H.E.A.L.T.H. Partners

Statewide Meeting to Reduce Medicaid Readmissions

IGNITE Presentation

Mary Joseph, Primary Care Coalition

April 1. 2015

8757 Georgia Ave, 10th Floor
Silver Spring, MD 20910

www.primarycarecoalition.org

About the Primary Care Coalition (PCC)

Vision:
A community in which all residents have the opportunity to live healthy lives
Montgomery County: A model for providing access to high quality, efficient care for all

Mission:
Develop and coordinate a community-based health care system that strives for universal access and equity for low-income, uninsured, and ethnically diverse community members.

About the Primary Care Coalition (PCC)

Core competencies:

- Collaboration
- Integration
- Process improvement

What We Do:

- Create models for providing access to high quality and efficient care for all
- Foster and coordinate a high quality, efficient community-based health care system
- Strive for universal access and health equity for low-income uninsured community members
- Administer countywide public-private partnerships that provide health care for low-income, uninsured, ethnically diverse county residents

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2011

- Partnered with DHHS Aging and Disabilities; Holy Cross Hospital; Housing Opportunities Commission; Primary Care Coalition of Montgomery County to improve care transitions for dual eligible patients in Montgomery County

2013

- Coalition formed with Delmarva
- 16 organizations and residents of Holly Hall
- Access to hospital Medicare admission and readmission data
- Small tests of change

2014

- Over 20 organizations represented
- Participation in new QIO project (VHQC)
- Spread to other senior housing units and expanding interventions

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Mission:
To improve the transition of care from hospital to community for residents of the region, thereby reducing preventable readmissions to acute care hospitals.

Purpose:

- Build and sustain a community coalition with a focus on improving transitions of care
- Encourage person-centered and person-directed models of care by providing a platform for the patient and family voice
- Collaborate and encourage efforts of organizations with shared visions
- Advance public policies that furthers the vision
- Share Best Practices in caring for community residents

H.E.A.L.T.H. Partners

Over 20 partners including:

- Department of Health and Human Services
    - Aging and Disabilities
    - Public Health
- Housing Opportunities Commission
- 6 Montgomery County Hospitals
- Dimensions Health System
- University of Maryland School of Nursing
- Montgomery County Fire and Rescue
- Associates in Process Improvement
- Alfa Pharmacy
- Primary Care Coalition of Montgomery County
- Community Residents
- VHQC
- Family Services, Inc.
- Easter Seals
- Many others….

First Site-Holly Hall

96 units/112 Residents
On site resident counselor

Race • **African American 49%** • **Asia 18%** • **White 32%** • **Middle Eastern 1%**	**Age** • **< 60 years 17%** • **> 60 years 83%**
Ethnicity • Hispanic 22% • Non-Hispanic 78%	**Disabilities:** • Medically Frail 42% • Physical Disability 29% • Psychological/Neurological 16% • Cognitive 10%

Interventions/Tests of Change

Set aims
Established measures
Selected changes

What are we trying to accomplish?
How will we know that a change is an improvement?
What changes can we make that will result in improvement?

Three Fundamental Questions

Planned the change
Tried the change
Observed the results
Acted on what we learned

Act
Plan
Study
Do

Plan-Do-Study-Act (PDSA) Cycle

Image: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

Data

- The H.E.A.L.T.H partners community (Montgomery County) has approximately 127,434 Medicare beneficiaries.

- VHQC provides part A & B claims data and ongoing analysis for communities to assist with the identification of improvement opportunities.
  - Readmissions
  - Admissions
  - ED Visits
  - # of days from discharge to readmission
  - Top Diagnoses and settings
  - Specific Focus Areas

Data

H.E.A.L.T.H. Partners* % of Discharges Readmitted Within 30 Days

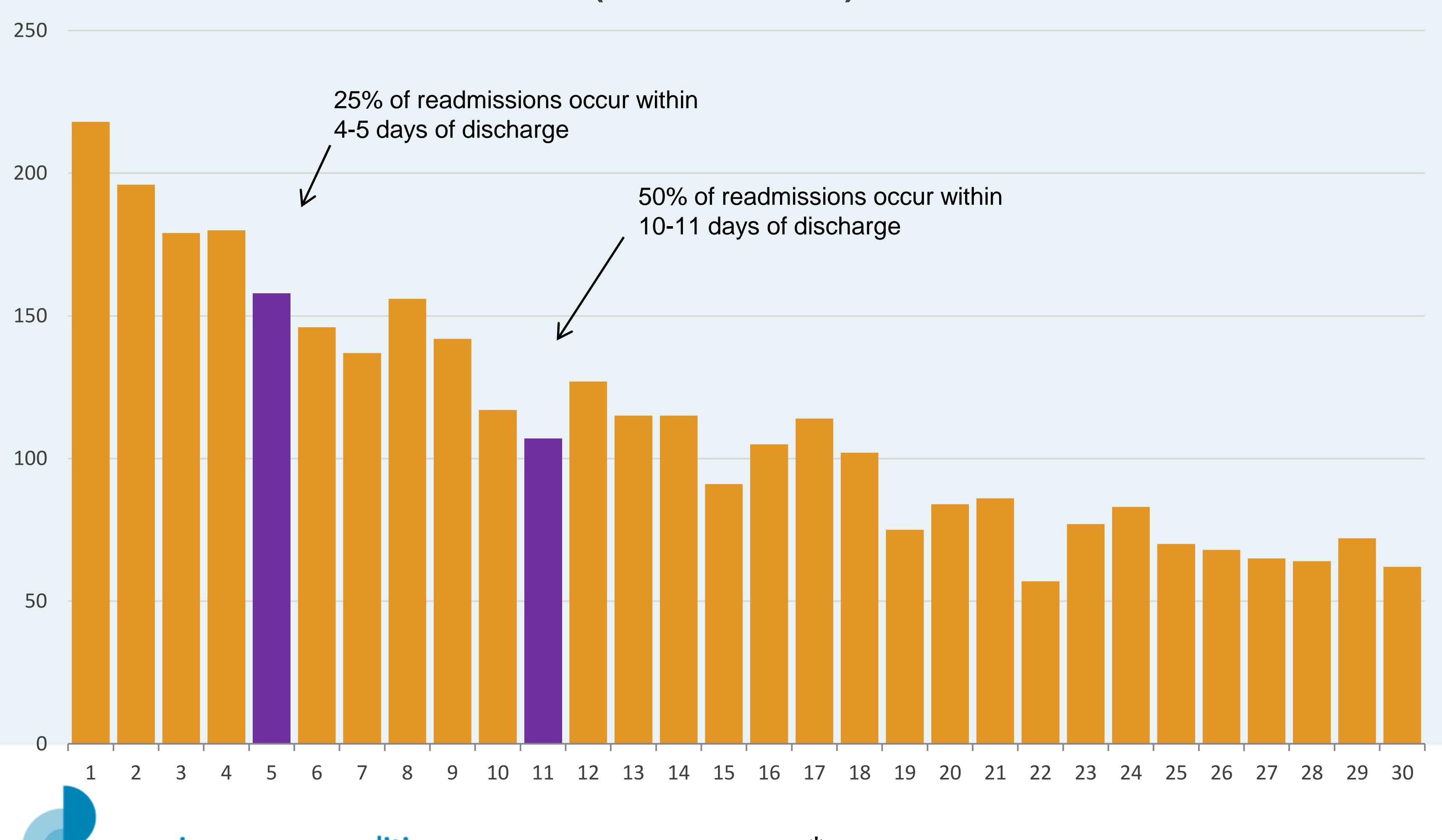
National · H.E.A.L.T.H. Partners · Maryland

22.00%
21.00%
20.00%
19.00%
18.00%
17.00%
16.00%
15.00%

Quarter	H.E.A.L.T.H. Partners
Q4-2011	20.73%
Q1-2012	19.47%
Q2-2012	19.39%
Q3-2012	18.45%
Q4-2012	18.02%
Q1-2013	17.28%
Q2-2013	18.26%
Q3-2013	17.05%
Q4-2013	18.11%
Q1-2014	17.05%
Q2-2014	17.51%
Q3-2014	16.98%

*Montgomery County Medicare Beneficiaries
Part A Claims Data - VHQC

Data



primary care coalition
of Montgomery County, Maryland

*Montgomery County Medicare Beneficiaries
Part A Claims Data - VHQC

Data

Holly Hall

(Example Summary: Medicare Part A Claims Data, March 2011 – May, 2014) - VHQC

Summary Statistics	Additional Analysis
• Medicare Beneficiaries: 40 • Hospital Admissions: 107 • Readmissions: 30 (28% of Claims) • Average # of days until readmission: 13.13 • Median # of days until readmission: 10 • Average claim payment amount: $15,519 • Median claim payment amount: $8,219	• One resident accounted for 47% of readmissions and 25% of admissions • Two residents together accounted for 60% of readmissions and 33% of admissions • Three residents together accounted for 73% of readmissions and 40% of admissions • Four residents together accounted for 80% of readmissions and 45% of admissions • All four residents have 30-day readmission rates of 40% or higher

Resident Engagement

- Resident Meeting
- Resident Brochure
- Resident Interviews

Did you know that nearly one in five people return to the hospital within one month of discharge? Statistics show 75% of readmissions are preventable.

There are many reasons why patients return to the hospital unnecessarily. The top five are:

1. The patient is discharged with an inappropriate recovery plan.
2. The patient was discharged without understanding their illnesses or treatment plans, or accidentally discontinues important medicines needed to stay well.
3. The patient's support team was not included in the discharge planning.
4. Patients may not have the right prescriptions or be able to fill them.
5. The patient does not schedule or attend the follow up doctor/specialist appointments.

H.E.A.L.T.H. Partners' Services

The services provided are confidential, free and only available to HOC participants. Our services are designed to remove all obstacles that a patient faces when being discharged from the hospital. They can also provide a patient with direct access to the community resources that will aid them in recovery and/or decrease the risk of an avoidable admission. H.E.A.L.T.H. Partners will:

- Work closely with the patient and the patient's hospital staff (the case manager and their doctors) to ensure a successful discharge plan is created;
- Help the patient acquire food and other nutritional items prior to returning home;
- Ensure the patient is aware of or has scheduled all follow-up medical appointments;
- Assist patients with filling and picking up prescriptions;
- Arrange reliable transportation to and from follow-up medical appointments;
- Provide ongoing follow-up with the patient, by phone or in person over a four-week period;
- Connect the patient with community-based resources; and,
- Assist the patient with obtaining home health care assistance.

Discharge Planning

- Release of Information

Housing Opportunities Commission
OF MONTGOMERY COUNTY

10400 Detrick Avenue
Kensington, Maryland 20895-2484
(240) 627-9400

Authorization to Release Hospital Discharge or Emergency Medical Services Information

I authorize the Housing Opportunities Commission (HOC) of Montgomery County, Resident Counselor at ____________________ to release and/or receive information from the organizations checked below:

________ Holy Cross Hospital ________ Medstar Montgomery Medical Center
________ Washington Adventist Hospital ________ Emergency Medical Services (EMS)
________ My Primary Care Physician ____________________

Information to be released and/or received may include:

________ File of life
________ Discharge plan
________ EMS notification of response to call from resident
________ Other: ____________________

_______ I understand that my authorization will remain effective from the date of my signature until ____________ (date), and that the information will be handled confidentially in compliance with all applicable federal laws.

_______ I agree that my File of Life, discharge plan and other discharge related information may be in Care2Care, which is a secured database accessible only to HOC Resident Counselors

_______ I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

_______ I understand that I may see the information that is to be shared with the HOC Resident Counselor and in Care2Care.

_______ I understand that the Resident Counselor will help me connect to my healthcare provider(s) but will not assume responsibility for the health care service delivery.

I hereby state that I have read and fully understand the above statements.

____________________ ____________ ____________
Resident's Name (printed) Date of Birth Phone number

____
Resident's Address

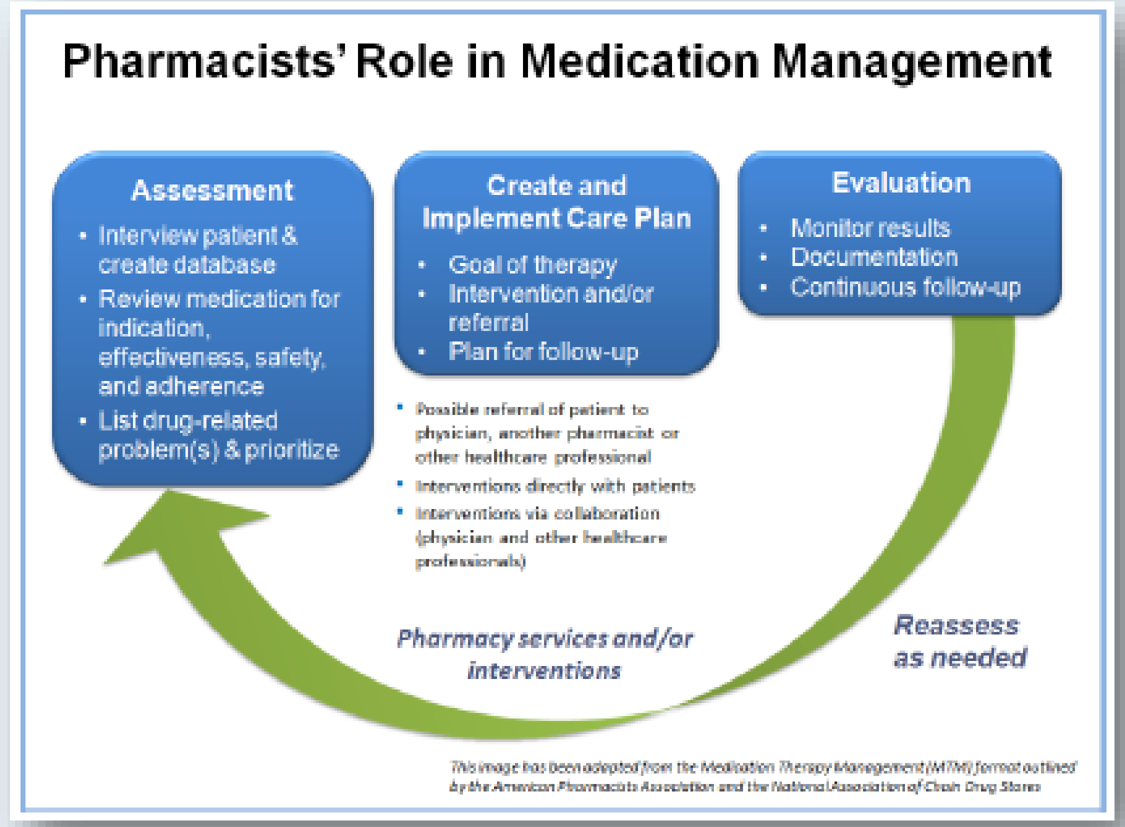
____________________ ____________
Signature of Resident or Legal Representative Date

____
Relationship to Patient, if signed by Legal Representative

____________________ ____________
Signature of Witness Date

Medication Therapy Management

- Pharmacist services provided by ALFA Specialty Pharmacy



EMS Interventions

Daily notification

New Hampshire Ave Incident Shift Date 808/09/2014						
Incident	**Date**	**Time**	**Call Type**	**Unit**	**Apartment**	**Location**
14-0090550	08/09/2014	19:02:58	26-A-11	A716	310	10120 New Hampshire Ave.

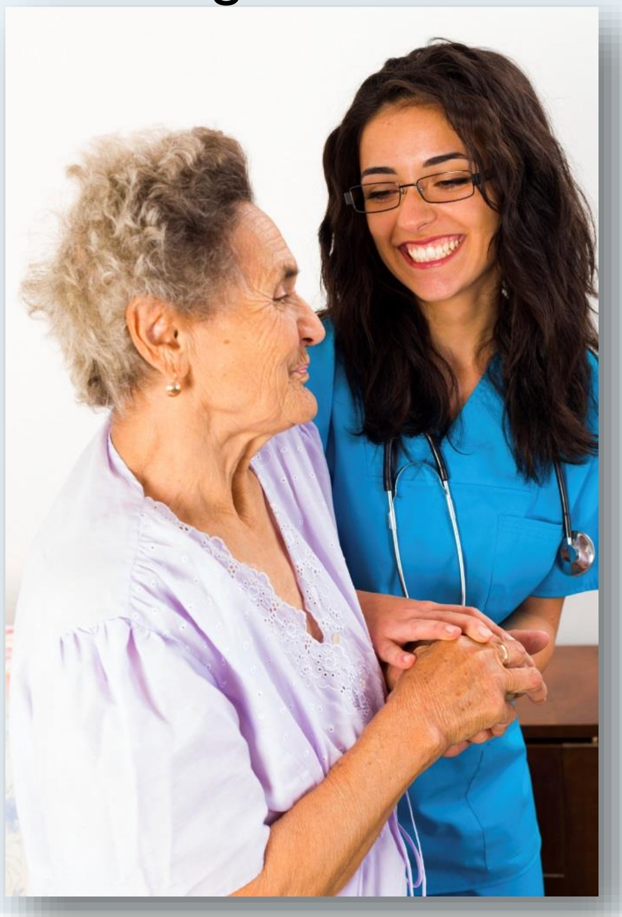
Monthly Stats

				2014 EMS Visits Holly Hall 2012-2013 Average = 4 per Month									
Building	1/14	2/14	3/14	4/14	5/14	6/14	7/14	8/14	9/14	10/14	11/14	12/14	Total
10100	3	2	4	2	3	3	5	2	1	1	2	4	32
10110	0	2	2	0	0	1	1	0	1	2	1	3	13
10210	0	0	0	0	4	1	1	2	0	2	2	0	12
Total	3	4	6	2	7	5	7	4	2	5	5	7	57

EMS Visits by Building (2012-2014)				
Building	Apartments	EMS 2012/100 Apartments	EMS 2012/100 Apartments	EMS 2012/100 Apartments
Arcola Towers	141	28	23	48
Elizabeth House	160	23	25	38
Forest Oaks	175	32	33	75
Waverly House	158	46	34	46
Holly Hall	96	55	45	63
Bauer Park	142		13	17
Town Center	112		13	20

Nursing Interventions

- University of Maryland School of Nursing
- 2 days /week
- Health Education
- Health Screening
- Assessments
- Case Management
- Referral and Follow-up



Technology

- Care2Care
  - Provides a patient-centered record including
    - Essential care elements
    - Barriers to care and self-management goals
  - Facilitates optimal outcomes as the patient moves through the continuum of care
- Community Health Gateway
  - Web and call center solution
  - Easy to understand discharge instructions & medication information
  - Help in navigating healthcare and community services
  - Increased community collaboration

Successes

- Community Engagement
- Over 60% of residents have signed release of information
- Hospital transitional care teams working together
- EMS notification and follow-up
- MTM with positive outcomes on 9 residents
- On-site nurses
- Introduction of technology to assist in personal health management

Contact:

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