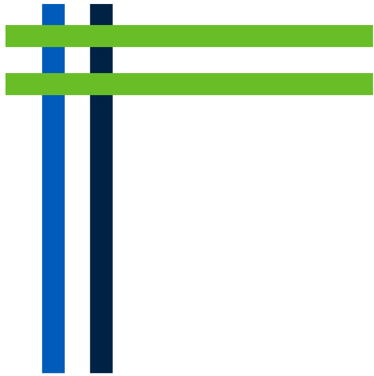


Maryland's Hospitals & Care Coordination

Carmela Coyle
President & CEO
Maryland Hospital Association

Care Coordination

- Not well defined
- In Medicare, mixed results
- Maryland is different
  - Testing in all payer environment
  - Significantly greater incentives
- Maryland hospitals focused on waiver success

Handle Transitions With Care

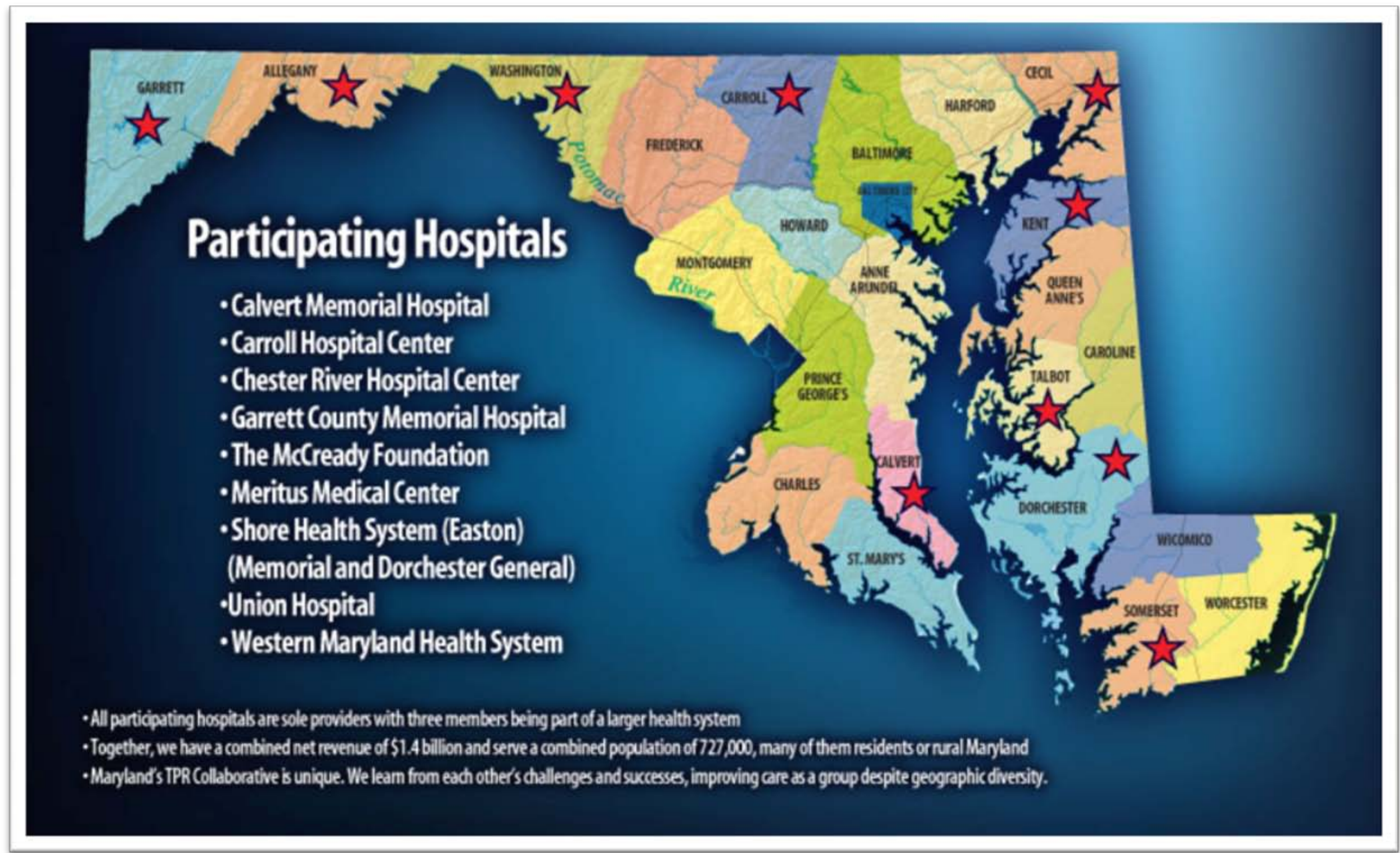
Partners Preventing Avoidable Readmissions

MHA Initiatives

- Learn – TPR Experience
- Partner – Dr. Amy Boutwell
- Convene – State care continuum partners
- Collectively Strategize – Portfolio approach/Best practices

HANDLE TRANSITIONS WITH CARE
Partners Preventing Avoidable Readmissions

Learn – TPR Experience



HANDLE TRANSITIONS WITH CARE
Partners Preventing Avoidable Readmissions

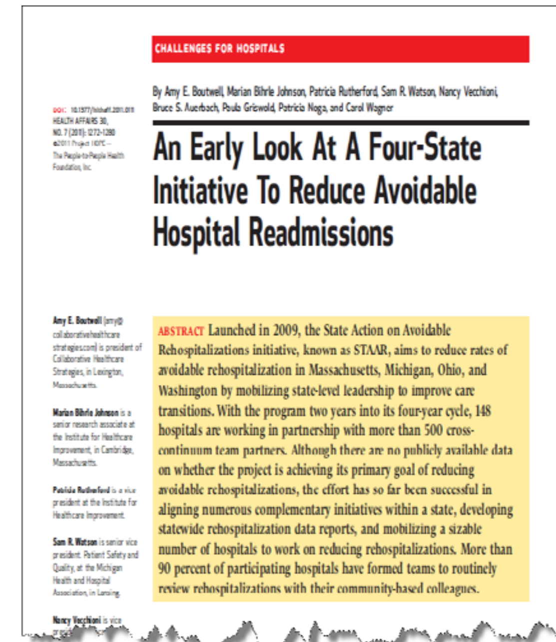
Learn – TPR Experience

- Pre-Acute Care
  - Added primary care practices
  - Created PCMHs
  - Developed high risk clinics
  - Partnered with urgent care centers
- Acute Care
  - Targeted high utilizers
  - Reviewed readmissions daily
  - Expanded care coordination: behavioral health and ED
  - "Discharge" redefined to 1st primary care visit
  - Discharge with meds
- Post-Acute Care
  - Care coordination teams
  - Expand home care resources
  - Community health workers
  - SNF transition care

Handle Transitions With Care
Partners Preventing Avoidable Readmissions

Partner – Dr. Amy Boutwell

- Co-designer IHI STAAR Initiative, first state/community based approach to reducing readmissions
- Advisor, national coordinating center for the CMS Care Transitions Aim
- Advisor, CMS Learning Systems for ACOs and Bundled Payments
- Co-Principal Investigator, AHRQ Reducing Medicaid Readmissions Project



CHALLENGES FOR HOSPITALS

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The People-to-People Health
Foundation, Inc.

By Amy E. Boutwell, Marian Bihrle Johnson, Patricia Rutherford, Sam R. Watson, Nancy Vecchioni, Bruce S. Auerbach, Paula Griswold, Patricia Noga, and Carol Wagner

An Early Look At A Four-State Initiative To Reduce Avoidable Hospital Readmissions

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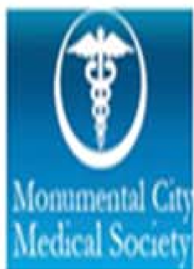
Nancy Vecchioni is vice

ABSTRACT Launched in 2009, the State Action on Avoidable Rehospitalizations initiative, known as STAAR, aims to reduce rates of avoidable rehospitalization in Massachusetts, Michigan, Ohio, and Washington by mobilizing state-level leadership to improve care transitions. With the program two years into its four-year cycle, 148 hospitals are working in partnership with more than 500 cross-continuum team partners. Although there are no publicly available data on whether the project is achieving its primary goal of reducing avoidable rehospitalizations, the effort has so far been successful in aligning numerous complementary initiatives within a state, developing statewide rehospitalization data reports, and mobilizing a sizable number of hospitals to work on reducing rehospitalizations. More than 90 percent of participating hospitals have formed teams to routinely review rehospitalizations with their community-based colleagues.

HANDLE TRANSITIONS WITH CARE
Partners Preventing Avoidable Readmissions

Convene – State Continuum Partners



mental health association of maryland

Convene – State Continuum Partners

- Focus on readmission reduction

"Rehospitalization is a system issue and the problem does not lie with one organization or one provider, but with the community and the local health care system. Addressing this issue will require organizations and providers to work together."

- *Anne-Marie Audet, VP, The Commonwealth Fund*

HANDLE TRANSITIONS WITH CARE
Partners Preventing Avoidable Readmissions

Who is High Risk?

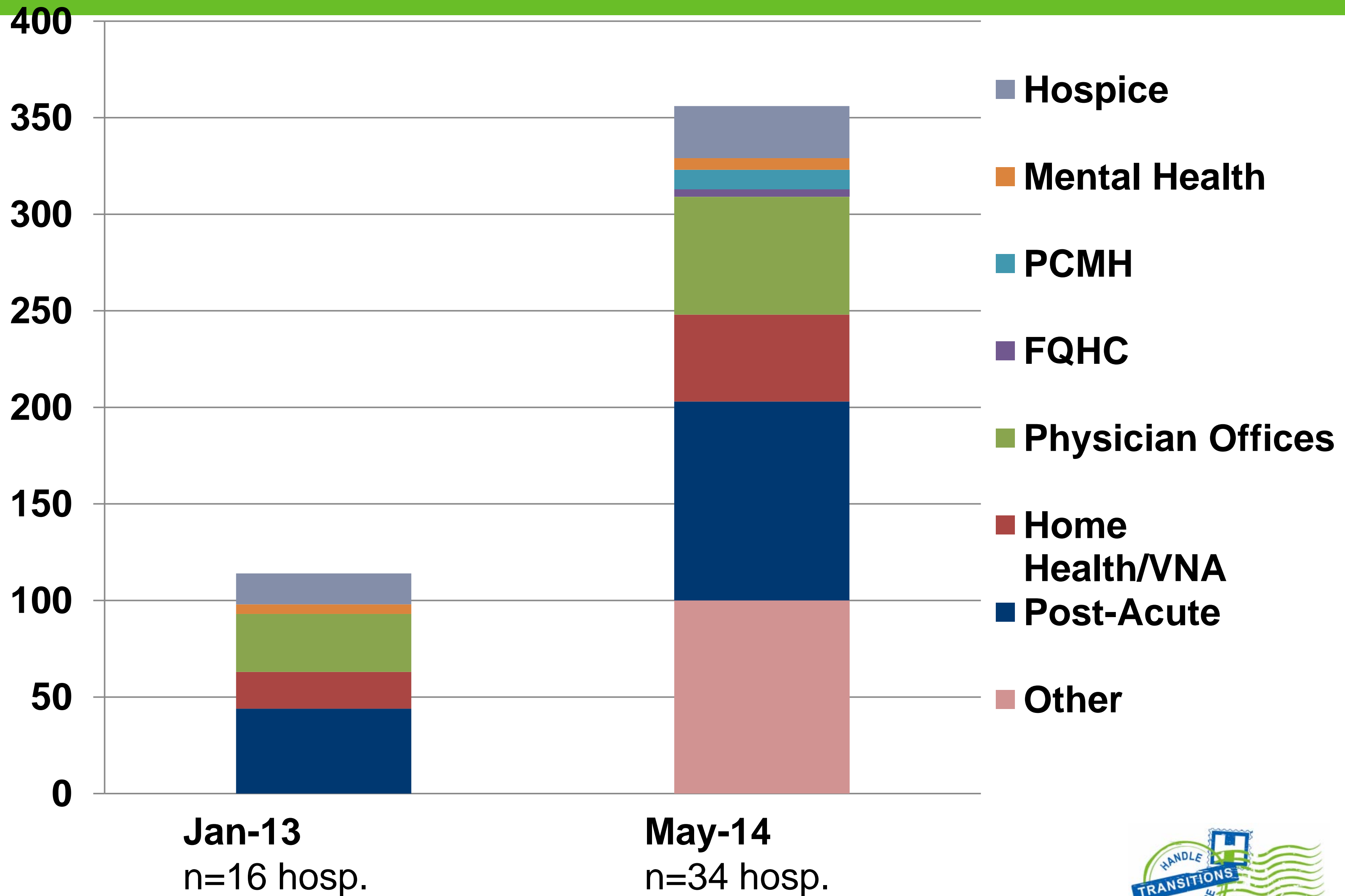
HANDLE TRANSITIONS WITH CARE
Partners Preventing Avoidable Readmissions

MHA's Initiatives

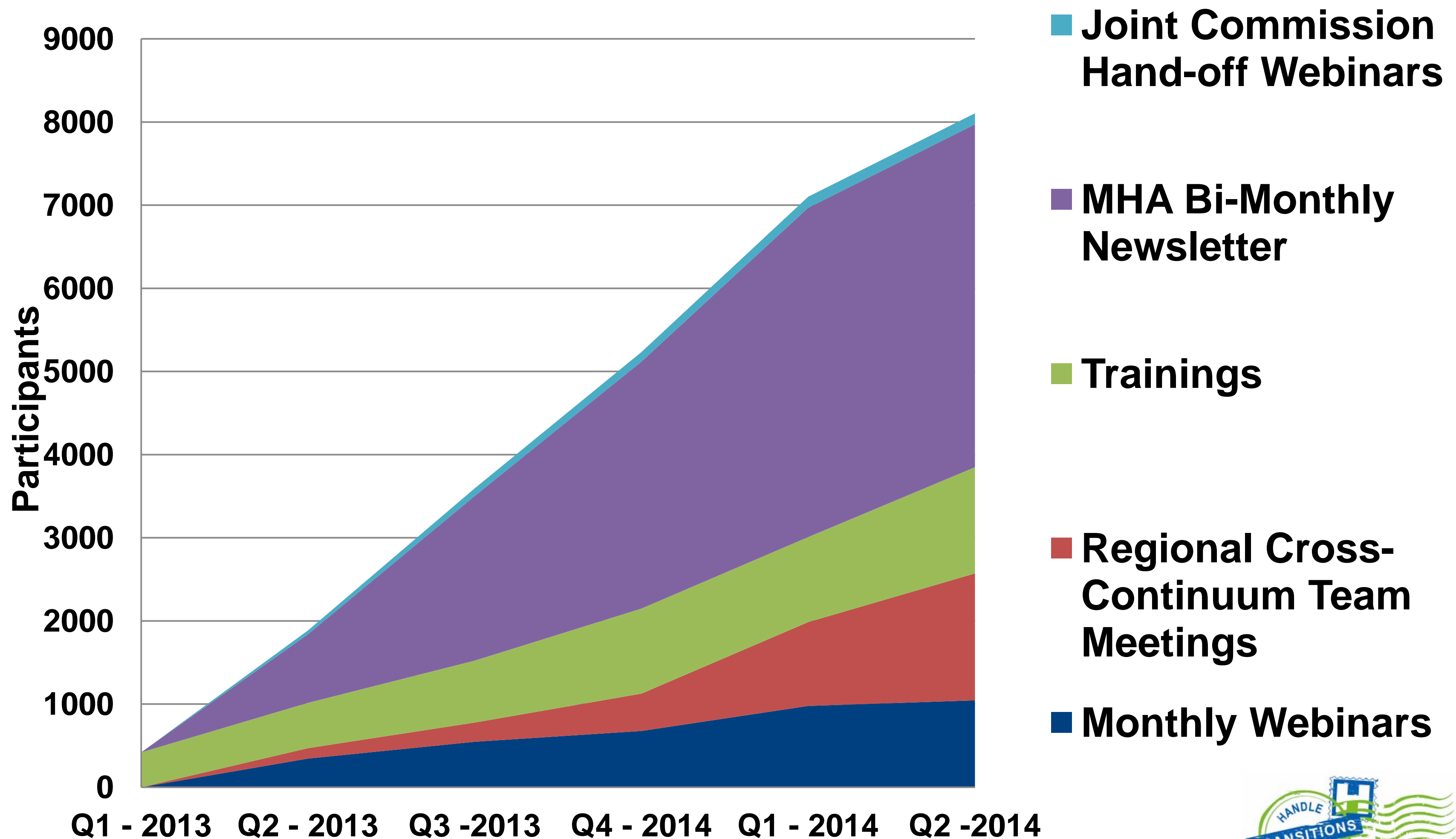
- Launched *Transitions: Handle with Care* campaign in January 2013
- Multi-stakeholder, statewide initiative to reduce readmissions by:
  - Fostering collaboration within state and across settings
  - Using data strategically
  - Implementing evidence based strategies at the local level

HANDLE TRANSITIONS WITH CARE
Partners Preventing Avoidable Readmissions

Cross-Continuum Team Representation



Points of Education and Collaboration March 2013-May 2014



Post Acute Interventions

- MHA sponsored training conducted by INTERACT founders for 86 post acute facilities and 10 hospitals

Facilities Trained in INTERACT

Legend

Facilities Trained in INTERACT

Baltimore Region

Source: Community Health Resources Commission
September 2013

HANDLE TRANSITIONS WITH CARE
Partners Preventing Avoidable Readmissions

Calendar of Events

October 2013
15 Maryland Association of Adult Daycare Conference

Transitions: Handle With Care
Shared Calendar of Events

February 2013

26	Materials: Pre-work for March 19 meeting, including data analysis, readmission interviews, cross-continuum team composition, sample invitation letters, and sample agenda.

March 2013

19	*Transitions: Handle with Care* Statewide Launch Meeting

April 2013

23	Steering Committee Meeting (1st)
23	Using Data to Improve Care Transitions Webinar

May 2013

9	Lifespan Leadership Summit on the Role of Post Acute Services in Health Reform
22	How HIE Can Help You Improve Transitions Webinar
22	Issue Brief: Using HIE to Improve Transitions & Reduce Readmissions

June 2013

4	Senior Care Provider Roundtable, Williamsport
19	Improving Care Transitions for Patients with Behavioral Health Needs Webinar
26	INTERACT Training
27	INTERACT Training
27	Steering Committee Meeting (2nd)

July 2013

17	Frederick Memorial & Boutwell: Medicaid Readmissions

August 2013

6	Multi-payer PCMH Learning Collaborative (keynote and 3-hospital panel)
6	University of Maryland Baltimore Washington Medical Center Site Visit
13	Senior Care Provider Roundtable, Southern Maryland
20	Frederick Memorial & Meritus Cross-Continuum Team Regional Meeting
20	Frederick Memorial & Boutwell: Behavioral Health Transitions
21	Involving Patients and Families in Reducing Avoidable Readmissions Webinar

September 2013

18	The Role of Pharmacists and Local Pharmacies in Reducing Avoidable Readmissions Webinar
18	Maryland National Capital Homecare Association Annual Meeting
18	Maryland National Capital Homecare Association - Breakout Session
19	Steering Committee Meeting (3rd)
23	MHA, MedStar Health and Genesis presenting to the Maryland Health Care Reform Coordinating Council's Healthcare Delivery Reform Subcommittee
23-26	Lifespan/HFAM: 2013 Art of Caring Conference: Together We Can

Collectively Strategize

- Portfolio Approach
  - Sepsis

Percent of Total Deaths by APR-DRGs
FY2013

DRG	Description	% Total Deaths
720	Septicemia & disseminated infections	29.69
133	Pulmonary edema & respiratory failure	5.02
194	I	
190	A	
710	I	
139	O	
137	I	
44	I	
130	I	

Distribution of Top 50 APR-DRG Categories at Index Admission (First Hospitalization) of All-Cause, All Hospital Readmissions, Maryland CMS Methodology All-Payor FY2013

APR DRG	Descriptions	# Index Admissions w/ Readmission
194	Heart failure	4,007
720	Septicemia & disseminated infections	3,440
140	Chronic obstructive pulmonary disease	3,079
139	Ot	
753	Bi	
460	Re	
750	Sc	
463	Ki	
751	Ma	
201	Ca	

PPC	ALL PAYER PPC Description	PPCs Expected	PPCs Actual	PPC Weighted Impact
PPC 4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	1,069.72	1,209	$ 39,634,647
PPC 65	Urinary Tract Infection without Catheter	2,388.77	2,048	$ 29,313,024
PPC 14	Ventricular Fibrillation/Cardiac Arrest	1,250.11	1,375	$ 27,780,500
PPC 24	Renal Failure without Dialysis	3,660.69	3,355	$ 27,672,040
PPC 5	Pneumonia & Other Lung Infections	1,288.80	1,169	$ 24,418,072
PPC 3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	2,326.32	2,209	$ 21,665,872
PPC 9	Shock	1,141.40	1,063	$ 20,538,223
PPC 35	Septicemia & Severe Infections	1,052.88	1,060	$ 19,984,180
PPC 21	Clostridium Difficile Colitis	1,028.00	1,030	$ 17,934,360
PPC 40	Post-Operative Hemorrhage & Hematoma without Hemorrhage Control	1,515.83	1,512	$ 14,846,328

Collectively Strategize

- Portfolio Approach

	Number	Rate
# Medicare admissions/year	5,000 admissions	
Medicare readmissions rate		20%
# Medicare readmissions/year	1,000 readmissions	
1. Improve standard care	5,000 admissions	20% readmissions rate
Expected effect		10%
# Expected readmissions reduction	100 readmissions avoided	
2. Collaborate with receivers	1,650 admissions (1/3 total)	30% readmissions rate
Expected effect		20%
# Expected readmissions reduction	99 readmissions avoided	
3. Enhanced service for pilot	200 admissions	25% readmissions rate
Expected effect		20%
# Expected readmissions reduction	10 readmissions avoided	
Hospital-wide readmissions impact	**209 readmissions avoided**	**209/1000= 20% overall**

HANDLE TRANSITIONS WITH CARE
Partners Preventing Avoidable Readmissions

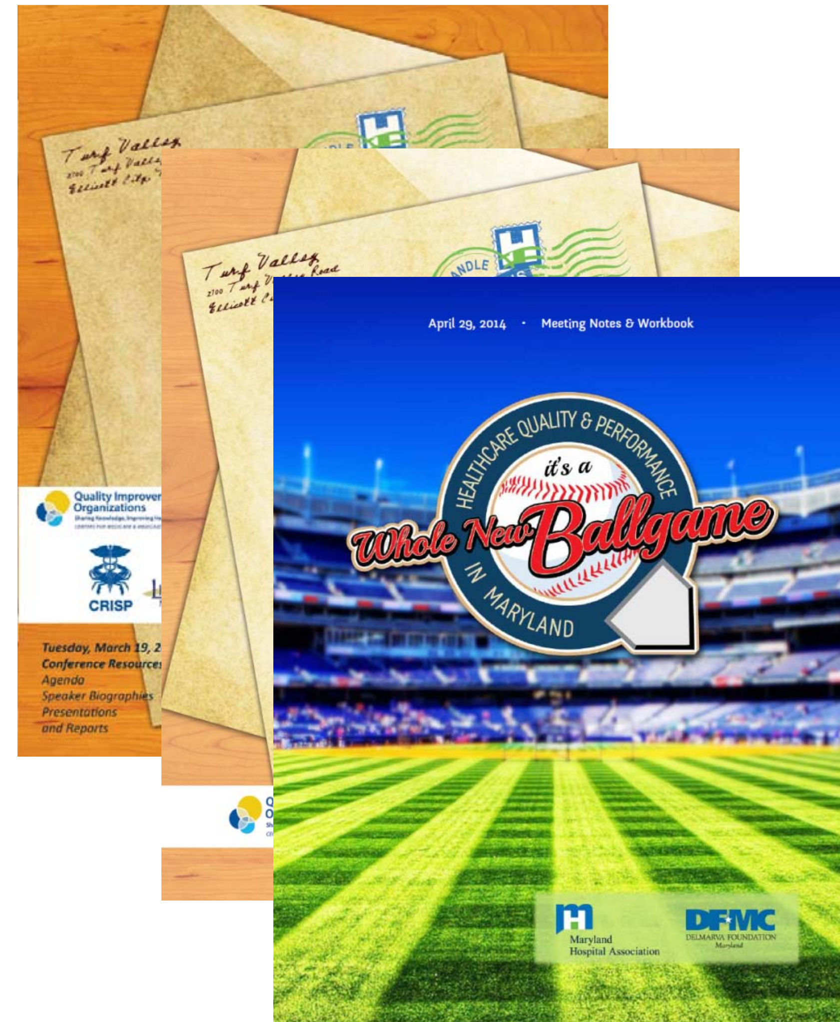
Collectively Strategize

- Share best practice

Webinars

(all presentations and recordings are available online)

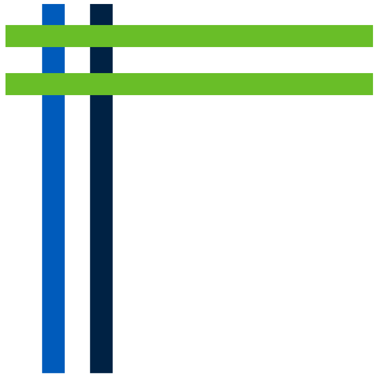
- *Knowing Your Readmissions Data: The First Step to Effective Change*
- *Improving Care Transitions for Mental Illness and Substance Use Disorder*
- *Involving Patients and Families in Reducing Avoidable Readmissions*
- *The Role of Pharmacists and Local Pharmacies in Reducing Avoidable Readmissions*
- *Partnering with Medicaid Managed Care*
- *Nursing Homes – Reducing Unnecessary Hospital Transfers, Admissions and Readmissions*
- *Improving Care Transitions between Hospital and Home Health*
- *Addressing Health Care Disparities and Health Literacy to Reduce Hospital Readmissions*
- *Partnering at the Local Level to Reduce Behavioral Health Readmissions*
- *Strategies for Success Under New Medicare Waiver: Part 1*
- *Strategies for Success Under New Medicare Waiver: Part 2*



Collectively Strategize

- Examples from the Field
  - Patient & Family Engagement
    - Anne Arundel Medical Center's SMART Discharge Tool
  - Care Preferences
    - Meritus Medical Center
  - Community Partnerships
    - Sinai Hospital and Health Care Access Maryland

HANDLE TRANSITIONS WITH CARE
Partners Preventing Avoidable Readmissions



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