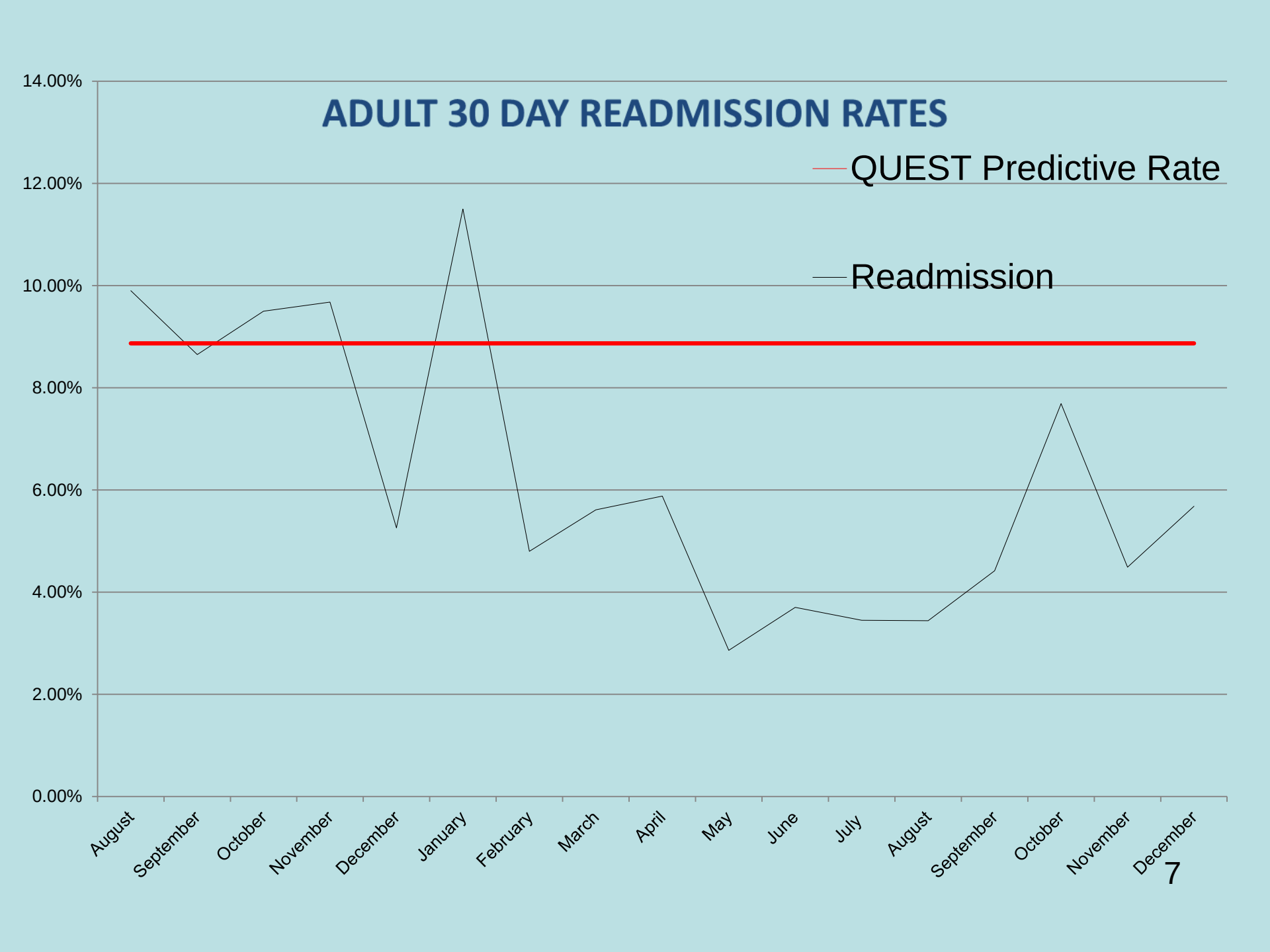


Discharged Patient Follow-Up



Hypertension patients on active management plan has risen from 84% to 89%


ADULT 30 DAY READMISSION RATES
QUEST Predictive Rate
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
August
September
October
November
December
January
February
March
April
May
June
July
August
September
October
November
December


ADULT 30 DAY READMISSION RATES
QUEST Predictive Rate
Readmission
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
August
September
October
November
December
January
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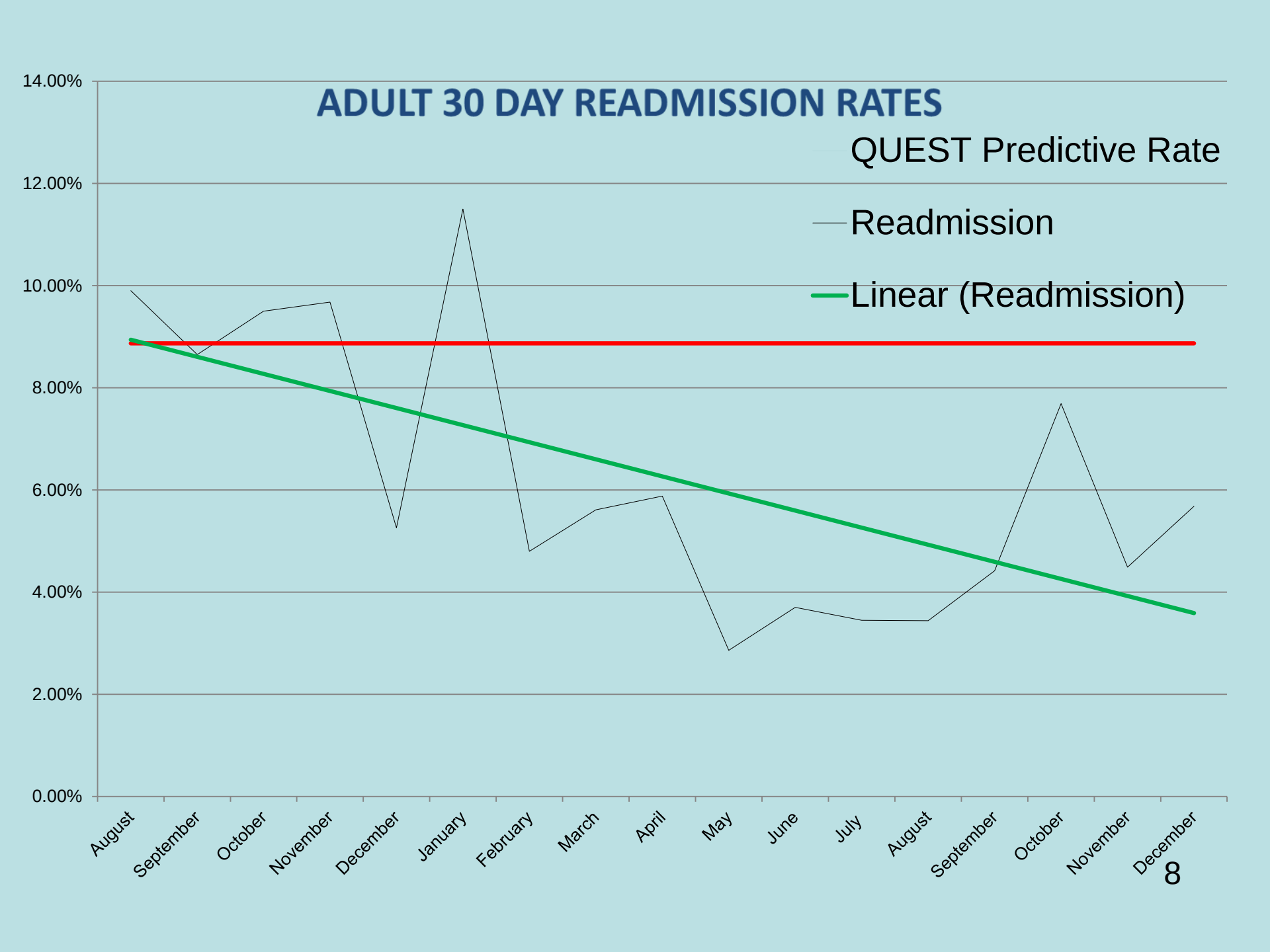
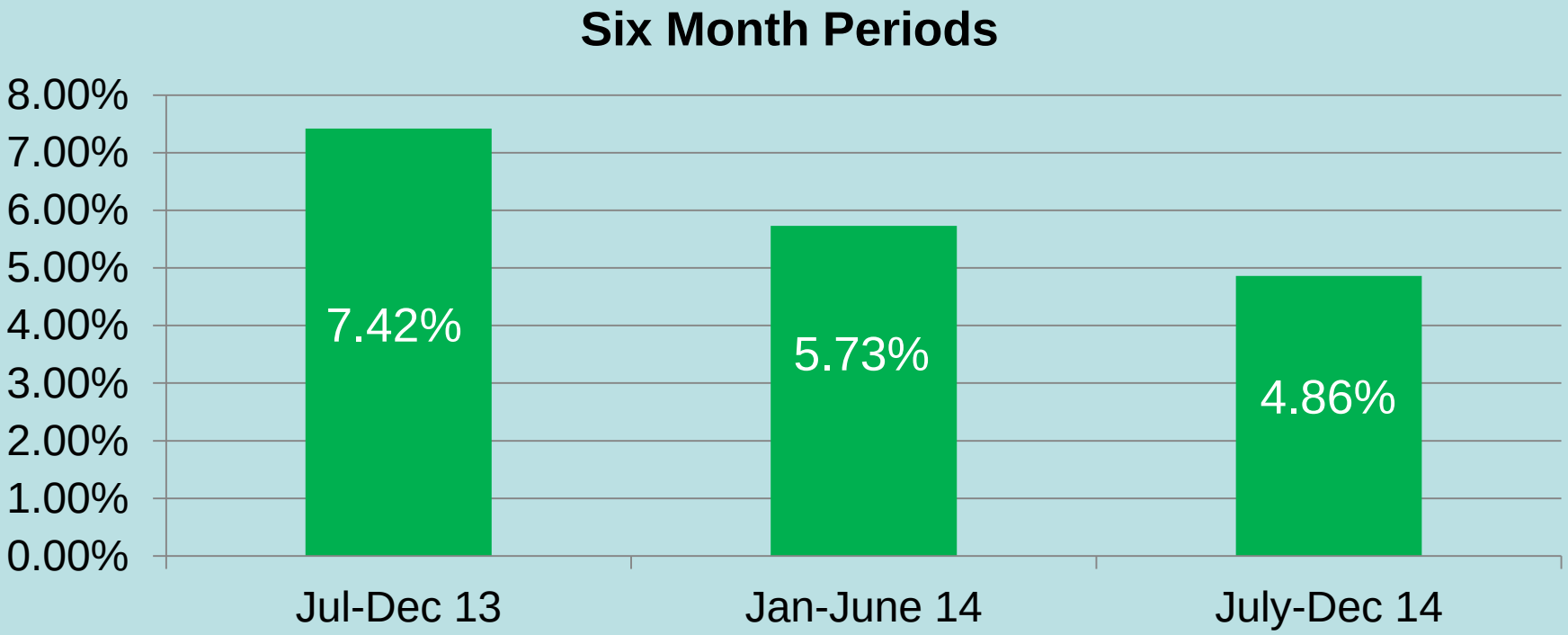

ADULT 30 DAY READMISSION RATES
QUEST Predictive Rate
Readmission
Linear (Readmission)
14.00%
12.00%
10.00%
8.00%
6.00%
4.00%
2.00%
0.00%
August
September
October
November
December
January
February
March
April
May
June
July
August
September
October
November
December

Adult Readmission Rate: 5.93% (n=1821)

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



Per Beneficiary Per Encounter Cost Reduction

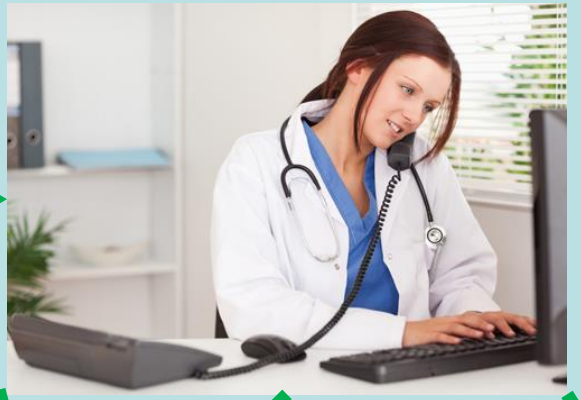
Payer	FY12	FY13	Net Change
Medicare/ Medicaid	**$536/encounter**	$457/encounter	**-15%**
All Payers	$630/encounter	$545/encounter	**-14%**

Payer	Clinic PBPE		Hospital PBPE	
	2012	2013	2012	2013
Medicare/ Medicaid	$134	$130	$1,187	$921
All Payers	$203	$207	$1,373	$1,028

Example: Transitional Care

Patient

Discharge Report



Next Course of Treatment

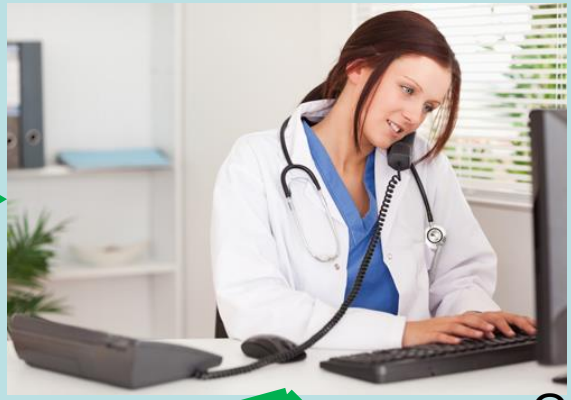
Medication Reconciliation

Hurdles to Care: Medical & Non-Medical

Example: Transitional Care

Patient

Discharge Report



Social Worker

PCP

Others: Financial, Education, Community assistance

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.