Balancing Tensions and Creating New Systems to Manage Patients After Discharge

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Disclosure Statement

I have no financial relationships or other conflict of interests to disclose, and I will not discuss off label use and/or investigational use in my presentation

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Institute for Clinical Systems Improvement

- Independent, non-profit organization
- Formed in 1993 by Mayo Clinic, HealthPartners and Park Nicollet
- Collaboration of 50+ medical group and hospital members representing approximately 8,500 physicians
- Also supported by three non-profit MN health plans and grants

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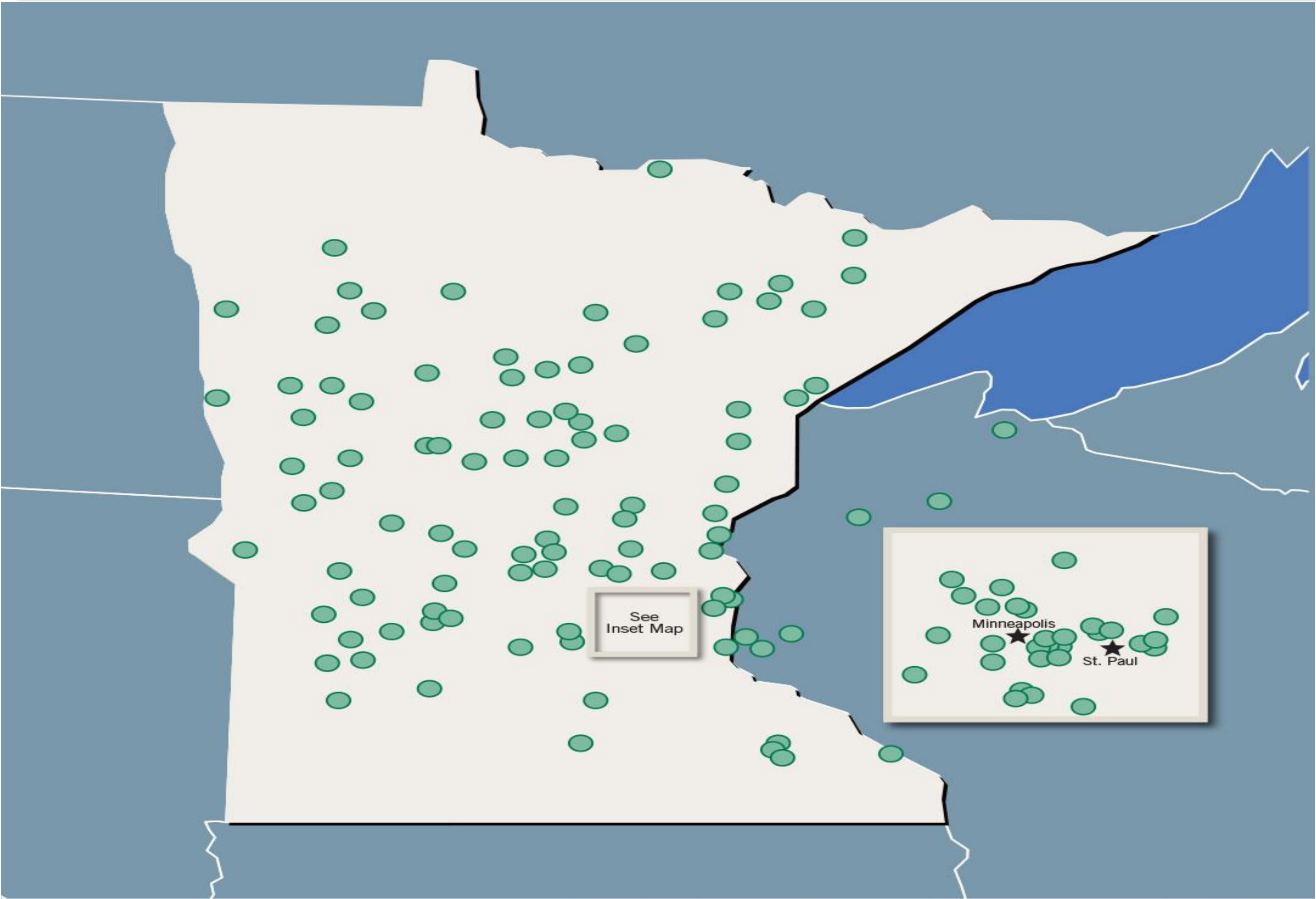
ICSI's Reach



Chronic Condition Management Project

Grant Partners:

- Minnesota Department of Health (CDC)
- HealthPartners Institute (Thomas Kottke, MD)
- Institute for Clinical Systems Improvement (ICSI)
- Stratis Health

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CCM Program Objectives

At the end of this work, the participating clinics will have a sustainable management approach for any patient with a chronic condition.

Participating Health Systems:

- Hutchinson Health, Hutchinson
- North Memorial Health Care, Minneapolis
- Tri-County Healthcare, Wadena
- Multicare Associates, Fridley
- St. Cloud Medical Group, St. Cloud

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We started with Hypertension

- Improve HTN processes and outcomes
- Demonstrate basic improvement science
- Build foundational components of chronic condition management
- Then move to another chronic condition, using the foundational components
- HTN is not a priority for primary care right now only because there are too many priorities

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AHA Out-of-Hospital Chain of Survival

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What is Seamless Care Design

- Primary care and hospital providers discuss goals of care for shared patients
- Hospital knows who patient's primary physician is and how to connect with them quickly
- Primary care knows where their patient is hospitalized, monitors their progress, and follows up within 24-72 hours post discharge
- There are systems in place to assure the discharge summary gets to all providers
- Discharge process for high risk patients include clear communication between all providers

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Current State of Affairs

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Desired Project Outcome is Simplification

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Chronic Condition Care Model Process

Before Visit

During Visit

After visit

Between Visit

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Suggested High Level Tasks on Your "Track"

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Changes to Between Visit Care

- New between-visit roles include:
  - – Transitional Care Nurses
  - – Care Coordinators
  - – Community Health Workers
  - – Health Care Coaches
  - – Community Paramedics
  - – Home Care and Public Health Nurses

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Between Visit Tasks with Patients

- Review discharge and self-management plan
- Reconcile medications
- Patient assessment, education & next steps
- Review all care since last visit
- Connect patient with community services
- Updating the patient registries
- Communicate with primary care team
- Proactively manage populations using registries

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Who supports those tasks?

- Hospitals add community paramedics and health care coaches to reduce readmissions
- Care coordination improves patient outcomes for “at-risk” clinic contracts and bundled payments
- Health Care Home, Medicare, and many private payers are creating incentives
- Larger systems support care coordination
- Insurers still manage high-cost cases
- Primary care manages attributed patients

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Let’s look at some examples

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Hutchinson Health

- Hospital and clinic setting
- The clinic only knows their patient is hospitalized when they get orders or a post MI visit
- "Heart of Hutch" organization includes clinic and community members (diet, exercise, wellbeing)
- If MI patient was at Abbott, discharging MD orders Cardiac rehab and nutrition consult
- Public health nurse liaison co-located onsite
- Health Care Home team works with the hospital Social Workers to coordinate patient supports

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Tri-County Health Care- Wadena

- Hospital and clinics serve a high poverty population
- Dedicated nurse oversees cardiac rehab and coordinates all care and follow-up
- They use home care and county workers
- Community paramedics work closely with care coordinators on the care transitions team
- BCBS has a project with paramedics to visit cardiac and stroke patients after discharge

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North Memorial Healthcare

- Follow-up is done by the Heart and Vascular Clinic (HVC) with communication to primary care
- Community Paramedics are used for various reasons to support patients in their homes
- Many patients have difficulty actually getting to cardiac rehab for several reasons

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Multicare Associates

- Multispecialty clinics in Fridley, Blaine and Roseville
- Receive daily patient lists from hospitals
- Added CMS CCM program to HCH
- Enrolled patients have a health care coach who does 20” phone call monthly
- Care Coordination is provided for all patients
- As primary care clinics they depend on cardiology to direct post-MI care and rehab

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St. Cloud Medical Group Example

- Merging with CentraCare Health System
- The Heart Center RN/ APP visit patient in hospital for education and to set up appts
- Same staff calls patient when they're home
- The clinic's Transitional Care Nurse also contacts the patient on discharge
- Aftercare and rehab is usually done via the Heart Center so their staff coordinates care and does a warm handoff to primary care

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What can you do to strengthen the chain?

- Develop strong relationships to facilitate transitions
  - Primary and specialty clinics
  - Public health nurses and home care agencies
  - Hospital social services
- Expand services provided by paramedics (e.g. home visits for status checks)
- Stay informed about how new payment models will impact the care continuum

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Any questions?

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