Deploying Care Coordination and Care Transitions - Illinois

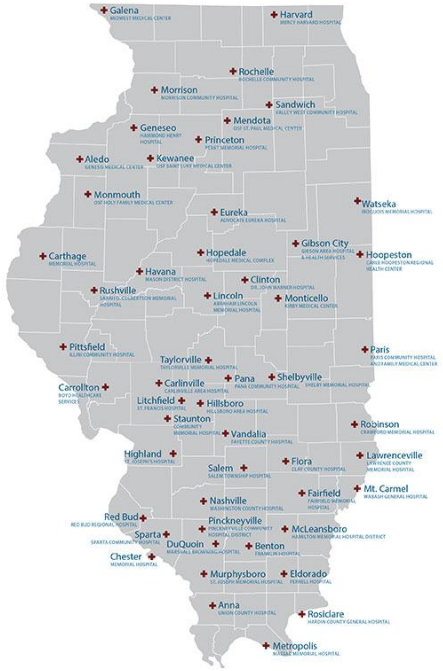
FLEX PROGRAM REVERSE SITE VISIT

JUNE 23, 2015

Illinois Department of Public Health Center for Rural Health – Flex Program grantee – 15 years

Illinois Critical Access Hospital Network (ICAHN) – sub-grantee

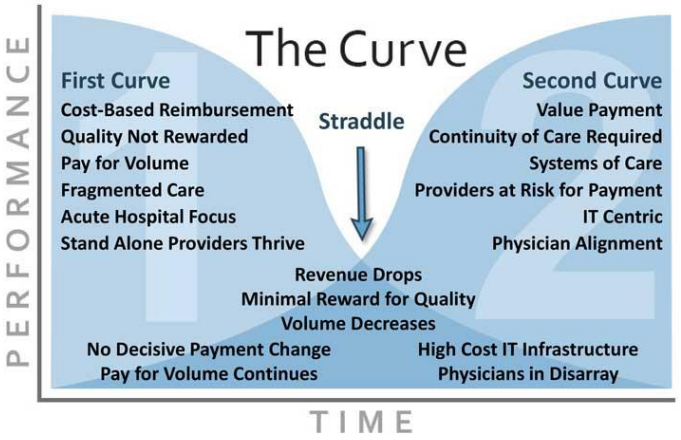
- Responsible for administration and implementation of grant activities and outcomes
- Serves as Flex coordinator: provides CAH technical assistance, CAH regulatory issues, MBQIP/quality reporting
- ICAHN represents the 52 Illinois CAHs (recently added a CAH)
- Since 2004 and work as partners with Center



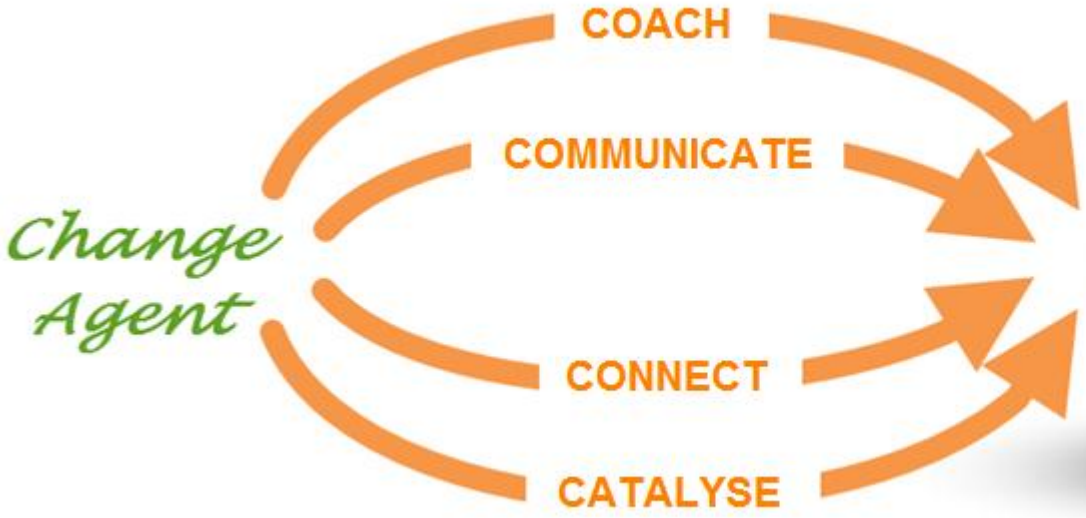
Moving from Volume to Value Based Care

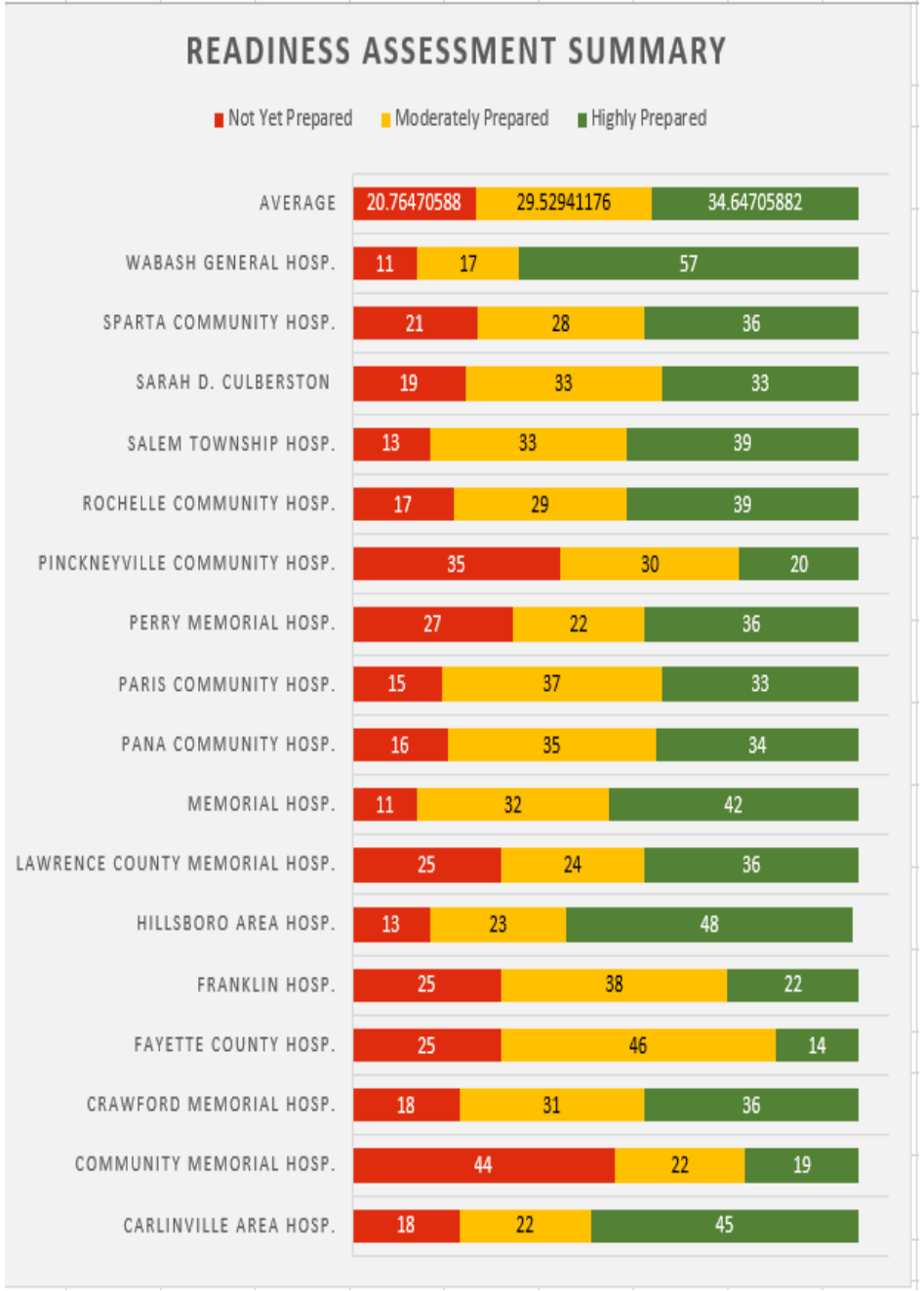
Health Care Reform – What does that mean for rural? Illinois CAHs?

- Triple Aim
- Clinically Integrated Networks
- Coordinated Care Program – Navigator Programs
- Transitional Care and High Costs
- Primary Care Driven
- Quality Reporting and Data Based Decisior
- Consumer – the new patient
- Market Share – fast growing systems
- Changing Reimbursement System
- Accountable Care Organizations



Flex Program – Change Agent





Hospital Readiness Assessment Tool

Care Transition: What does that mean?

Working Definition: *Process of moving a patient or beneficiary from one level of care/service to the next level of care/service (examples: ED to trauma center; hospital to long term care or home health)*

- *Impact/Concerns:*
  - *Communication critical (provider to provider)*
  - *Fully informed care plan and treatment*
  - *Continuation of proper treatment*
  - *Problems identified – prevent errors*
  - *Documentation*
  - *Focus on outcomes*
  - *Prevent duplication of tests*
  - *Patient comfort*

Prime Example: wound care treatment plan…hospital to long term care

CAH to Resource Hospital
by Helicopter

Patient Transitions are Key

How they Enter Hospital

Discharge from Hospital

Interdisciplinary Team Meetings

- Who is on the team
- When do they meet/round

Navigators for care transition implementation

- Disease specific
- Risk specific

Flex Program – Role and Activities

ROLE/Care Transitions

- make available resources, technical assistance, create awareness and provide education
- Provide opportunities to improve patient outcomes and reduce costs
- Flex Core Programs – quality, operational services and innovative systems of care

Activities - examples

- MBQIP transfer measures
- Project dollars for individual CAH QI project (hospital to nursing home for wound care)
- Workgroup to develop common transfer protocol
- Quality improvement project – are patients coming back for cardiac rehab or PT therapy?
- Medication management from one level of care/service to the next (medication reconciliation)
- Swing bed marketing program

Care Coordination

Definition: Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.

- ***Agency for Healthcare Research and Quality***

Care Coordination: Why needed?

"Triple Aim – better care, better cost and better outcomes"

Critical for population health

ACO management

Quality Improvement

Patient outcomes

Communication

Efficiencies

Team based

Opportunity for CAHs to excel!

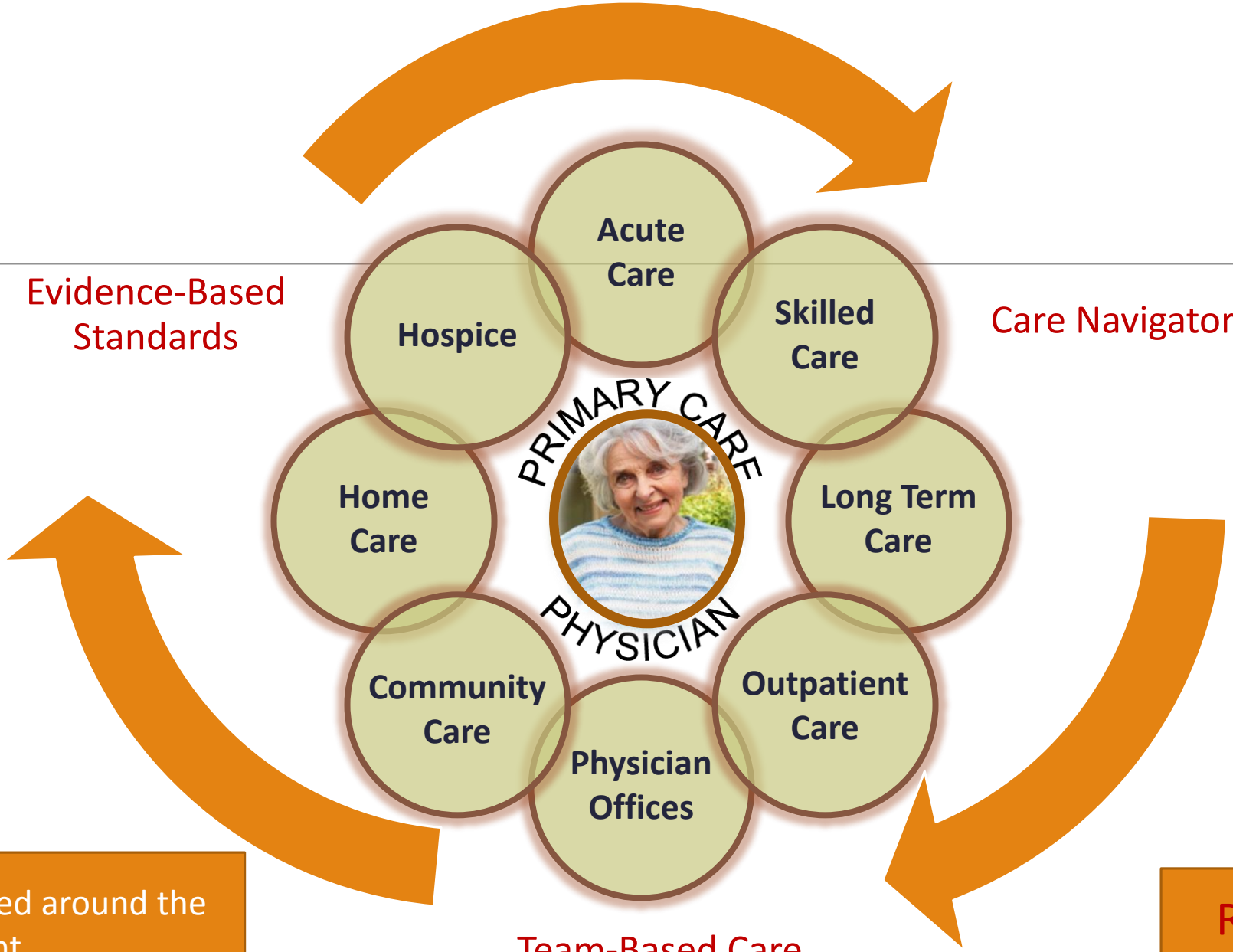
Connecting with Primary Care

- Hospital and Physician Partnership –*a must*
- Physician Engagement
- Physician Leadership
- Culture Change
- Role of Non-Physician Practitioners
- Value to Physicians
  - Improved patient care/outcomes/efficiencies
  - Incentives – time and financial
- Primary Care Platform – *Patient Centered Medical Home*

A Year in the Life of a Patient

Evidence-Based Standards

Care Navigator



Team-Based Care

Healthcare wrapped around the patient
Care Navigator ensures team-based and use of EBP

Result: Triple Aim
Higher Quality
Higher Service
Lower Costs

Outcomes of a Robust Care Coordination

- Determine and update care coordination needs
- Create and update a proactive plan of care
- Communicate
  - Between healthcare professionals & patients/family
  - Within teams of healthcare professionals
  - Across healthcare teams or settings
- Facilitate transitions
- Connect with community resources
- Align resources with population needs

Your Medical Neighborhood – Resource for Care Coordination

- High-Functioning Medical Neighborhood (*patient – family – community)*
  - Community and Social Services
  - Acute and Post-acute Care
  - Ambulatory Care
  - Communication – Complete Circle
  - Patient/population Responsibility
  - Public Health
  - Diagnostic Services
  - Pharmacy
  - Wellness/Disease Management
  - Economy and Opportunity
  - Primary Care – Specialty Care
- Desired Outcomes/Model for CAHs
- Conducting your own community analysis

Flex Program – Role and Activities

Role/Care Coordination

- make available resources, technical assistance, create awareness and provide education
- Provide opportunities to improve patient outcomes and reduce costs AND support MBQIP
- Flex Core Programs – quality, operational services and systems of care

Activities

- Population Health pilot projects
- Community Navigator/community worker pilot projects
- Individual grant projects such as stroke networks or STEMI
- EMS community navigator pilot
- Workshops – certification programs
- Network activities – ACO efforts
- Support for CAHs to make change at grassroots level

Illinois Rural Community Care Organization

Care coordination for each CAH and their providers/clinics is critical – all types of ACOs

Part of quality measures – GPRO/ACOs

Tremendous learning curve and culture change

Proven care standards

Data driven

Building our own programs

Challenges

Not a new concept for hospital inpatient care but new for community care

Many systems of care are doing well – learning curve

Health information exchange

Building partnerships

Evaluation performance of all providers

Cost

No consistency and all sorts of expectations

Social media

Other

Opportunity for Flex Programs

You have resources to help CAHs add these programs necessary for long term survivability.

Pat Schou
Illinois Flex Coordination
pschou@icahn.org