Bridging Traditional Long Term Services and Supports

With New Models of Value-Based Care

September 1, 2015
Using Community Care Coordination and Mobile Technology to Impact Health Outcomes and Reduce Avoidable Hospital Encounters
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The Mission

To partner with people of all ages and abilities and those who support them in the community to achieve their aspirations for independence, health and meaningful community life.
Our Care Transitions Approach

- Hospital to Home
- Hospital to SNF/Acute Rehab.

Goals:

- To reduce hospital readmissions and other avoidable hospital encounters

- To build partnerships to positively impact health

- To provide effective person-centered services
Target Population and Conditions

- CHF: 21%
- COPD: 16%
- Diabetes > 1 Hospital or ED visit per year: 20%
- ESRD: 9%
- Psychosis: 3%
- Pneumonia: 9%
- Septicemia: 4%
- Other Bacterial Skin Infection: 1%
- Major Depression or other depression: 11%
- Frequently Readmitted Patient > 2 in 6 months: 1%
- Major Depression or other depression: 1%
- Other Bacterial Skin Infection: 1%
- Major Depression or other depression: 1%
- Other Bacterial Skin Infection: 1%

Total Served: 5,471
Geographical Area of Focus - West Baltimore
## Community Demographics

<table>
<thead>
<tr>
<th></th>
<th>Southwest Baltimore</th>
<th>Baltimore City</th>
<th>Maryland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment</td>
<td>43%</td>
<td>34%</td>
<td>23%</td>
</tr>
<tr>
<td>Median HH Income</td>
<td>$23,070</td>
<td>$30,078</td>
<td>$56,250</td>
</tr>
<tr>
<td>Infant Mortality Rate (per 1,000 live births)</td>
<td>18.0</td>
<td>11.7</td>
<td>7.9</td>
</tr>
<tr>
<td>Life Expectancy</td>
<td>64.2</td>
<td>70.9</td>
<td>77.5</td>
</tr>
</tbody>
</table>

Sources: U.S Census Bureau, Maryland Department of Planning, Maryland Department of Health and Mental Hygiene, Baltimore City Health Department
Mortality Rate Comparison (per 10,000)

<table>
<thead>
<tr>
<th></th>
<th>Southwest Baltimore</th>
<th>Baltimore City</th>
<th>Maryland</th>
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</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>39.1</td>
<td>28.9</td>
<td>21.9</td>
</tr>
<tr>
<td>Cancer</td>
<td>27.7</td>
<td>23.4</td>
<td>19.2</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>9.8</td>
<td>5.2</td>
<td>0.96</td>
</tr>
<tr>
<td>Stroke</td>
<td>6.5</td>
<td>5.8</td>
<td>4.9</td>
</tr>
<tr>
<td>Diabetes</td>
<td>5.8</td>
<td>3.6</td>
<td>2.6</td>
</tr>
<tr>
<td>Chronic Lower Respiratory Disease</td>
<td>4.9</td>
<td>3.9</td>
<td>4.0</td>
</tr>
</tbody>
</table>

CLRD includes COPD, emphysema, bronchitis, and asthma.

Sources: U.S Census Bureau, Maryland Department of Planning, Maryland Department of Health and Mental Hygiene, Baltimore City Health Department
Staffing Composition

- Program Director
- Hospital Liaisons
- Scheduler
- RN Care Coordinator
- Health/Transition Coaches

* Ancillary Staff
  - Finance
  - Quality
The Hub Model

- RN Care Coordinator
- Scheduler
- Community Coach
- Community Coach
- Community Coach
- Community Coach
- Community Coach
Intervention

• 30 day Intervention based on the Coleman Model with a modified BOOST Model incorporated

• Liaison in each hospital to identify high risk population and enroll

• Pre-discharge visit and personal goal

• Post-discharge visit within 3 days
  ▫ Emphasis on physician follow up within 7-14 days
  ▫ Emphasis on Red Flags (early symptoms)
  ▫ Medication review
  ▫ Personal health record
  ▫ CAH – Care at Hand Survey

• 3 follow up phone calls (and CAH Survey)

• Tier 2 Option
Mobile Technology

- Community Coaches survey person at each encounter

- Survey questions are based on the person’s active issue(s)

- Risk alerts of early health decline are sent to RN Care Coordinator

- Deployment of clinical staff as needed, driven by data

- Creation of dashboards for trending and performance
CAH Measures - Prevented ED visits

Improvements performance

Prevented ED

Frequency: Weekly

Due date from: 02/01/2015

Due date to: 08/23/2015

Coach: Filter by Coach

Any Improvement
Early Disease Identification
Better outcome
Prevented ED

Notes

Add Note
ROI – Return on Investment

- **Financial Impact**
  - Money saved by reducing hospital encounters
  - Cost-savings on staffing configurations

- **Partnership Impact**
  - Hospitals, providers of care
  - Community-based organizations
  - Technology providers

- **Educational Impact**
  - Health disparities
  - In the hospital, in the community

- **Personal Impact**
  - Personal empowerment
  - Self-management skills
  - Strategies for long term
Mrs. Smith’s Story
 . . . and the Four Pillars

Personal Goal: Keeping her medication readily available and be well enough to go back to work as a cook.

Follow up Apt: Did not have PCP. Missed first apt. at community clinic, next available was one month later. Coach found an alternate clinic to take her sooner.

Medications: Trouble with transportation to pharmacy. In problem solving, coach found local pharmacy that delivered.
In her own words . . .

I cannot put into words how u have my life that now I want to live. If every hospital had u in it we could all live. When I had no hope you made me see other. I am blessed to have u in my life and my granddoughter now has her grandmom and I have u to thanks. Love

My little way of saying “thanks.”

U. Showed me a way of life I am blessed.
For questions or more info:

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