WESTERN MARYLAND HEALTH SYSTEM
CENTER FOR CLINICAL RESOURCES

Addressing Chronic Health Conditions

Managing Chronic Conditions

- Important Strategy for Achieving Triple Aim of Healthcare and Successfully Operating Under TPR
- Local data used to identify top chronic conditions
- Three separate clinics established:
  - Congestive Heart Failure
  - Diabetes Medical Home
  - Outpatient Anticoagulation Clinic

Center for Clinical Resources

- Realized patients had multiple chronic conditions
- Lobbied for space where all current clinics could be housed
- Recommended by CFO to plan clinic as a free service
- Addressed how to meet patients' socioeconomic needs
  - Allocated funds to assist with other patient needs
  - Staff empowered to access funds

Resources in the CCR

- Nurse Practitioners
- Registered Nurses
- Dietitians
- Pharmacists
- Respiratory Therapists
- Care Coordinators
- Certified Diabetes Educators
- Exercise Physiologist
- Wellness Coach
- Community Resource Liaison

Advantages

- Coordinates care to ensure patients receive the right care in the most appropriate setting
- Centralizes services to remove the logistical barriers of multiple appointments in multiple locations
- Serves as a resource for Primary Care Providers. Can refer their patients who need extra help managing their health.

CCR Core Services

- Diabetes Management
- Chronic Heart Failure
- COPD Clinic
- Outpatient Anticoagulation Clinic
- Medication Therapy Management

CCR Central Services

- Office Coordinator/Navigator
- RN
- Intake Coordinator
  - Spending the time to identify issues
  - Addressing social/economic issues
  - Linking them to WMHS & community resources
- Community Health Workers

High Utilizers

- Identified high utilizers of hospital services
  - 8 or more visits in a 12-month period
  - Close to 300 patients
- Worked with IT to develop an alert when they arrive in the ED or are admitted
  - Notifies Care Coordinators and CCR
- Visit each one while they are here to encourage use of CCR

Admissions & Readmissions

- Initiated process where all patients being registered are asked about CCR
- Alerted when a CCR patient is readmitted
- Notified when an inpatient is a candidate for CCR
- Implemented process for Community Health Workers to visit these patients
- Try to have appointment date for them scheduled before leaving the hospital
- Developing Diabetic Care Team for newly diagnosed diabetics – focusing on education

Congestive Heart Failure

CHF Admissions Per Patient Managed by CCR

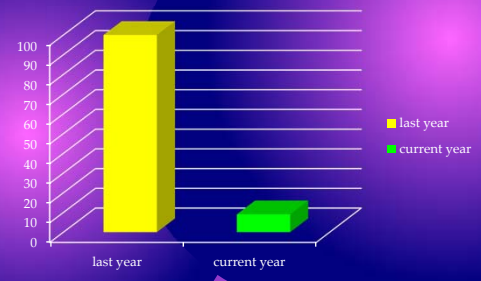
Diabetes

Inpatient Admissions & OBS Visits Down 27%

ED Visits Down 16%

For Diabetic Patient Managed by CCR

OPAC



Reduction in readmissions to hospital within one year

$avings:

$3,123,757

For CHF/Diabetic/OPAC Patients

The Team

CCR Summary

- Effectively manages at-risk patients to reduce their use of ED, Observation, and inpatient services.

  Targets patients with:

  - Diabetes
  - Chronic Heart Failure
  - Anti-Coagulation Medications
  - COPD
  - Complex or Multiple Medications
  - or a combination of any of the above