Case Conference: Care Coordination Continuum Task Force

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Care Coordination Continuum Task Force

Case Conference Project

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Case Conference Project

Purpose: create case conference process that will bring together caregivers of identified high utilizers of healthcare and will provide targeted multidisciplinary intervention to coordinate care for these complex cases

- Problem to address: Patients that have frequent use of health care (Hospital Readmissions, ER visits, and Primary Care) are often complicated by socioeconomic related factors

- Process to Improve: Initiate Case Conferences as a way to identify gaps in patients access to resources and link the care team by reviewing shared complex patients; communicate challenges and create a consistent plan of care
Background

- 2013, the Centers for Medicare and Medicaid Services initiated the Hospital Readmissions Reduction Program (HRRP) ¹

- Value-based reimbursement system is based on patient outcomes ⁴

- HRRP penalizes hospitals that have higher than average readmission rates among patients with common but serious conditions, such as heart failure and pneumonia ¹

- ACA: unexpectedly, more utilization of ER was noticed after the ACA was implemented, especially by Medicaid users who had new access to healthcare ²
Medicare beneficiaries contributed the most to high hospital spending on readmissions. Hospital readmissions cost Medicare about $26 billion annually, with about $17 billion spent on avoidable hospital trips after discharge.\(^4\)

Majority of cases, HRRP penalties is less than 1% of the hospital's total Medicare payment.\(^1\)

Readmission rates averaged more than 20 percent six years ago before the penalties kicked in. Hospitals' efforts cut that to 15.3 percent in 2017.\(^5\)

**Examples:**

- Beaumont Hospital in Royal Oak lost $2.4 million in Medicare reimbursement in 2018 with a 17.6 percent readmission rate, slightly above the national average of 15.3 percent.\(^5\)
- St. John Hospital and Medical Center in Detroit lost $277,000 in 2017 with a 16 percent readmission rate.\(^5\)
- And Henry Ford Hospital in Detroit lost $837,990 with a 16.8 percent readmission rate.\(^5\)
A look at the Aurora Sinai Medical Center Pilot Project

- Only hospital left in a mostly poor area of downtown Milwaukee
- 313 patients who visited ER at least five times in four months were identified
- The social workers chose 39 people out of the 313
- Developed a plan for each patient that included finding transportation to a doctor, securing child care for the appointment, making a first appointment, and they even sometimes accompanied them to the visit
- After the visit, the social workers ensured that the patient made at least two follow-up appointments

Results

- In the first four months, visits by these 39 people to the Aurora Sinai emergency room fell by 68 percent, from 487 to 155
- Compared to four months before the program, the cost fell from $1.5 million to $440,000
Case Conference Project

- Implemented the Lean Six Sigma DMADV framework to identify the problem, capture current processes, analyze available resources, and design a process that is achievable, functional, efficient, and maximizes benefit to the patient.
Further Implementation Opportunity:
Monitor readmission rates, and develop targets (as needed) to measure our success.

Data (patient list):
Analytics creates ranked list based on decided upon weighted score of factors like inpatient re-admission, ED visits, Outpatient care, and Principal inpatient dx of behavioral health.

Case conference committee:
Care managers, MSW, RN, home care services, pharmacy, 211 central Michigan, specialists, PCP, Case manager, community paramedics, transition coordinator, telemonitoring, lab and imaging,

Conference meeting:
Monthly to discuss barriers of care including social determinants of health, create a consistent plan of care.

EPIC:
Plan of care is documented and uploaded to Epic.

Assessment:
Failure or success of care Plan is assessed by qualitative assessment of assigned care manager.

Further Implementation Opportunity:
Monitor readmission rates, and develop targets (as needed) to measure our success.
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**Project Charter**
- **Problem Issue**
  Patients that have frequent use of health care are often complicated by socioeconomic related factors
- **Process to Improve**
  Targeted multidisciplinary intervention to coordinate care; done with a Case Conference format
- **Metric to Change**
  Implementation of Case Conference
- **Target of Performance**
  Decrease rates of healthcare use and hospital re-admission

**Analysis of Causes**
- Patient are increasingly affected by influences surrounding their healthcare
- No current process for identifying and following patients who need access to community resources

**Improvement Actions**
- Initiate Case Conferences as a way to identify gaps in patients access to resources
- Link the care team by reviewing shared complex patients; communicate challenges and creating a consistent plan of care

**Next Actions**
- Monitor readmission rates, and develop targets (as needed) to measure our success

**Lessons Learned**
- Implementing the DMADV framework
- Develop and improve the process of measuring success of the project
- Providing confidential access to all stakeholders

**Results**
- Identified owners to the process and created standard work to ensure success in the adaptation of the new process

**Case Conference Workflow**
- Case Conference Leader
  - Solicits and accepts input from Committee members about patients that may require a Case Conference
  - Uses rank list and input from case conference team to determine 2-4 patients that will receive Case Conference at next session
  - Contact Case Conference team, either email list or Epic Pool List and notify of upcoming case conference
  - Determine if additional specialties (or their representatives) or parties are required
  - Notify/invite via email to Case Conference, using standard template
- Case Manager
  - Review assigned patients, and prepare possible interventions based on their area of expertise
  - Assign patient to a Care Manager, preferably one that has already worked with the patient
- Care Manager
  - Completes "Social Determinants of Health" and sends data to team preferably by upload in Epic but may supply via email if not on Epic
  - Gives input to Case Conference Leader, suggesting possible patients for Case Conferences
- Case Conference:
  - Occur on the first Monday of every month, from 9:30 - 10:30 AM. Attendance is in person or by Skype.
  - IF EPIC, then simply refer stakeholders to EPIC Inbasket Task and message. A notification does not have to be sent, as a task message will be received to email or Lync message.
  - IF stakeholder does not have EPIC, will be notified by email or Lync message.
Case Conference Workflow

Pre-Conference

Analytics

- Creates ranked excel list based on decided upon weighted score

Case Conference Leader

- Solicits and accepts input from Committee members about patients that may require a Case Conference
- Uses rank list and input from case conference team together, to determine 2-4 patients that will receive Case Conference at next session

Care Manager

- Assign patient to a Case Manager, preferably one that has already worked with the patient

Case Conference Team

- Determines if additional specialists or parties are required
- Review assigned patients, and prepare possible interventions based on their area of expertise

Case Conferences: Occur on the First Monday of every Month, from 9:30-10:30AM. Attendance is in person or by Skype

Complete “Societal Determinants of Health”

Notify/invite via email to Case Conference, using standard template

Send data to team preferably by uploading in Epic but may supply via email if not on Epic

Send electronic copy of list to Case Conference Leader and Director of Population Management

IF EPIC, then simply refer members to EPIC InBasket Task/message. IF stakeholder does not have EPIC, will be notified by email or my Lync message.
References


3. “Reducing Hospital Readmissions: It’s About Improving Patient Care, " Health Affairs Blog, August 16, 2013. DOI: 10.1377/hblog20130816.033808
References
