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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 rates [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 [2]

Results

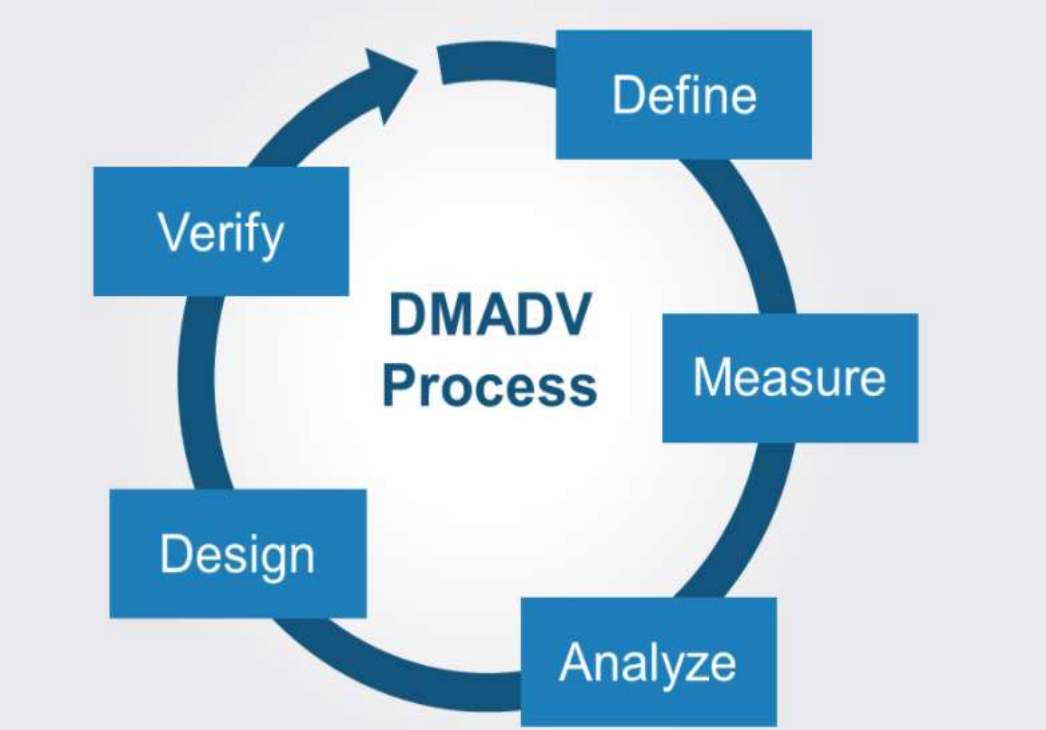
- In the first four months, visits by these 39 people to the Aurora Sinai emergency room fell by 68 percent, from 487 to 155

- Compared to four months before the program, the cost fell from $1.5 million to $440,000 [2]

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.

Lean Six Sigma: DMADV



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 is 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

Team Members

- **Executive Sponsor**
  Wendy Boersma
- **Process Owner**
  Margaret Brown
- **Subject Matter Experts**
  Nancy Arce
  MaryJo White
  Jeff Holden
  Alyse Rainey
  Linda Klee
  Sharon Petri
  Michael Yangouyian, DO

Analysis of Causes

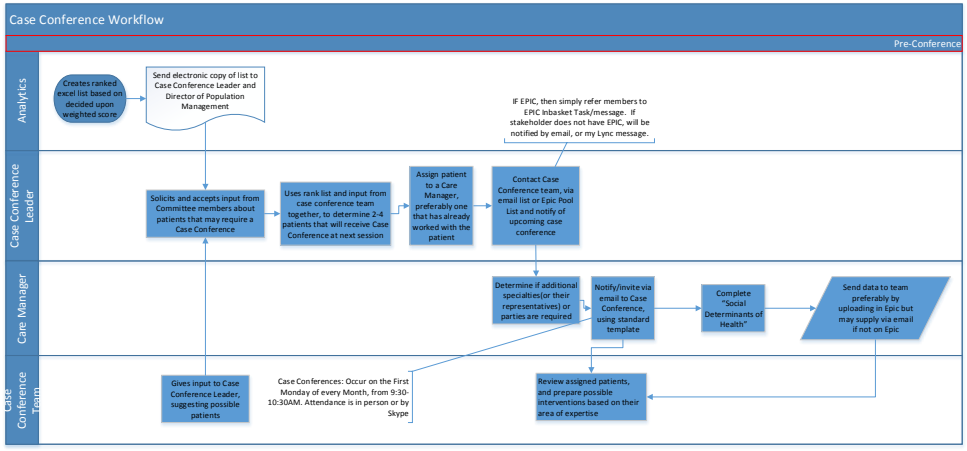
- Patient are increasing affected by influences surrounding their healthcare
- No current process for identifying and following patients who need access to community resources

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

Results

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

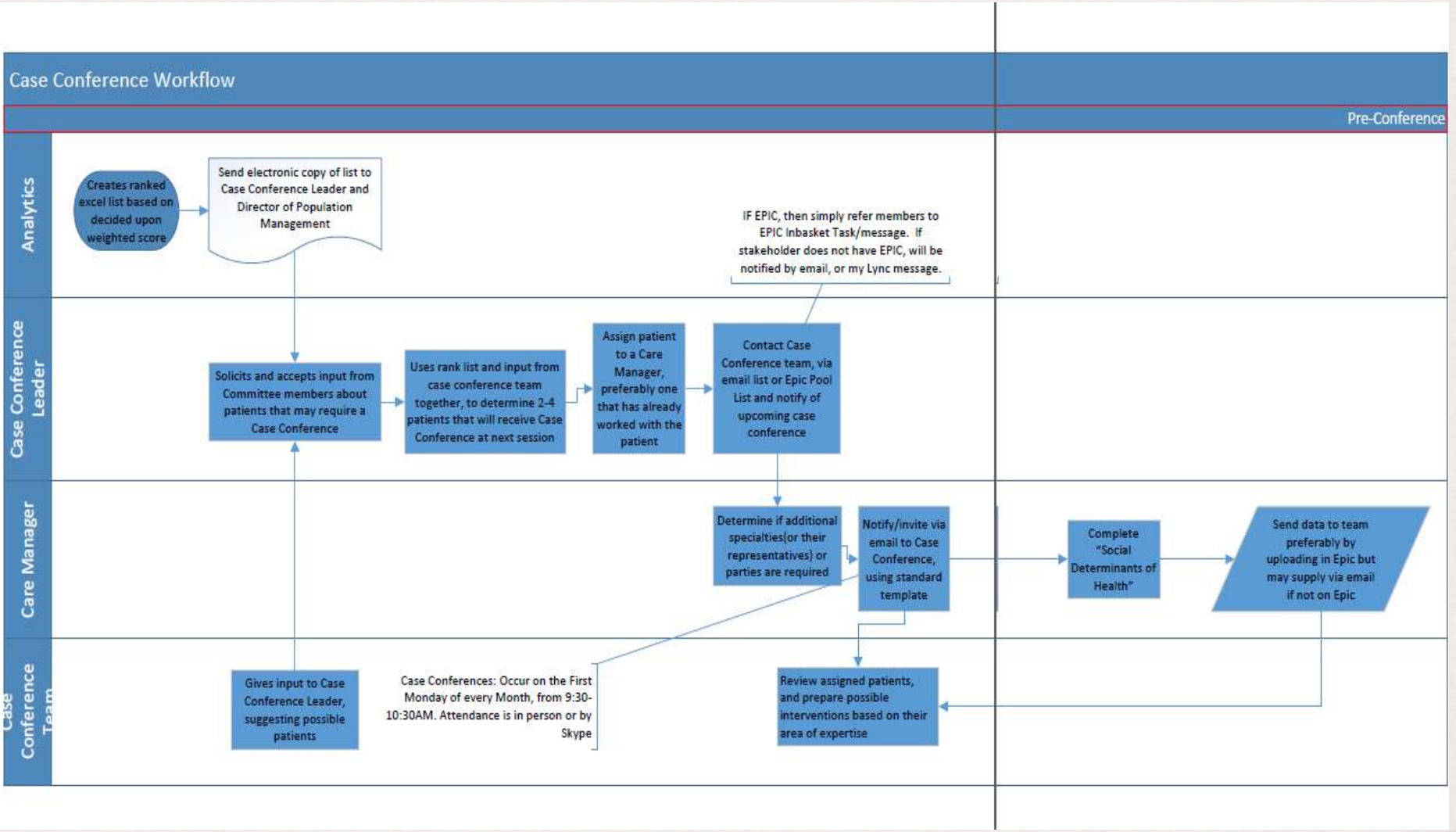


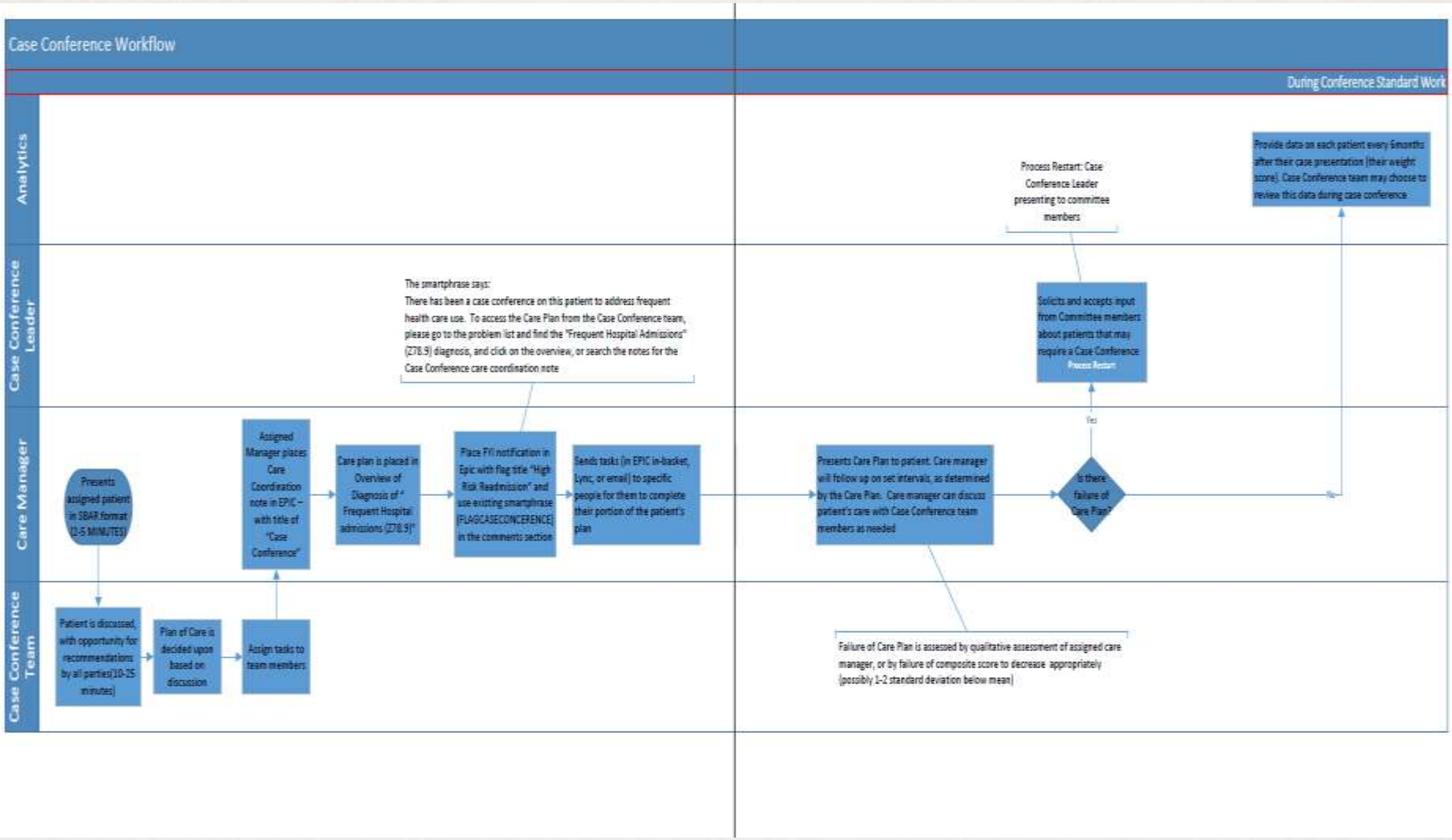
Next Actions

- 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


Case Conference Workflow
Pre-Conference
Analytics
Case Conference Leader
Care Manager
Case Conference Team
Creates ranked excel list based on decided upon weighted score
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.
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
Assign patient to a Care Manager, preferably one that has already worked with the patient
Contact Case Conference team, via 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
Complete "Social Determinants of Health"
Send data to team preferably by uploading in Epic but may supply via email if not on Epic
Gives input to Case Conference Leader, suggesting possible patients
Case Conferences: Occur on the First Monday of every Month, from 9:30-10:30AM. Attendance is in person or by Skype
Review assigned patients, and prepare possible interventions based on their area of expertise


Case Conference Workflow
During Conference Standard Work
Analytics
Case Conference Leader
Care Manager
Case Conference Team
Provide data on each patient every 6months after their case presentation (their weight score). Case Conference team may choose to review this data during case conference
Process Restart: Case Conference Leader presenting to committee members
The smartphrase says:
There has been a case conference on this patient to address frequent health care use. To access the Care Plan from the Case Conference team, please go to the problem list and find the "Frequent Hospital Admissions" (Z78.9) diagnosis, and click on the overview, or search the notes for the Case Conference care coordination note
Solicits and accepts input from Committee members about patients that may require a Case Conference
Process Restart
Yes
Presents assigned patient in SBAR format (2-5 MINUTES)
Assigned Manager places Care Coordination note in EPIC – with title of "Case Conference"
Care plan is placed in Overview of Diagnosis of " Frequent Hospital admissions (Z78.9)"
Place FYI notification in Epic with flag title "High Risk Readmission" and use existing smartphrase (FLAGCASECONCERENCE) in the comments section
Sends tasks (in EPIC in-basket, Lync, or email) to specific people for them to complete their portion of the patient's plan
Presents Care Plan to patient. Care manager will follow up on set intervals, as determined by the Care Plan. Care manager can discuss patient's care with Case Conference team members as needed
Is there failure of Care Plan?
Patient is discussed, with opportunity for recommendations by all parties(10-25 minutes)
Plan of Care is decided upon based on discussion
Assign tasks to team members
Failure of Care Plan is assessed by qualitative assessment of assigned care manager, or by failure of composite score to decrease appropriately (possibly 1-2 standard deviation below mean)

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QUESTION

References

1. Stubenrauch JM. Project RED Reduces Hospital Readmissions. Am J Nurs. 2015 Oct;115(10):18-9. doi: 10.1097/01.NAJ.0000471935.08676.ca. PubMed PMID: 26402279.

2. NPR. A Hospital Reduces Repeat ER Visits By Providing Social Workers. 2015 Oct. https://www.npr.org/sections/health-shots/2015/10/23/451154605/a-hospital-reduces-repeat-er-visits-by-providing-social-workers.

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

References

4. LaPointe, Jacqueline. 3 Strategies to Reduce Hospital Readmission Rates, Costs. Revcycleintelligence. 2018 January. https://revcycleintelligence.com/news/3-strategies-to-reduce-hospital-readmission-rates-costs

5. Greene , Jay. Hospitals use home health to cut costs of readmission. Crainsdetroit. 2018 June. https://www.crainsdetroit.com/article/20180624/news/664501/hospitals-use-home-health-to-cut-costs-of-readmission