Transitional Care in a Rural Setting:

Redesigning Hospital Discharge to Enhance Patient Care

Tuesday, February 7, 2017
Welcome

L. Lee Isley, Ph.D, FACHE
Chief Executive Officer

Wendi Yancey, BSW
Transitional Care Director

Jason Brand, MHA, M.Ed.
Administrative Director, Emergency Medicine
A Competitive Region
Granville County, NC

- Granville Population: 51,341
- Total Service Area Population: 150,013
- 40 Miles North of Raleigh, NC
GHS Snapshot

Structure
• Independent hospital (One of a few left in NC)
• Local Board of Trustees
• Not for profit

Key to the Local Economy
• Leading employer in the Communities we serve
• 645 employees
• Granville Health System (FY17 Budgeted)
  Annual Payroll: $29.1 million
  Annual Benefits: $7.8 million
  Total Net Operating Revenue: $62.9 million
GHS Partnerships

Partnerships: Local & Regional

- Regional partnerships with tertiary facilities:
  - UNC: Cardio Vascular and ENT
  - WakeMed & Wake Forest Baptist Health TeleStroke/Neurology
  - Duke Medicine: Primary Care Residency
- Transition of County EMS to Granville Health System
- Currently preparing to enter a Clinically Integrated Network (CIN) partnership with the UNC Health Alliance.
  - Working with local business; supporting a population health management approach to delivering care and managing cost.
The Challenge

How does the Health System remain competitive and viable?

• GHS splits the primary service area market share with competitors
  • Duke is the largest competitor and a 30-minute drive South
  • Other Duke-Lifepoint hospitals flank GHS to the East and West

What we knew:

• As the landscape of healthcare changed, the way GHS conducted business would need to evolve. We had identified:
  • How we maximize reimbursement rates for our commercial and high level of Medicare/Medicaid participants thru a quality-based program?
  • How we would prepare the Health System for population health and participation into a clinically integrated network?
  • How we would manage the healthcare expenses of GHS employees and other area companies through plan design and narrow networks.
GHS Turned to Transitional Care

How did Transitional Care evolve?

• Quality Program
• Reimbursement guidelines based on:
  • ACA
  • Managed Care
  • Capitated Models
  • CMS Quality & Pay for Performance
• The new environment of healthcare: Pay for performance, based on quality and outcome.

The realization?

1. Ultimately, we are responsible for the decisions our patients make.
2. If we get our patients out of the hospital and back to their Primary Care Provider (PCP), good things will happen.
Building the Model: Strategy

In order to be successful, the Transitional Care Program required:

• Board of Trustee Buy-in
• Medical Staff Led with Identified Physician Champions
• Rethinking the traditional Case Management model
• Inclusion and Participation from all Involved Areas:
  • Transitional Care (Case Management)
  • Hospitalists
  • Emergency Medicine
  • Primary Care (including non-GHS, area physicians)
  • Local Home Health Agencies and other Community Partners
  • Long Term Care
• Establish the goal to come together as a medical community and support the concept of the medical home as the anchor of the program.
• Working with patients to make better decisions leading to improved quality of life.
Timeline: GHS Transitional Care
A program born from Primary Care and Quality:

2012
- The Board and Medical Staff approve the creation of a service line dedicated to managing patients’ continuum of care.
- Primary Care Service Line (PCSL) develops discharge education and pathways
- PCSL identifies CMS core measures
  - Evolving methodology for identifying measures
  - Initial focus on Diabetes; additional diagnosis are introduced to the program: CHF, COPD, PNA
- Care coordination begins upon admission

2013
- PCSL incorporates home visits: complete medication reconciliation
- Care management protocols developed
- Diabetic patients to be scheduled for eye exams
- ED readmit flag
Timeline: GHS Transitional Care

2014

- PCSL develops into “Community Transitional Care”
  - Patients to follow up with PCP within 14 days; appointments made while patient is still in the hospital. PCP follow up confirmation
  - Focus on readmissions (added as a metric) and medication reconciliation
- Works to identify additional internal resources to support program
  - Community Alternative program (CAP) and EMS identified as support resource for home visits and safety checks
- EMS and CAP begin visiting homes

2015

- EMS increases home visits: Implements Mobile Integrated Health Program
- Granville commits Primary Care Practices to reserve 7 slots per day to schedule transitional care patients
- Focus on reduced readmissions, improves PCP follow up to 7 days and home visits within 3 days for high-risk diagnosis patients
  - Reevaluate definition of high-risk diagnosis
Timeline: GHS Transitional Care

2016

• Home visit criteria reevaluated, resulting in an increase in the number of patients qualifying for home visits (increased from 30 patients in previous year to 86 in 2016).

• Emergency Department begins scheduling PCP appointments for high risk diagnosis patients
  • Focus on reduction of Emergency Department bounce backs
  • Begin monitoring compliance with PCP follow up visits

• Identified a need to increase program resources in order to care for additional qualified patients.

• Secured a grant source to fund the expansion of the program.
Success Stories

Readmission for new onset of Diabetes
• Was not taking Medications as prescribed due to cost.
• Transitional Care Coordinator (TCC) identified issues with patient’s insurance coverage, worked with patient and pharmacy to correct insurance error, significantly decreasing patient’s monthly co-pay
• Decreased the cost from more than $200.00 per month to $20.00 per month.
• EMS followed up with a home visit to review medications

The Outcome
• Patient following up with PCP
• Patient now compliant with medications.
• No new readmissions
Success Stories

New Onset of Diabetes & did not have a PCP

- Due to the nature, and timing, of the diagnosis, the patient was identified as a readmission risk

The Outcome

- TCC identified an accepting Primary Care Physician
- Provided additional education on monitoring blood glucose levels and a glucometer at discharge.
- Conducted a home visit to confirm patient’s compliance and understanding of medical condition.
- Eye doctor appointment made as part of protocol revealing incidental need for corrective lenses.
- Six month follow up demonstrate patient managing diabetes.
- No new readmissions and followed up with his PCP.
Success Stories

Dangerous Home Conditions

- The Emergency Department initially identified a patient as a high-risk patient due to diagnosis and readmit flag due to previous admission. ED staff then contacted TCC.
- TCC intervened and indentified unsafe living conditions for the patient; not conducive to a healthy home recovery.
- Because of the home environment, high risk diagnosis, and readmission the patient was identified as a readmission risk.

The Outcome

- TCC worked with the patient and family to secure placement in Skilled Nursing Facility, allowing for the correct level of care.
- No new readmissions and followed up with her PCP.
Collecting the Data

How we monitored, measured, and adjusted the program

* Prior to FY 2015 – Collected Data at the Department Level

FY 2015

Unassigned Patients from ED requiring follow-up care are discharged with appointment to PCP
Baseline: 0%  Goal: 80%  Final: 79%

High Risk Hospital Inpatients seen by PCP within 7 days of Discharge
Baseline: 0%  Goal: 95%  Final: 95%

High Risk Hospital Inpatients discharged with f/u visit from a transitional care team member
Baseline: 0%  Goal: 85%  Final: 94%

Decrease readmissions for High Risk Dx (HF, PNA, Joint, COPD) as a percent of total available admissions
Baseline: 5.1%  Goal: 3.5%  Final:(1,763 / 42) 2.4%
Collecting the Data

How we monitored, measured, and adjusted the program

FY 2016

High Risk ED Patients seen by PCP within 7 days of Discharge
Baseline: 0%  Goal: 80%  Final: 86%

High Risk ED Patients discharged with no primary care received a follow up visit from a Community Paramedic
Baseline: 0%  Goal: 60%  Final: 50%

Decrease readmissions for High Risk Dx (HF, PNA, Joint, COPD) as a percent of total available admissions
Baseline: 2.4%  Goal: 1.4%  Final: (1,497 / 15) 1.0%
Collecting the Data

How we monitored, measured, and adjusted the program

FY 2017

Transitional Care will reduce the number of 30 day ED bounce backs for those high risk individuals who participate in the Community Paramedic Program

Baseline: 17%  Goal: 9%

High Risk ED Patients discharged with no primary care will receive a follow up visit from a Community Paramedic

Baseline: 50%  Goal: 60%

Decrease readmissions for High Risk Dx (HF, PNA, Joint, COPD) as a percent of total available admissions

Baseline: 1.0%  Goal: 1.0%
Program Results

The data supports our success

**FY 2016 Summary**

- Reduction in Inpatient Readmissions of patients with high risk Dx
  - $73,595 (GHS Board prepared to accept cuts in Fee for Service vs. Pay for Performance)
- Reduction in Self Pay Readmissions of patients with high risk Dx
  - $11,500 (Recognized Savings)

**FY 2017 Projected Revenue Increase**

Increased referrals back to Primary Care Practices

- 200 patient caseload (200 patients following up with their PCP)
  - PCP office visit TC codes post hospitalization @ $35.93 per visit = $7,186
  - Post PCP visit Chronic Care Management $42.60 (non face to face) each month per patient = $102,240
  - PCP visits: higher payor reimbursements for RHC clinics
- Total Increased Revenue = $109,426
Moving Forward

The Transitional Care Program to expand in 2017

• Duke Endowment Grant
  • EMS Mobile Integrated Health Program purchases a dedicated vehicle
  • Transitional Care adds additional FTE

• Chronic Care Managers added to Primary Care Practices to:
  • Provide 1 on 1 telephone conversations to address self-management of care, medication compliance and to ensure all necessary services, resources and equipment is utilized.
  • Establish effective monthly care plan and review problem lists.
  • Monitor patients’ physical, mental and social conditions.

• Further development and integration of the Hospitalist Program
  • Continue to develop care protocols

• Improved documentation and analytics
Lessons Learned

Commit to Building your own recipe for Transitional Care

Commit as an organization
• The program should be CEO Championed
• GHS monitors Transitional Care under our Quality Pillar
• The program remains directly tied to the Primary Care Service Line in terms of organizational planning and goal setting.

Establish buy-in early with your Board and Medical Staff
• Commitment to the mission and support of Care Protocols by PCPs is critical to the success of the program; including dedicated visit slots in the schedule.
• Continuous communication is key; keep the Board and Medical Staff apprised of the programs success and growth.
Lessons Learned

Commit to Building your own recipe for Transitional Care

Your bench will never be deep enough.

- Your recipe for success may not look like ours and resource solutions will differ:
  - GHS retooled the Case Management Department to transform into Transitional Care; adding only 1 FTE over 4 years.
  - Use your own solution; GHS does not have an established Home Health program, so the program recruited EMS and CAP for home visits.
  - Prepare your organization for a matrix approach to transitional care
    - There may not be solid lines in your reporting structure.
Lessons Learned

Commit to Building your own recipe for Transitional Care

You don’t know what you don’t know and you’ll never be ready
  • This is an evolving program and you must be comfortable with change
  • Your final solution may not exactly reflect the original blueprint of the plan

Indentify how you will collect and measure data
  • Remember, this is an evolving program and your measures may need to adjust to reflect change in the program and patient base.

Don’t underestimate the potential for growth
  • GHS Transitional Care program increased its patient load X3 over 12 months.
Thank You!

Granville Primary Care, Oxford providers left to right: Beverly Anderson, NP; Anita Rogers, PA; Marc Rogers, MD; Francine Chavis, MD; Michael Mahan, MD; Linda Mulhollen, FNP-BC; and Ted Carteaux, PA
Questions?

L. Lee Isley, Ph.D, FACHE
Chief Executive Officer
919.690.3405
lisley@granvillemedical.com

Wendi Yancey, BSW
Transitional Care Director
919.690.3298
wyancey@granvillemedical.com

Jason Brand, MHA, M.Ed.
Administrative Director, Emergency Medicine
919.690.3433
jbrand@granvillemedical.com