BON SECOURS BALTIMORE HEALTH SYSTEM

Bon Secours Health System

REACHING OUT TO OUR HIGH RISK POPULATION

PRESENTED BY:

AFRYEA L. BROWN, MSW, RN

DIRECTOR OF OUTCOMES MANAGEMENT AND SOCIAL WORK

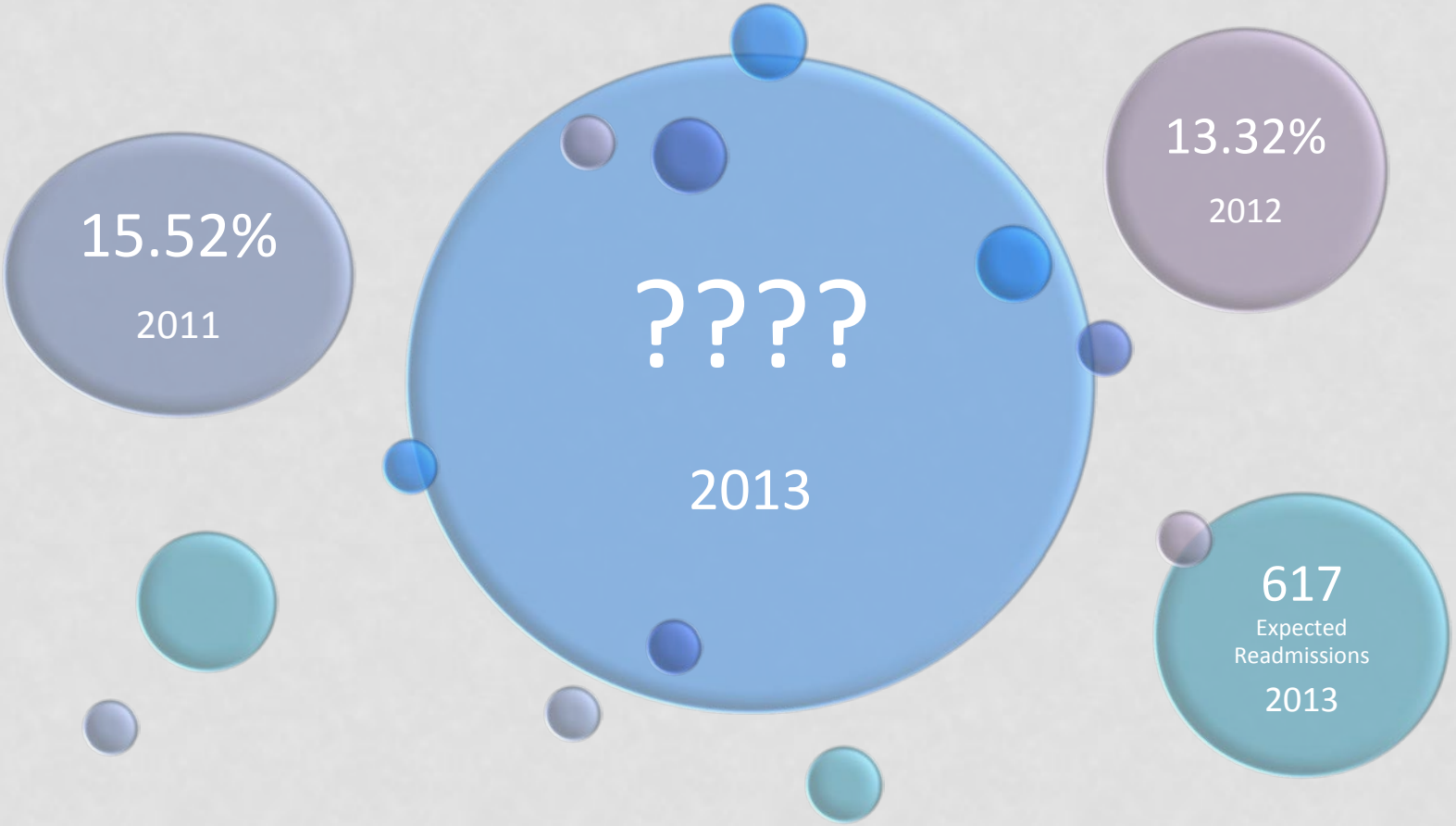
WEST BALTIMORE

Mapping the Course for Change

BON SECOURS BALTIMORE HEALTH SYSTEM

- Over 50% of readmissions are linked to illicit drug and/or alcohol abuse.
- Cardiovascular disease, diabetes, and COPD: two to three times higher than Maryland and Baltimore City.
- Emergency department visits are about 12% higher than the state average.
- Fewer Primary Care Doctors than other places in the state.

READMISSION DATA



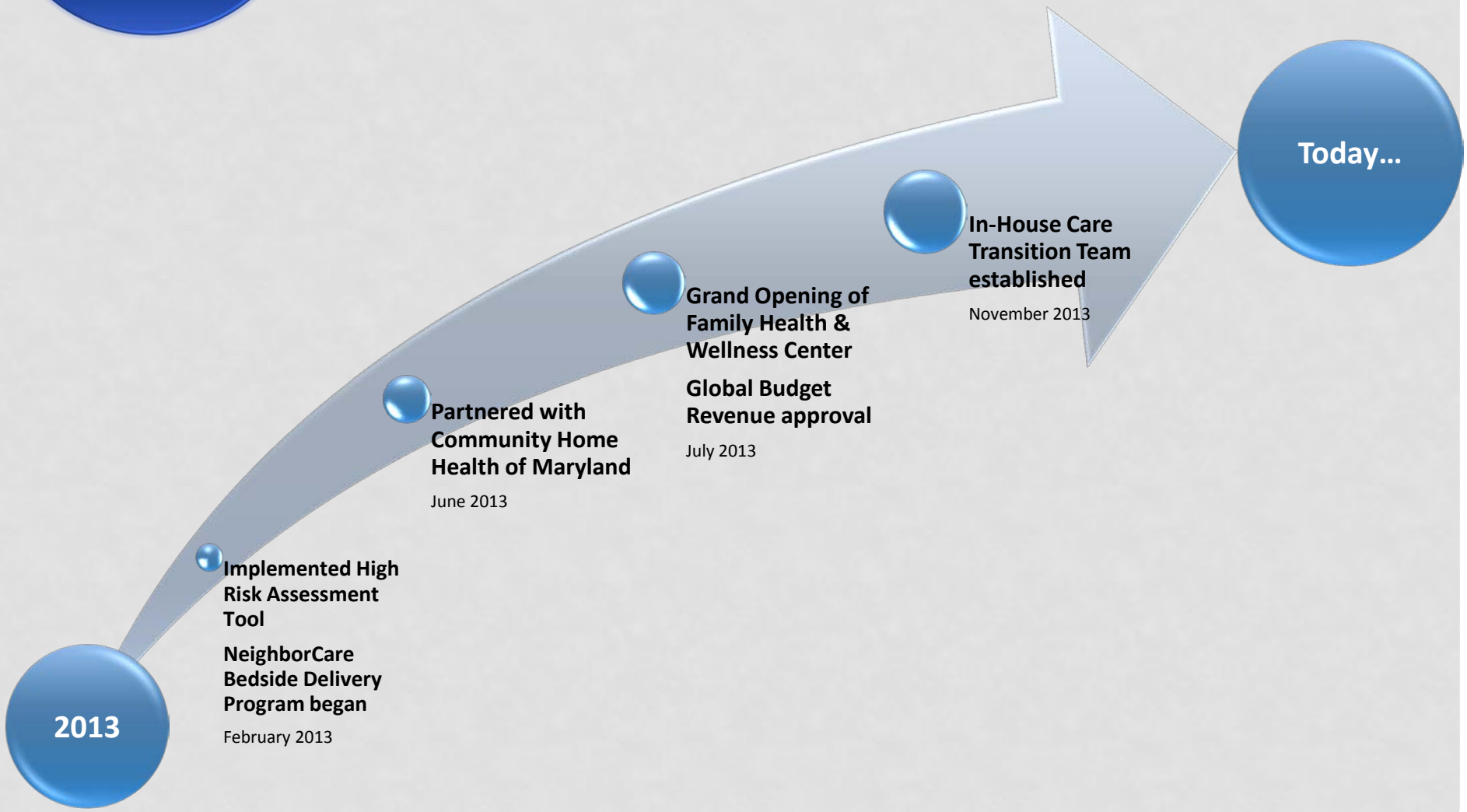
BON SECOURS BALTIMORE'S VISION

- Inpatient Care to Health Management
- Shift from Volume to Value
- People Care to Population Care
- Promoting Wellness

MAPPING THE COURSE FOR CHANGE…

MAPPING THE COURSE FOR CHANGE

MAPPING THE COURSE FOR CHANGE



ELEMENTS OF SUCCESSFUL CARE COORDINATION…

ELEMENTS OF SUCCESSFUL CARE COORDINATION

Nursing Home Readmissions:

- Significantly decreased from **18%** to less than **2%**.

Good Help ACO:

- **131** Medicare patients identified
- Working alongside the Family Health and Wellness Team and Physicians to create outpatient care plans for readmitted patients

ELEMENTS OF SUCCESSFUL CARE COORDINATION

The SBIRT Peer Recovery Coach Program:

- **3,800+** patients assessed
- **574** were referred to treatment
- **268** of those patients entered treatment

ELEMENTS OF SUCCESSFUL CARE COORDINATION…

The Coordinating Center's

West Baltimore Readmission Reduction Collaborative:

- **744** Medicare A & B patients enrolled
- Readmissions fell from **22%** to **14.3%** among three participating hospitals

ELEMENTS OF SUCCESSFUL CARE COORDINATION

The Heath Enterprise Zone Program:

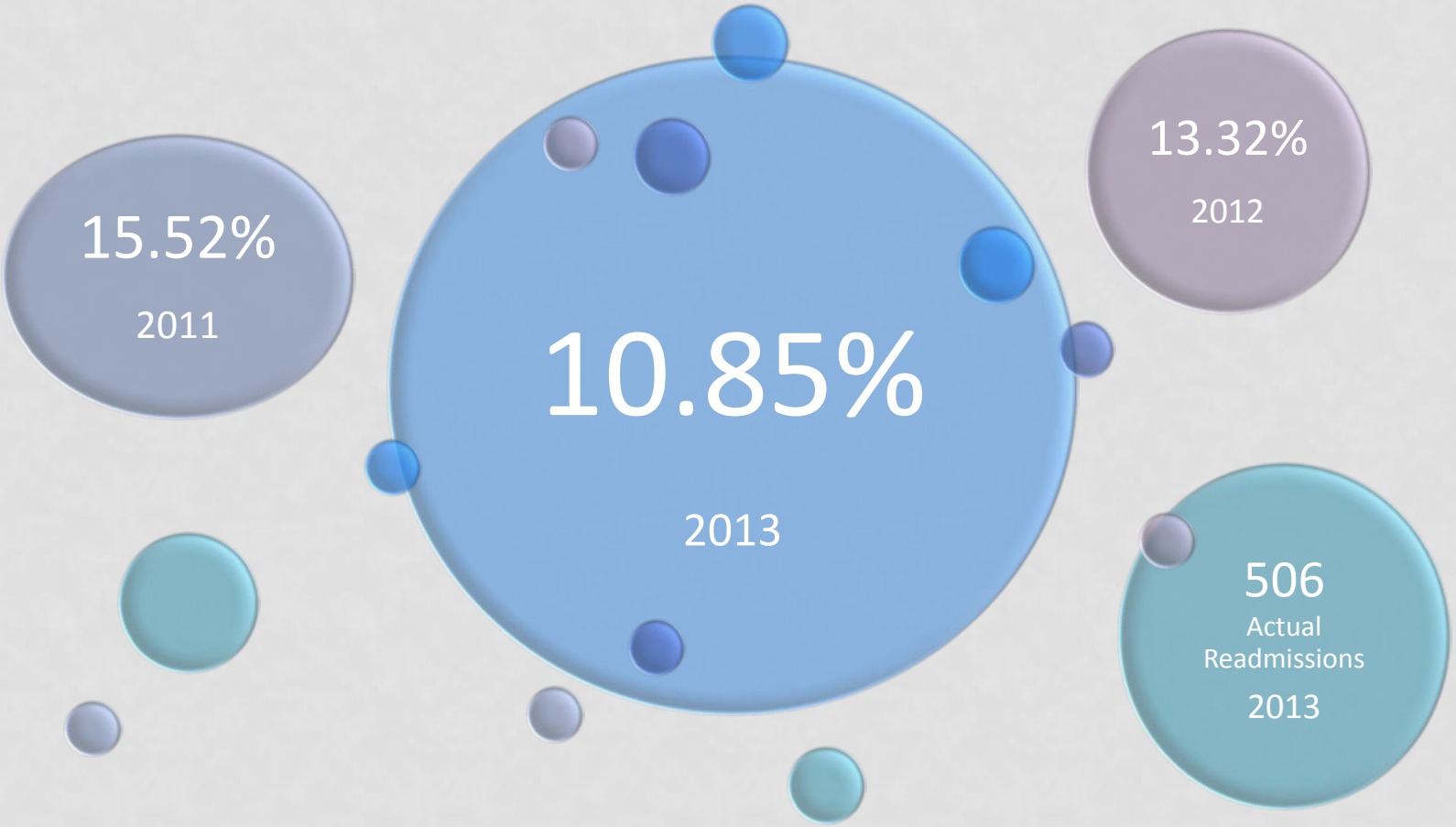
- **23** New Healthcare Providers in W. Baltimore
- **172** Community Members Partnered with Community Health Workers
- **11** Free Weekly Fitness Classes offered
- **250** W. Baltimore residents enrolled regularly in classes

IMPACT OF CARE COORDINATION…

The In-House Care Transition Team:

- High Risk for Readmission Assessments on new Med-Surg admissions
- Over **200** post discharge home visits
- Over **600** scheduled follow up appointments
- **13%** increase in overall show rate in 90 days

IMPACT OF CARE COORDINATION



IMPACT OF CARE COORDINATION

- Favorable ARR Charge per Episode Performance in FY13: $1,403,472
  - Rate Year to Date Expected: 617
  - Actual readmissions: 506 (decrease of 111)

- Core Measure Readmissions (AMI, HF, PNU, and COPD) have dropped significantly.
  - 0.90 Baseline (October 2012-June 2013)
  - 0.87 FY14 Readmission Index Target
  - 0.59 as of November 2013

WHAT WE HAVE LEARNED

Readmission Reduction = Improved Patient Outcomes

- Effective care coordination is the cornerstone of community sustainability.
  - Increase Partnerships within the Community
- Establish protocols for drug seeking patients.
- Continue to develop non traditional pathways to address the needs of our patients.
- Expand Primary Care with the addition of a Nurse Navigator