



Cecil County Community Case Management Program Pilot

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Why is This Linkage Important?

- To set the stage to participate in State's plan to develop a "community-integrated medical home" (CIMH) model of care.
- Union Hospital adopted HSCRC's Total Patient Revenue (TPR) methodology in FY 2011.



What is TPR?

- Fixed annual revenue
 - No adjustments for volume or case mix
 - Adjustment for inflation, population and market share (future)
- Incentive to:
 - Reduce utilization (length of stay, use rates, readmissions, unnecessary tests, etc.)
 - Reduce cost of care and improve collections/denial management
 - Align with Medical staff
- Shift from paying for volume to paying for the care of population



What is TPR? (continued)

Focus on Quality of Care

- Annual reimbursement impact for:
 1. MHACs (MD Hospital Acquired Conditions): 4% I/P revenue at risk
 2. Readmissions: .5% reward potential
 3. Quality Based Reimbursement (QBR): 1% at risk



What is TPR? (continued)

Finally....

Incentive to reinvest savings through:

- 1) Care coordination (right setting at the right time)
- 2) Managing episode of care
- 3) Treating chronic conditions BEFORE they require acute care hospitalization
- 4) Adding services such as home visit program, etc.



Cecil County ED Usage for Chronic Disease

- 236 emergency department visits for hypertension per 100,000 Cecil County population compared to 222 visits per 100,000 population in the State of Maryland
- 289 emergency department visits for diabetes per 100,000 Cecil County population in 2012 vs. 275 visits per 100,000 Cecil County population in 2011

Source: Maryland State Health Improvement Plan 2012



More Data

- 50% of annual Union Hospital re-admissions have some behavioral health history;
- 80% of annual hospital admissions come through the emergency department; and
- 20-25 readmissions per month are for COPD/ respiratory diseases, heart failure/ heart disease and diabetes.

Source: May 30, 2013 interview with Union Hospital Senior VP/CFO



Goals of Cecil Community Case Manager Program Pilot

- Reduce unnecessary hospital readmissions for certain chronic conditions - COPD/ respiratory diseases, heart failure/ heart disease and diabetes



Objectives of Cecil Community Case Manager Program Pilot

- Provide 4-6 week patient-centered plan of care that focus patients, families and caregivers to better self manage their disease processes in an outpatient setting and to avoid a health crisis requiring hospital readmission or ED visit
- Plan of care to address medication adherence, continued health care provider support, education on disease “red flags” (disease crisis signals which may alert to the need for community intervention or a return to the hospital), removing barriers the care, and establishing a personal health record



Operationalizing Community Case Manager Program Pilot

- Hire 1 FTE Health Department nurse case manager with MD Community Health Resources Commission funds to augment 1 FTE Health Department nurse case manager funded by Union Hospital
- Voluntary program
- No cost to the patient
- Evidence-based “Project Re-Engineered Discharge (RED)” Boston University Medical Center
<http://www.bu.edu/fammed/projectred/index.html>



Operationalizing Community Case Management Program Pilot

- Hospital Complex Case Manager selects patients based on diagnosis, barriers to care, risk of readmission, insurance status
- Hospital discharge planners and community case managers keep in contact daily and meet every other week to discuss referrals and patients in the pilot to identify barriers and progress that the patients have made, including discharges from the pilot.



Role of Community Case Manager

- **Assist with coordination of services and implementation of disease management strategies** which could lead to:
- Earlier identification of health issues,
- Earlier connection to community resources, greater awareness of alternatives to hospital-based care, and
- Strategies to better self-management of their chronic diseases in the home or outpatient environment – all outside the walls of the hospital.



Visit #1

- The community case manager's first visit with the patient will occur pre-discharge from the hospital, where the patient will be offered and can sign up for the post-discharge service.
- Sometimes referrals are received after discharge



Visit #2

- Visit #2 will occur immediately after discharge. This visit, and hopefully all future visits, will be at the patient's home. At this visit, a physical assessment is completed, discharge instructions are reviewed, goals are established, and disease education, including “red flags”, occurs.



Visit #3

- Visit #3 happens about one week later - another physical assessment is completed and “red flag” disease education is reviewed. If needed, patient develops a health care plan to accomplish patient-centered goals.
- Subsequent visits are scheduled according to the needs/acuity of patient.



Visit #4

- During Visit #4, about one week later, the community case manager conducts another physical assessment, reinforces the “red flags” with the patient and family, revisits goals and modifies same as needed, and follows up with the primary care provider and any other community agencies providing services.



Visit #5

- It is hoped that Visit #5 will be the final visit. The community case manager would re-cap the patient's accomplishments, identify any further work that needs to be done, review "red flags" and community resources, and complete the patient's personal health record.



Barriers to Success

- Transportation
- Medication adherence
- Compliance
- Personal finances
- General unwillingness to comply
- Physicians are referring patients to the ED when follow-up appointments (non-emergent care) are requested by the CCM nurses
- Social issues
- Behavioral health issues, including tobacco use



Evaluation Plan

Community Case Manager Program Pilot

- 95% of first/second visits with readmitted patients made within two days of discharge, with 75% of those contacts a home visit
- 75% of patients referred will complete the Community Case Management Program pilot
- 58% reduction of hospital readmissions (from 60 to 25) within a 30 day post-discharge window for Community Case Management Program pilot patients



Evaluation Plan

Community Case Manager Program Pilot

- Each enrolled patient will access at least two community and/or provider resources (clinic, primary care, home health, etc.) that contribute to the successful accomplishment of the patient's health care plan and goals
- 75% of enrolled patients will be able to establish a personal health record
- 75% of patients/ family who complete the program would recommend the program to others



Sustainability Plan

Community Case Manager Program Pilot

- Union Hospital is continuing the home visit program with weekly visits for high risk and readmitted patients by nurse practitioners (part of Union's Hospitalist Program).



Results through August 31. 2014

- In the 30 days prior to referral to the CCMP, 160 patients had **198 ED visits, 60 hospital admissions, and 28 observation stays** related to the chronic diseases mentioned above.
- At 30 days post discharge from the CCMP, these same patients had **53 ED visits, 25 hospital admissions and 9 observation stays, a 70% decrease in visits.**



Results through August 31, 2014

- During the time the 160 patients were in the CCMP, only 15 ED visits and eight hospital admissions occurred related to the above-mentioned chronic diseases.



Questions?

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