Aaron Truchil & Kelly Craig
January 13, 2015

Camden Coalition
of Healthcare Providers

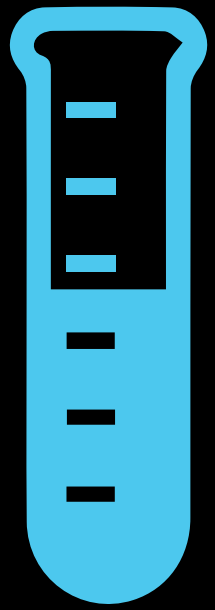
Improving Care & Reducing Costs with Hotspotting & Community-Based Care Management

Agenda

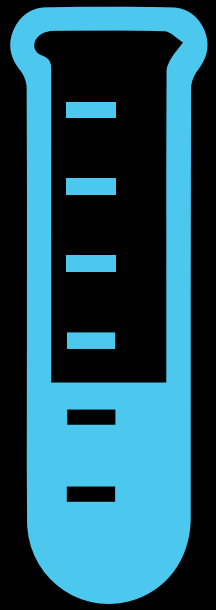
afternoon session

1 CCHP's Care Management Strategies
   .1 Care Planning
   .2 Individual Engagement
   .3 Community Engagement
2 Continuous Improvement and Operational Efficiency
   .1 Purposeful design and planning
   .2 Using data to drive operations
3 Growing your hotspotting program
   .1 Evaluating and Scaling
   .2 Telling patient stories

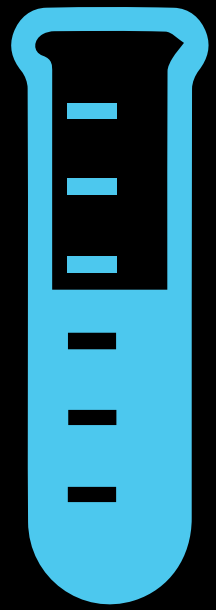
§1 Patient Engagement



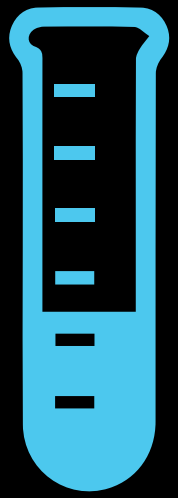
IMPORTANCE



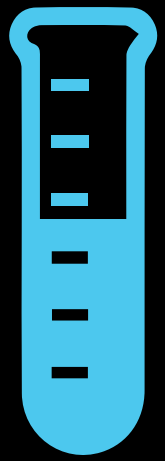
BELONGING



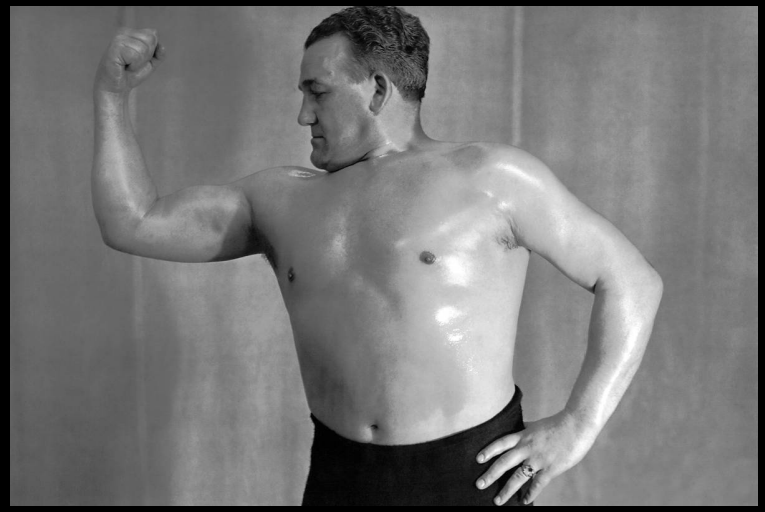
SECURITY

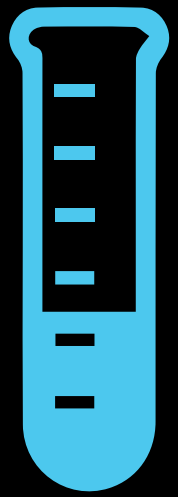


BELONGING= The deep desire to feel accepted and cared for



IMPORTANCE= The deep desire to feel signifant and recognized





SECURITY= The desire to know what's coming next, and to have controlled surroundings

BOOM
Significance
Significance

CMI.Case Conference WhiteBoard

PATIENT INFORMATION

First Name

Patient Photo Consent Form

Patient Test Tube

- [ ] Significance
- [ ] Love and Belonging
- [ ] Certainty and Safety

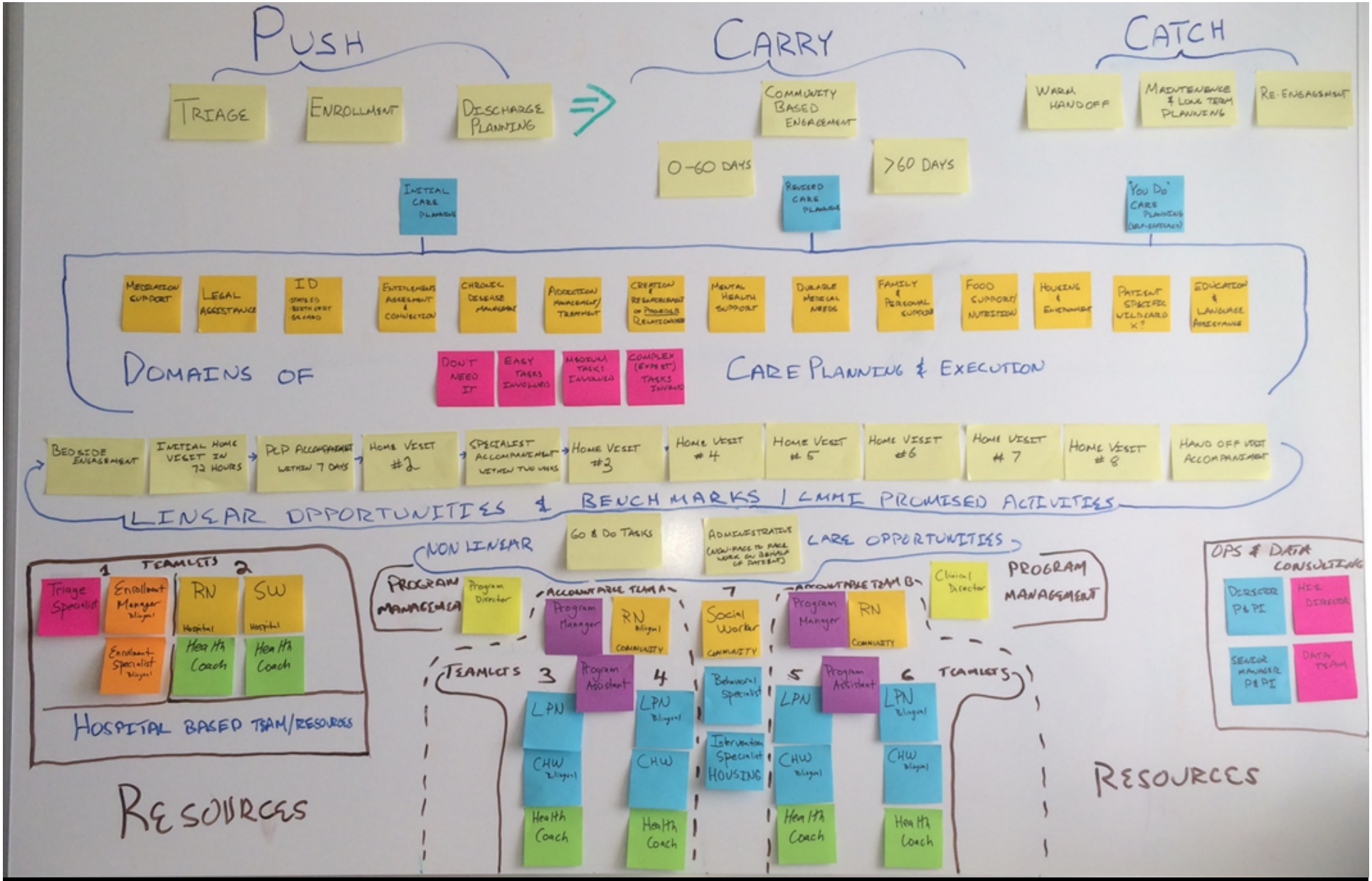
Patient Test Tube Description

Using the worksheet provided, please write about an experience where you had a strong emotional reaction to an interaction you had with a patient. Ideally this should be something that happened within the past week. Please consider the following:

- What were your test tubes?
- What were the patient's test tubes?
- Name one strategy you can use when coping with this feeling in the future.

§1.2 Care Planning

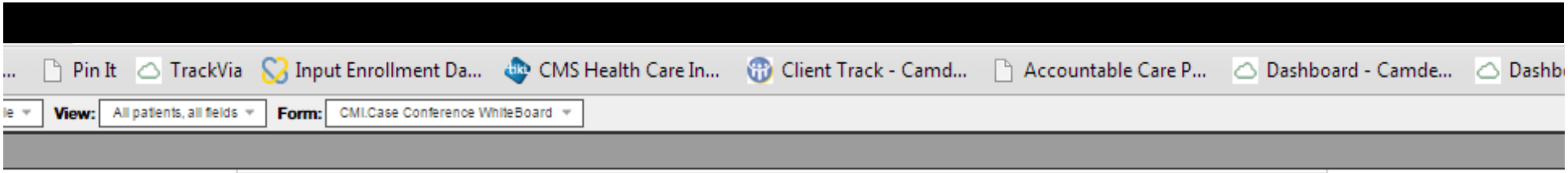

PATIENT
ORG.
CITY
(AMBER)
NO CITY CENTER
FOOD DESERT
POVERTY



Care Planning: Domains

Domains of Care Planning

- Addiction
- Advocacy & Activism
- Benefits & Entitlements
- Education and Employment Connection
- Family, Personal, Peer Support
- Food and Nutrition Support
- Health Maintenance, Management, and Promotion
- Housing & Environment
- ID Support
- Legal Assistance
- Medication and Medical Supplies
- Mental Health Support
- Provider Relationship Building
- Transportation Support
- Patient-Specific Wildcard



PATIENT DRIVERS

Please Insert quotes from the patient that represent their goals and drivers that inform the Care Plan

Patient Driver 1

Patient Driver 2

Patient Driver 3

Patient Driver 4

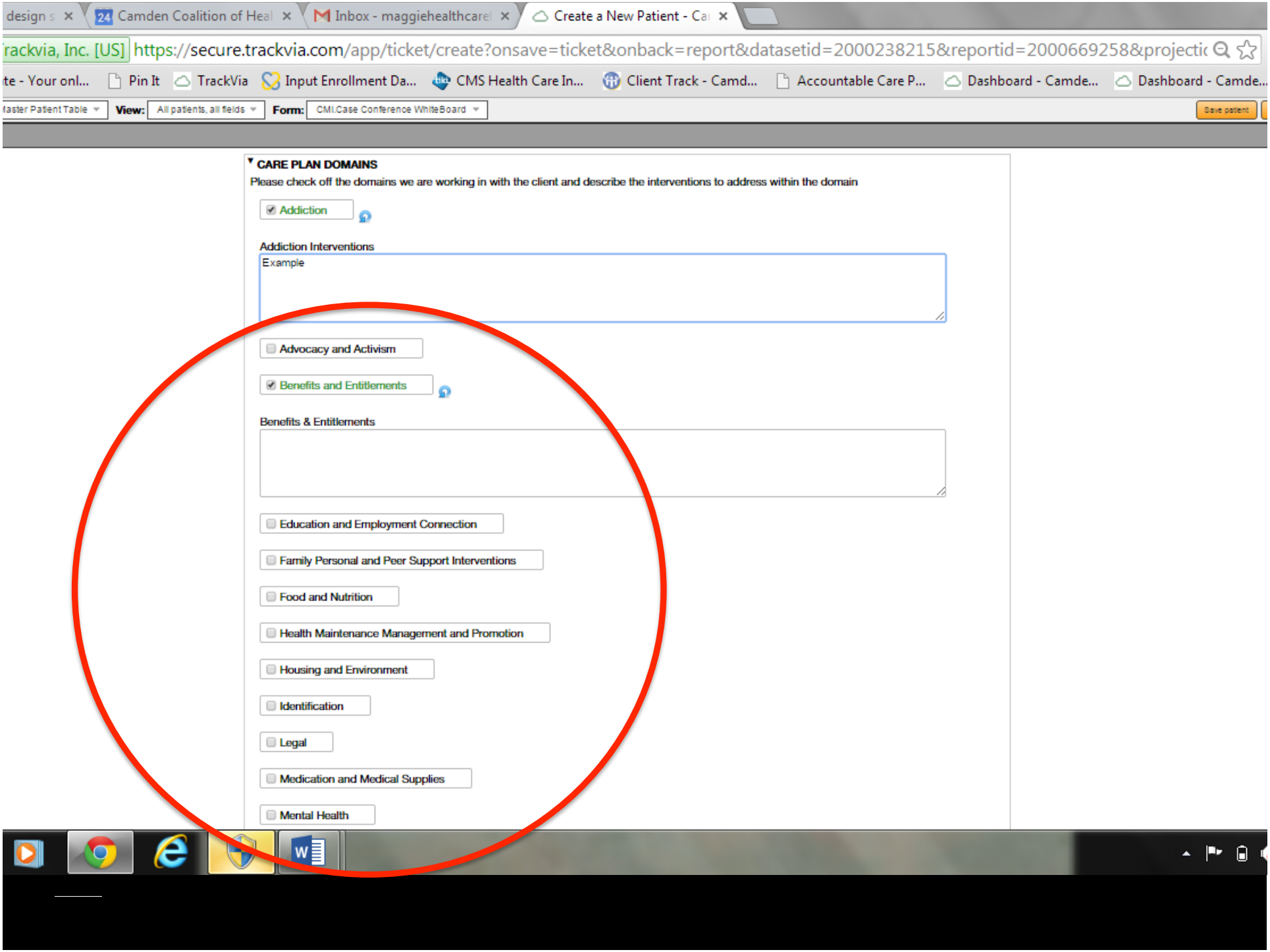
CARE PLAN

Care Plan Created?

☐ Yes

Date Care Plan Created

Medical Appointments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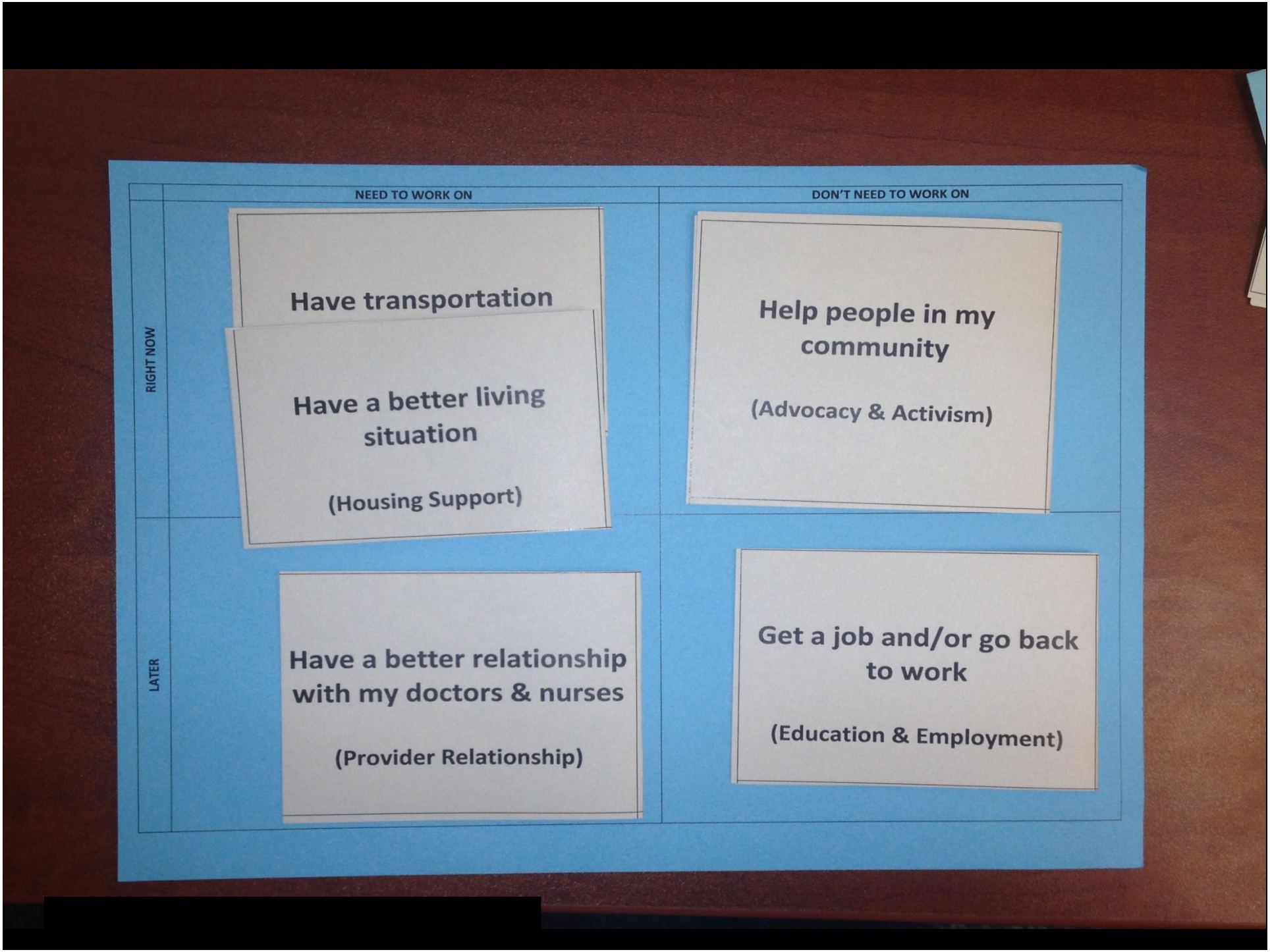
Inbox - maggiehealthcarel
Create a New Patient - Ca
rackvia, Inc. [US] https://secure.trackvia.com/app/ticket/create?onsave=ticket&onback=report&datasetid=2000238215&reportid=2000669258&projecti
te - Your onl...
Pin It
TrackVia
Input Enrollment Da...
CMS Health Care In...
Client Track - Camd...
Accountable Care P...
Dashboard - Camde...
Dashboard - Camde...
laster Patient Table
View:
All patients, all fields
Form:
CMI.Case Conference WhiteBoard
Save patient
CARE PLAN DOMAINS
Please check off the domains we are working in with the client and describe the interventions to address within the domain
Addiction
Addiction Interventions
Example
Advocacy and Activism
Benefits and Entitlements
Benefits & Entitlements
Education and Employment Connection
Family Personal and Peer Support Interventions
Food and Nutrition
Health Maintenance Management and Promotion
Housing and Environment
Identification
Legal
Medication and Medical Supplies
Mental Health

	NEED TO WORK ON	DON'T NEED TO WORK ON
NOW		
LATER		

Backwards Planning: Gameboard


NEED TO WORK ON
DON'T NEED TO WORK ON
RIGHT NOW
LATER
Have transportation
Have a better living situation
(Housing Support)
Help people in my community
(Advocacy & Activism)
Have a better relationship with my doctors & nurses
(Provider Relationship)
Get a job and/or go back to work
(Education & Employment)

“Real Play”

Debrief: What did you notice?

- What did you notice about the interaction?
- What was hard about it?
- How did it make you feel?

We will call on audience members to share their experiences.

§1.3 Engaging Community Partners

Why Build a Healthcare Coalition?

- Develop a cadre of resources
- Build support for your program as it grows
- Identify barriers to good care at a community level

Strategies for Engagement

- Outreach to individuals as you make connections
- Encourage them to invite colleagues
- Focus on frontline staff
- Build meetings around patient case presentations

Potential Participants

- VA medical clinics
- Local hospital physicians/nurses/ social workers
- Visiting nurse/home health agencies
- Durable medical equipment providers
- Nursing home and sub-acute rehabilitation representatives
- Wound care clinics
- Care management/care coordination agencies
- Homeless service providers
- HIV/AIDS service providers
- County jail representatives
- Board of Social Services (local Medicaid office)
- Pharmacies
- Behavioral Health providers
- FQHCs
- Other(s)

§2 Purposeful design & planning

Purposeful Design and Planning

Camden's Health Information Exchange

Admitted Past Month (High Use)

Back to ApplicationDashboard

User: aaron.truchil | Sign Out | My Profile
Provide Feedback

CAMDEN Health Information Exchange

Select Report

Reports

- Population
  - Admitted Past Month (High Use)
  - ED or Inpatient Past 2 Months
  - CAMCare
  - Cooper UHI
  - NGII
  - United
    - Cooper Ambulatory
    - Cooper Family Med
    - Cooper Physicians
    - Lourdes
- Teams
  - Awesome
  - Dynamite
  - IDC
  - Unassigned
- Historical Load
  - Cooper Historical
  - Lourdes Historical
  - Virtua Historical

Report Preferences

Add To Favorites
Hide

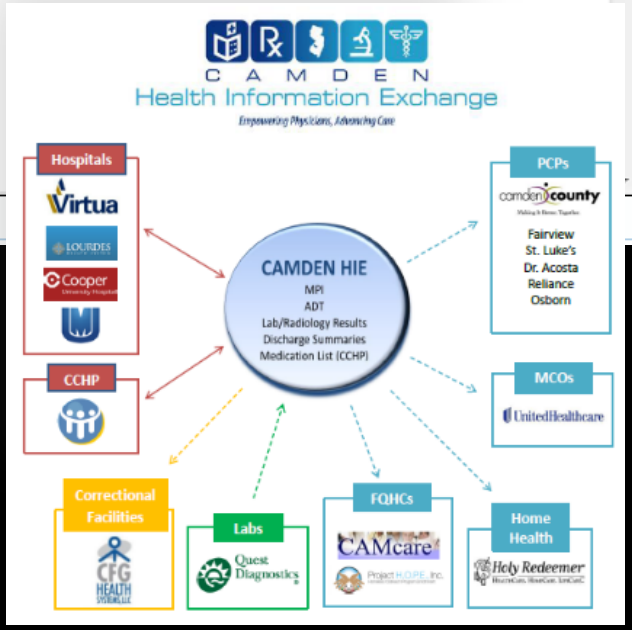
Facility: Any Unit: Any Provider: Any

Subscribe Export PDF

Displaying 170 results
Generated:

Name	DOB	Age	Gender	Admit Date	Discharge Date (Day)	Facility	Total Days (6mo)	Inp (6mo)	ED (6mo)	Provider	Practice	Insurance	Adm Diagnoses
		50 yo	M		(Day 2)	CUH	30	3	4				
		56 yo	F		(Day 1)	CUH	8	4	5				
		80 yo	F		(Day 1)	CUH	8	3	1				
		92 yo	M		(Day 1)	LGA	7	3	3				
		53 yo	F		(Day 1)	CUH	4	3	2				
		36 yo	F		(Day 1)	VIRTUA	40	11	3				
		65 yo	M		(Day 1)	CUH	26	3	1				
		48 yo	F		(Day 3)	CUH	17	3	0				
		52 yo	M		(Day 2)	CUH	5	4	1				
		61	M		(Day 3)	CUH	15	5	1				

Show Query Definition



Web-based Event Triggering & Data Capture

Pre-Enrolled Pending Enrollment

Enter Discharge Date Once Individuals are Discharged

TrackVia

Master Patient Table

CMI.Pre-Enrolled Pending Enrollment

Search this view... Add patient

First Name	Last Name	UniqueID	CMIGroup	Care Team Assignment	Care Team Assignment Date	Team Lead	Pre-Enrollment Interview Date	DischargeS
Still Admitted (7 patients)								
			RCT	Awesome	Jul 10, 2014		Jul 11, 2014	Still Admit
			RCT	Awesome	Aug 20, 2014		Aug 21, 2014	Still Admit
			RCT	Supreme	Aug 20, 2014		Aug 21, 2014	Still Admit
			RCT	Awesome	Aug 31, 2014		Sep 2, 2014	Still Admit
			RCT	Awesome	Aug 28, 2014		Sep 2, 2014	Still Admit
			ACO	Supreme	Aug 18, 2014		Aug 25, 2014	Still Admit
			ACO	Supreme	Aug 26, 2014		Aug 26, 2014	Still Admit
In sub-acute rehab (3 patients)								
			RCT	Supreme	May 26, 2014	Kim Pe		
			RCT	Supreme	Aug 21, 2014			

Showing 1 - 10 of 10

Enrolled Individuals Initial Home Visit Needed

Sorts all enrolled patients by home visit status

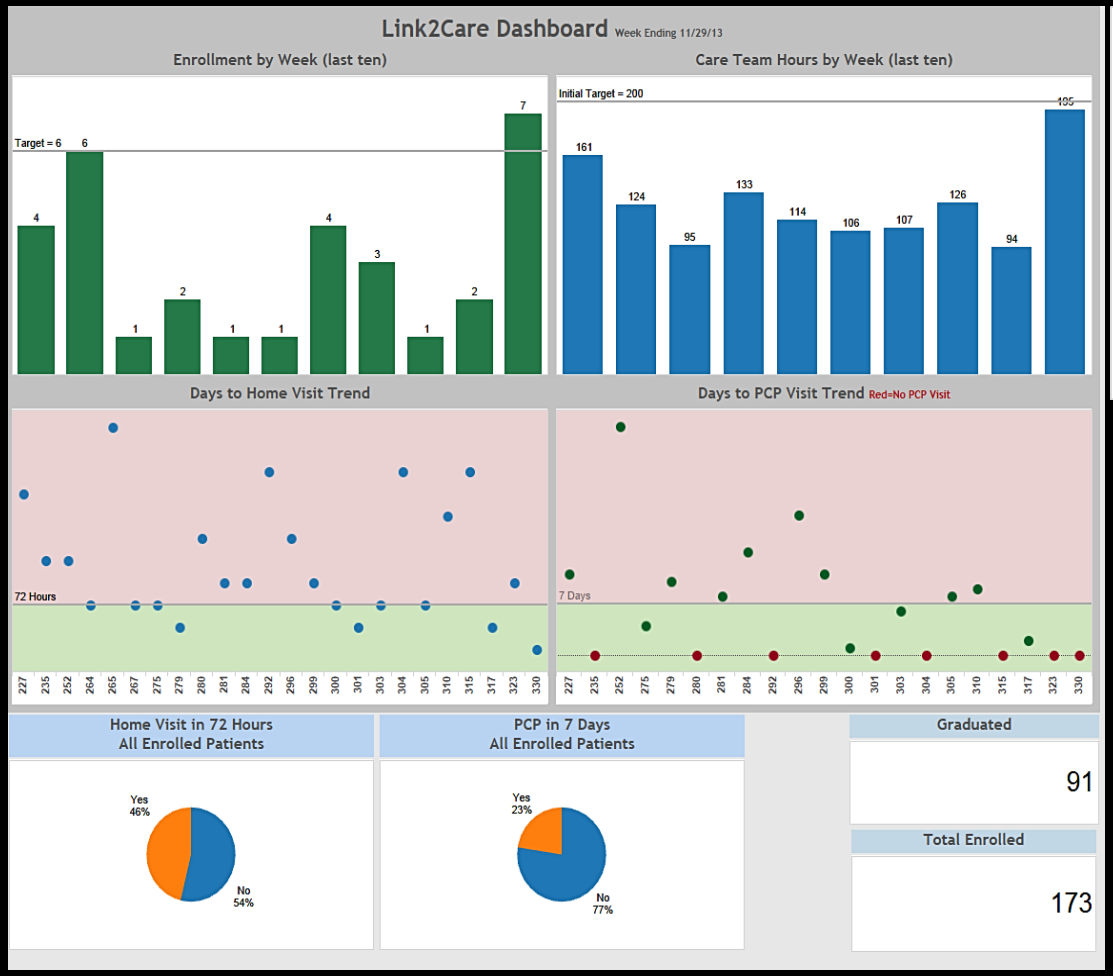
Master Patient Table

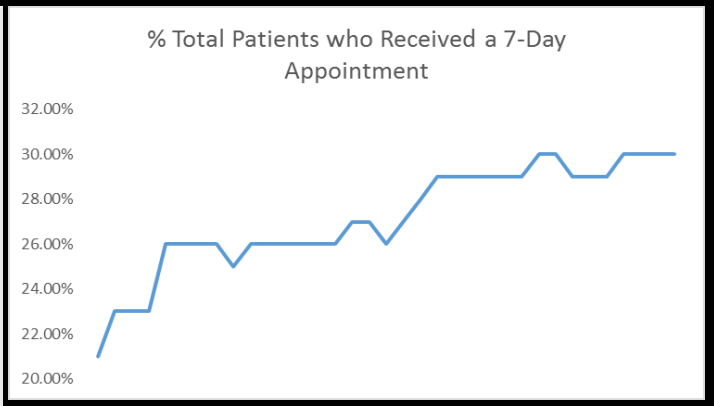
CMI. Enrolled Initial Home Visit

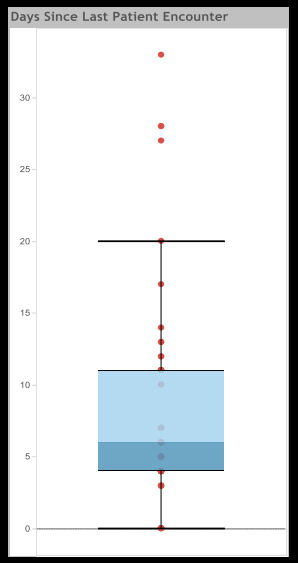
UniqueID	Enrollment Date	Re-Engagement Patient	Number of Days Post-Discharge	Initial home visit complete
(none) > Supreme (1 patient)				
	Aug 29, 2014		4	

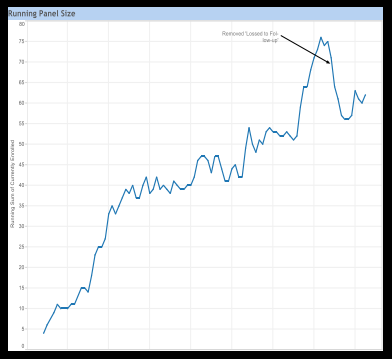
Showing 1 - 1 of 1

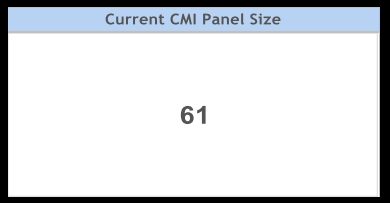
Real-time Feedback Loops: Weekly Scorecards



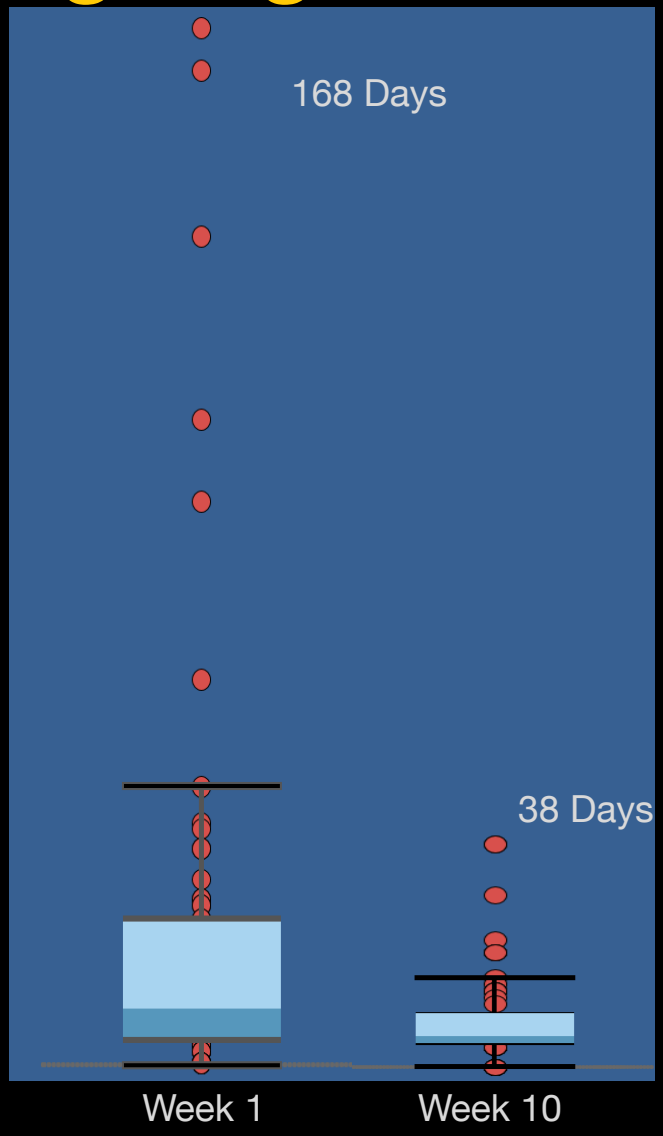




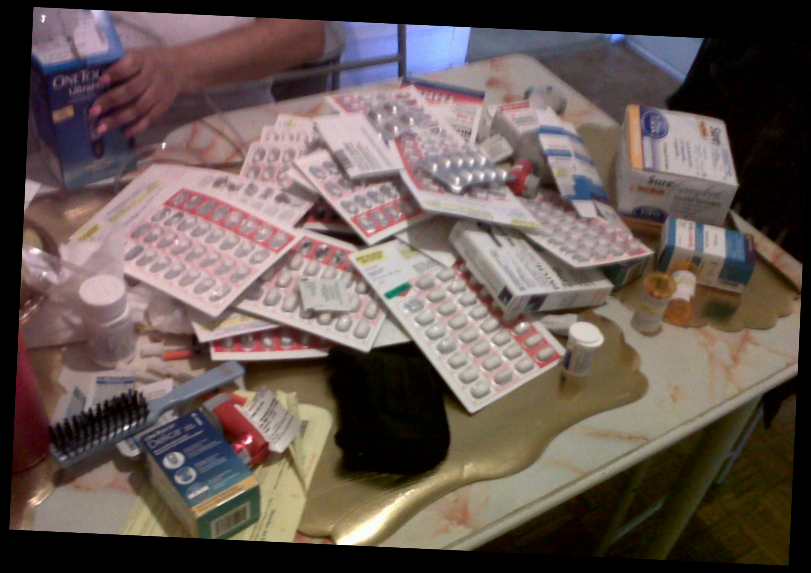




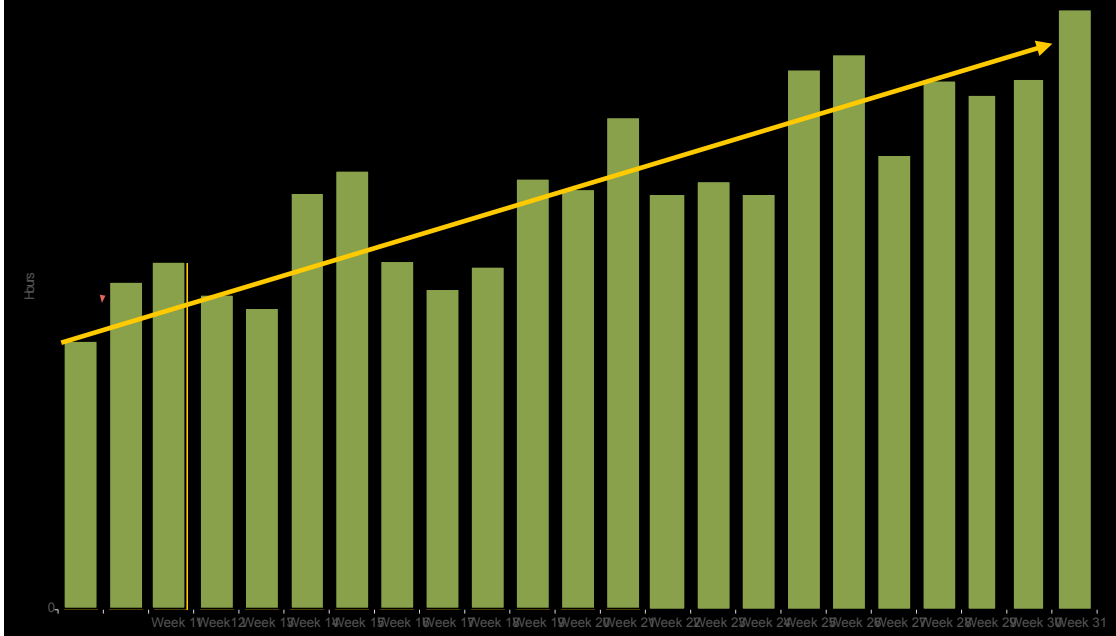
Ongoing Patient Engagement



Days Since Last Engagement



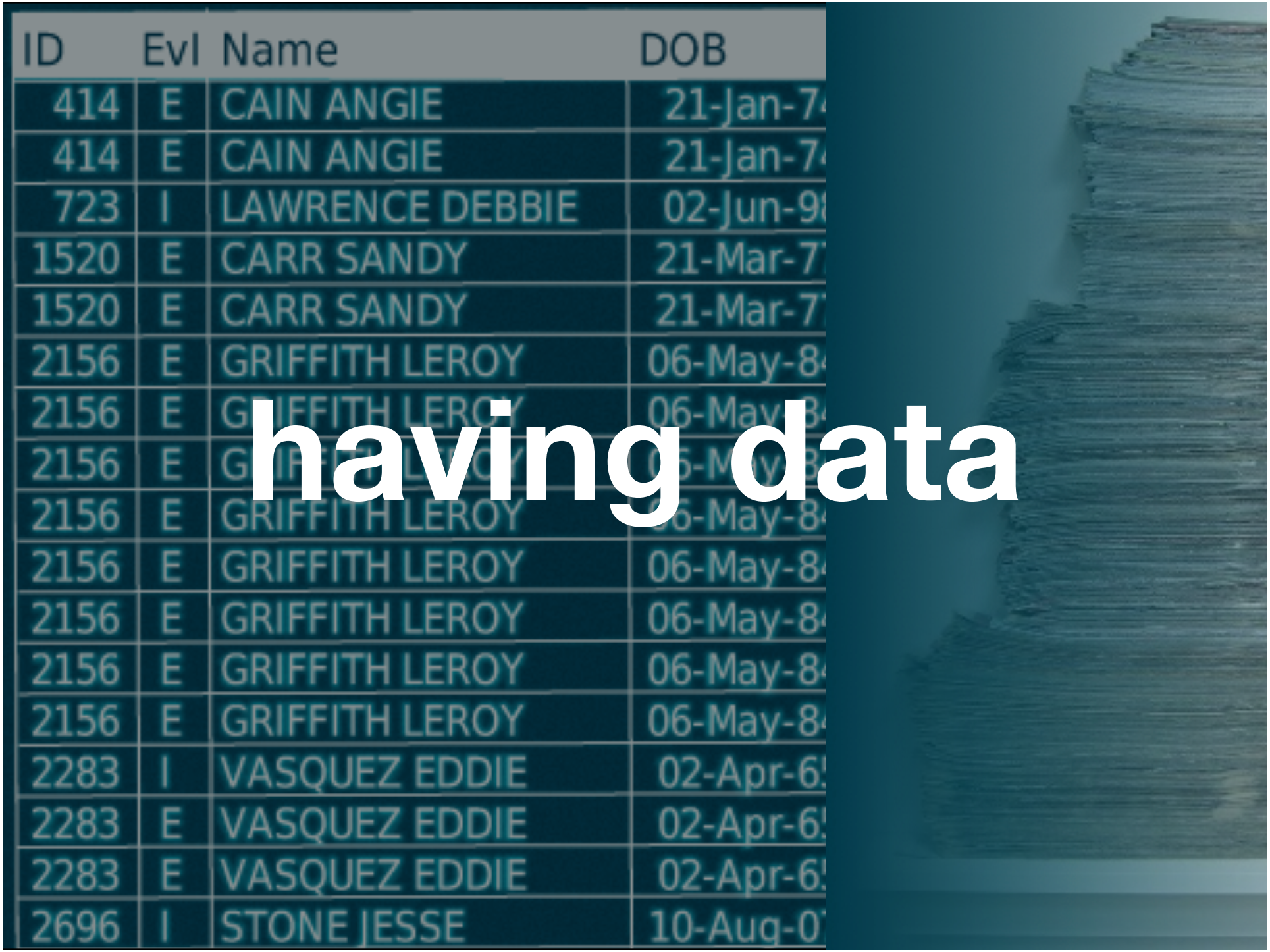
Ongoing Patient Engagement



weekly staff hours with patients

§3 Evaluating & demonstrating success

§3.1 Why is evaluating difficult?


ID EvI Name DOB
414 E CAIN ANGIE 21-Jan-7
414 E CAIN ANGIE 21-Jan-7
723 I LAWRENCE DEBBIE 02-Jun-9
1520 E CARR SANDY 21-Mar-7
1520 E CARR SANDY 21-Mar-7
2156 E GRIFFITH LEROY 06-May-8
2156 E GRIFFITH LEROY 06-May-8
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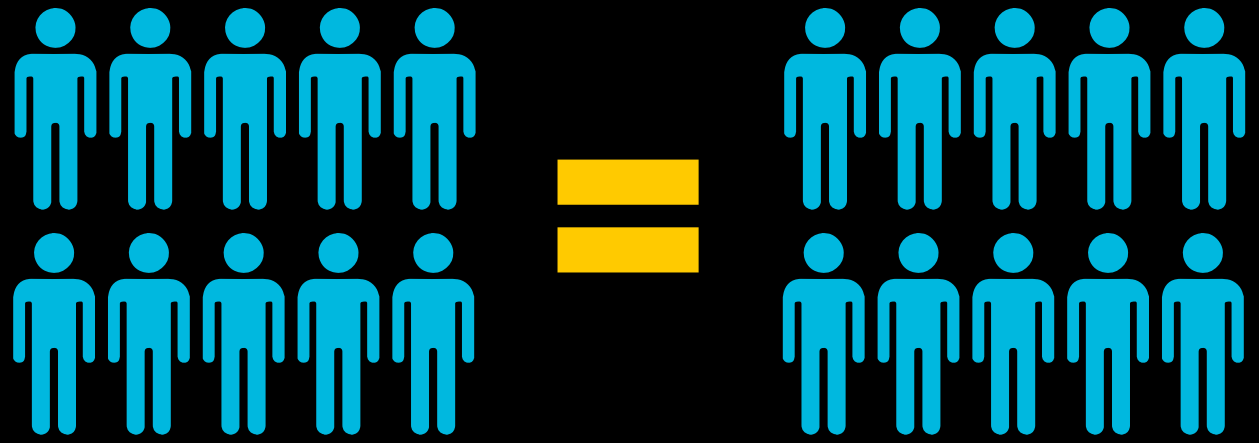
2156 E GRIFFITH LEROY 06-May-8
2283 I VASQUEZ EDDIE 02-Apr-6
2283 E VASQUEZ EDDIE 02-Apr-6
2283 E VASQUEZ EDDIE 02-Apr-6
2696 I STONE JESSE 10-Aug-0
having data

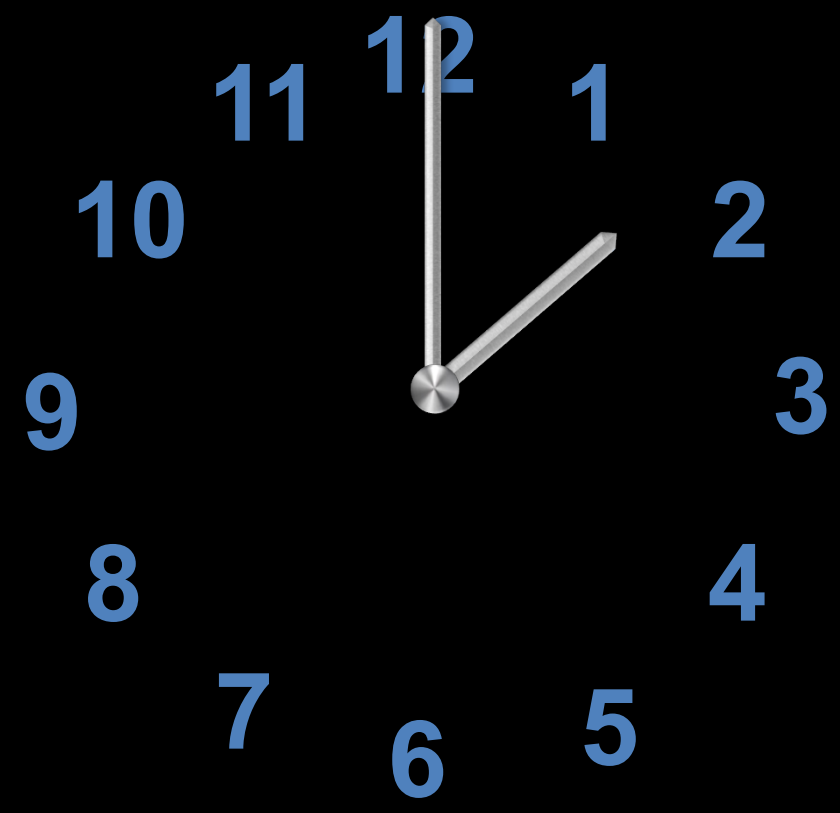
patients w/ complexities = complex intervention

finding an appropriate comparison group



regression to the mean

it takes time!



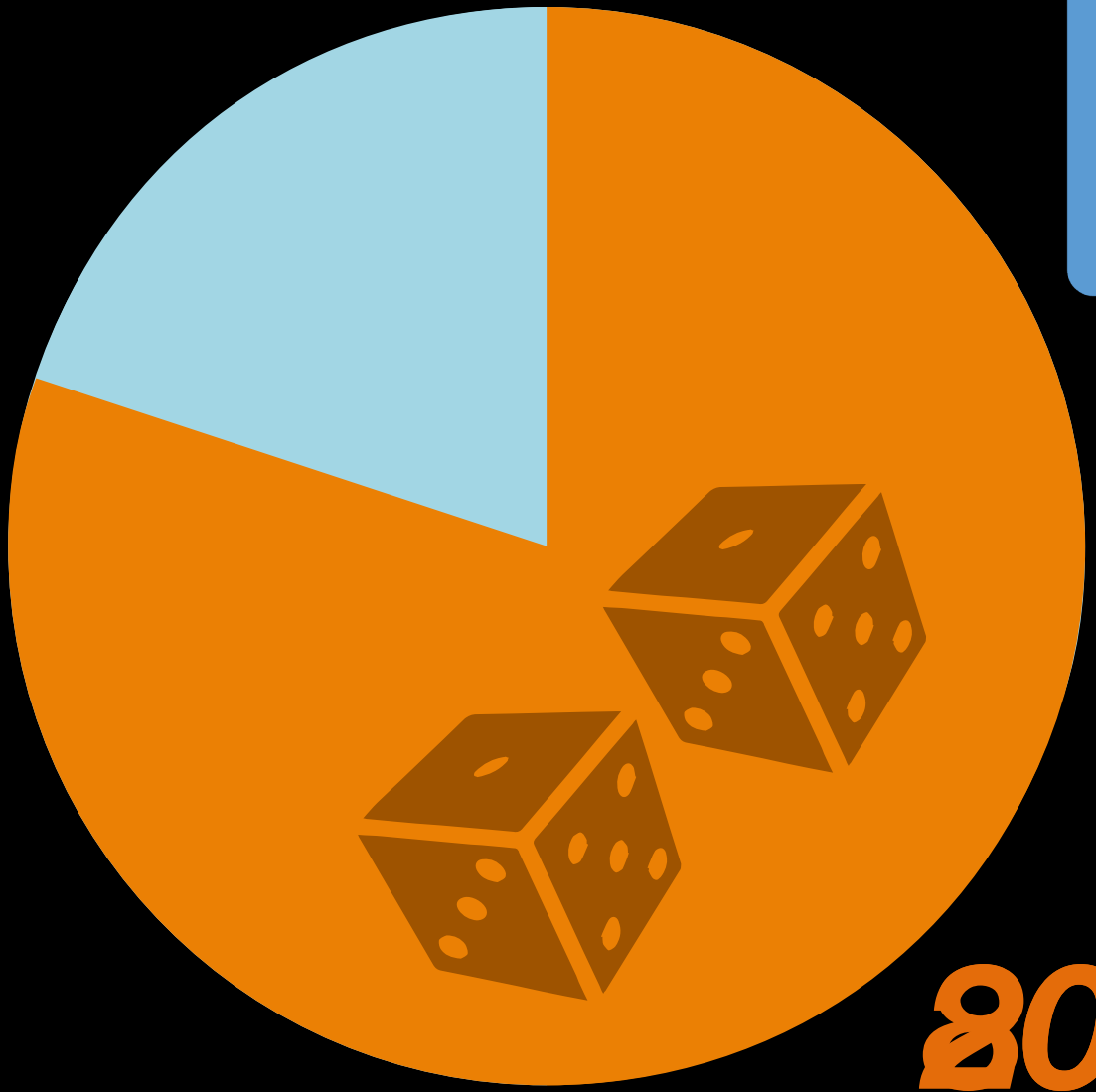
§3.2 Choosing an appropriate timeline

Program Timeline

§3.3 Two frameworks in dialog

Randomized Trials

Medication Delivery Studies



80%

Why?

Clear, credible results on causal effects

Helpful in attracting sustainable funding and scaling a program

When?

Timing – not too early and not too late

Time, expertise, and funding to do it right

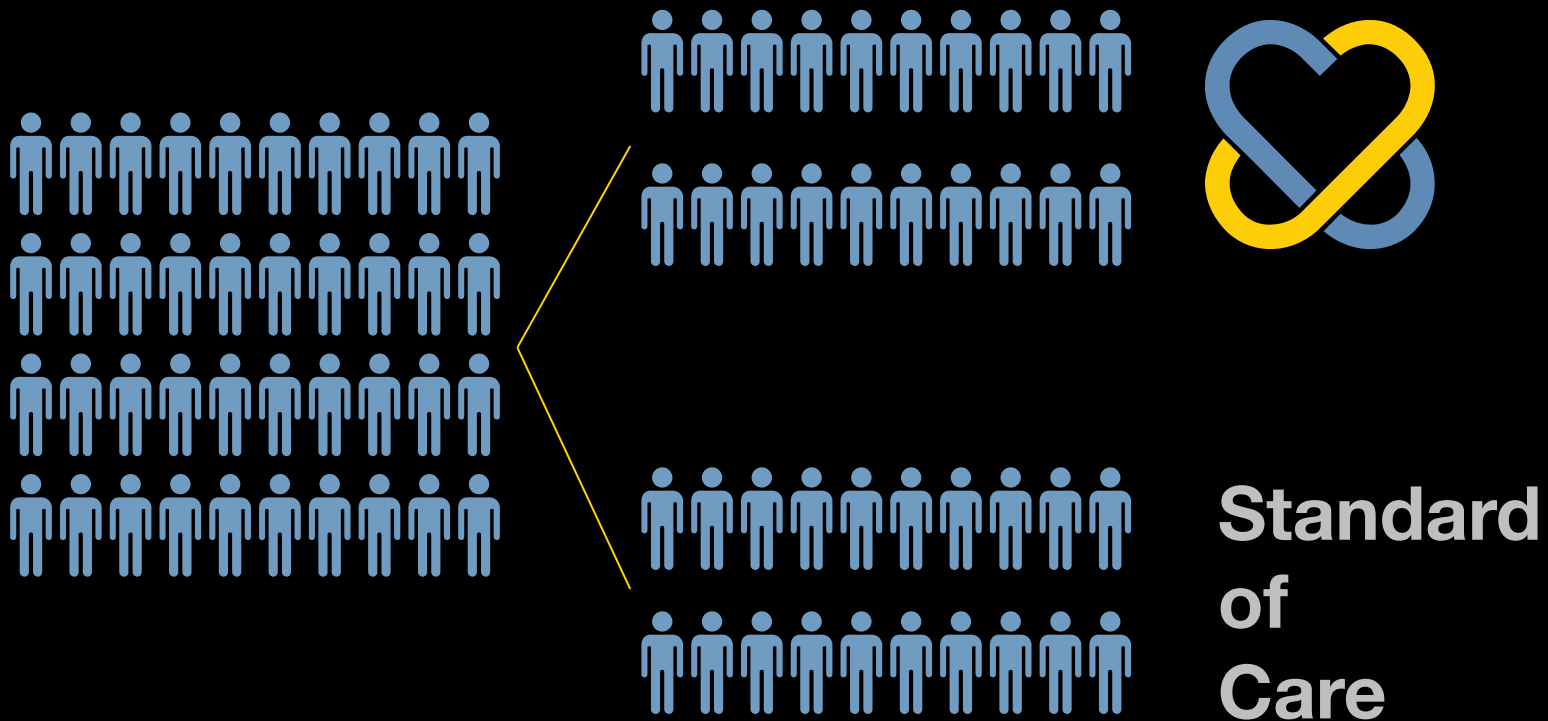
Key Issues

Sample Size

Randomizing before or after consent?

Data (what's collected administratively? -available for the control group?)

CCHP's Care Management RCT



Key Outcomes: reduced re-hospitalizations and ED visits in 12 month period following discharge

current N = **220** / 800

Findings:

Transitional Care of Older Adults Hospitalized with Heart Failure: A Randomized, Controlled Trial

Mary D. Naylor, PhD,[*†] *Dorothy A. Brooten, PhD,*[‖] *Roberta L. Campbell, PhD,*[*] *Greg Maislin, MS, MA,*[¶] *Kathleen M. McCauley, PhD,*[*] *and J. Sanford Schwartz, MD*[†‡§]

HealthAffairs

HOME | ABOUT | ARCHIVE | TOPICS | BLOGS | BRIEFS | THEN

Six Features Of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions Of High-Risk Patients

Randall S. Brown[1,*], Deborah Peikes[2], Greg Peterson[3], Jennifer Schore[4] and Carol M. Razafindrakoto[5]

Qualitative Evaluation

Why ?

Useful for describing complex phenomena

Explores the how, and why,
behind an effect or phenomenon

Gives more recognition to the individuals in the processes

How ?

Interviews gathered & coded, become **Data** from which we extract **Themes**

"She talked to me as a person, not as a patient"

"They showed me how to bring myself back"

Finding:

Generating Hypotheses About Care Needs of High Utilizers: Lessons from Patient Interviews

Dawn B. Mautner, MD, MS,[1,2,*] Hauchie Pang, MPH,[3,**] Jeffrey C. Brenner, MD,[4,5] Judy A. Shea, PhD,[6,7] Kennen S. Gross, PhD,[4,5] Rosemary Frasso, PhD, MSc, CPH,[3] and Carolyn C. Cannuscio, ScD, ScM[6,8,9]

Population Health Management

The Heart of Healthcare: The Role of Authentic Relationships in Caring for Patients with Frequent Hospitalizations

Charlotte Weisberg, BA, Margaret Hawthorne, MPH, Marianna LaNoue, PhD, Jeffrey Brenner, MD, and Dawn Mautner, MD, MS

Camden Coalition of Healthcare Providers
*Operations & Engagement Strategies for Community Based Care**

poster by Andrew Katz, Program Manager, Care Management Initiatives

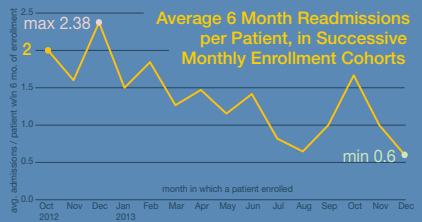
CARE MANAGEMENT INITIATIVES (CMI): *the Results to Date*

Ultimately the CMI intervention aims to reduce costs by increasing the quality of care. While cost results have yet to be directly calculated, several strong proxy metrics suggest we are moving towards that goal.

We have seen a **statistically significant reduction in patients' risk scores *and* unhealthy days** at 30, 60, and 180 days after discharge. Patients' **perception of care has also improved** between baseline and program graduation.

Our first 186 clients have demonstrated a **statistically significant reduction of inpatient hospital admissions** in the first six months after their date of enrollment in the intervention to a **mean of 1.28** from **2.86** in the 6 months prior.

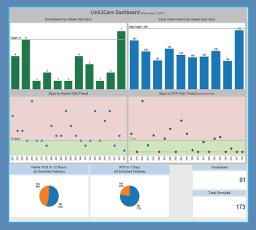
The monthly downward trend in hospitalizations during those six months after enrollment further suggests continued improvement in the efficacy of the intervention over time.



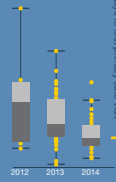
INTERVENTION: *CMI Operations*

To maximize the CMI intervention's chances of success, the Camden Coalition merges a patient-centered focus with business best practices. Staff continually log care plan progress, home and primary care visits, re-admissions, staff hours spent with patients, and the care plan domains among which that time was divided. Activity tracking informs our daily and weekly conversations around operational efficiency and allows management to monitor performance indicators in real time and begin quality improvement projects where necessary.

Example: Patients connect to primary care too slowly.
Action: Create a scorecard.



Measure weekly successes and failures transparently.



Results: By constraining process variability and addressing outliers, we were able to reduce the average days to PCP visit by 40%.

"Just to have them come around and sit and talk...is what I enjoyed"

"They Showed me how to bring myself back"

"She talked to me as a person, not a patient"

"They took the time to listen, they took the time to explain"

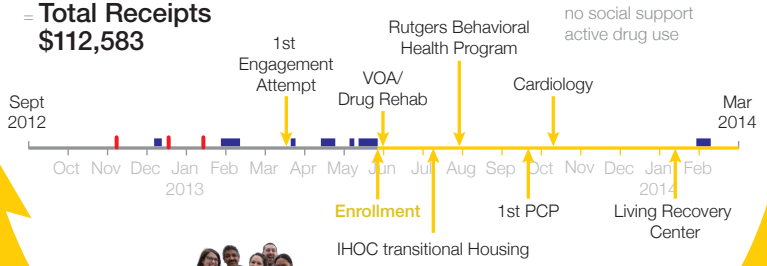
Miguel
the Patient Experience

Hospital Utilization in the 9 months prior to enrollment:
3 Emergency Department visits
+ 7 Inpatient stays
= 61 days hospitalized
= **Total Receipts $112,583**

System Failures
misspelling on SS card
slowed paperwork
follow-up paperwork mis-filed
common name compounded
simple mistakes

Driving Diagnoses
Hepatitis C
Hypertension
Congestive Heart Failure

Social Indicators
unemployed
no income
uninsured
homeless
no social support
active drug use



Hospital Utilization in the 9 months post enrollment:
0 Emergency Department visits
+ 1 Inpatient stays
= 3 days hospitalized
= **Total Receipts $3,955**

DATA: *the Building Blocks of Care Management*

Hospital billing data allowed us to identify, investigate, and segment our population retrospectively. We filter real time Admissions-Discharge-Transfer (ADT) feeds to activate our community operations team and trigger our intervention.

Hospital Data → H.I.E.

Triage Process

Daily Feed

INTERVENTION: *CMI Timeline*

Home visit in 72 hours → PCP visit in 1 week

COACH: *a new approach =*
Connect tasks with vision & priorities.
Observe normal routine.
Assume a coaching style.
Check backwards plan. &
Highlight progress with data.

Weekly care planning & home visits (RN, LPN, CHW, HC's) → Day 60: handoff to HC's

The **COACH** model helps staff to identify clients' strengths and weaknesses, clarify clients' internal motivations for bettering their health, and guide clients through the stages of behavioral change.

≈Day 90 after hospital discharge: clients graduate

The relationships our staff are able to develop with clients form an integral part of our intervention. Staff undergo multiple rounds of interviews and are assessed primarily on organizational fit and empathy. After hiring, staff receive training in the COACH model, motivational interviewing, and trauma-informed care. The intervention depends on building genuine health relationships to empower patients for sustained self-care and greater autonomy.

*The Link2Care program, a Cooper University Hospital initiative operated by the Camden Coalition of Healthcare Providers

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Miguel
the Patient Experience

"Just to have them come around and sit and talk...is what I enjoyed"

"They showed me how to bring myself back"

"She talked to me as a person, not a patient"

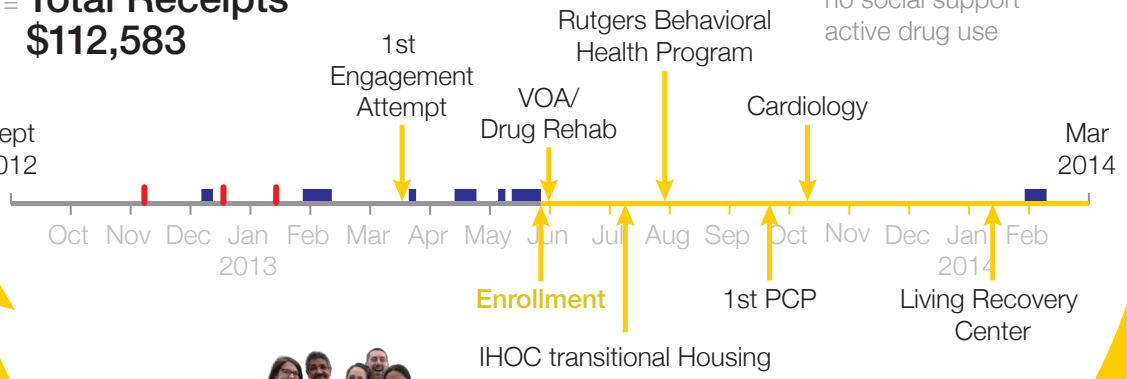
"They took the time to listen, they took the time to explain"

Hospital Utilization
in the 9 months prior to enrollment:
3 Emergency Department visits
+ 7 Inpatient stays
= 61 days hospitalized
= **Total Receipts $112,583**

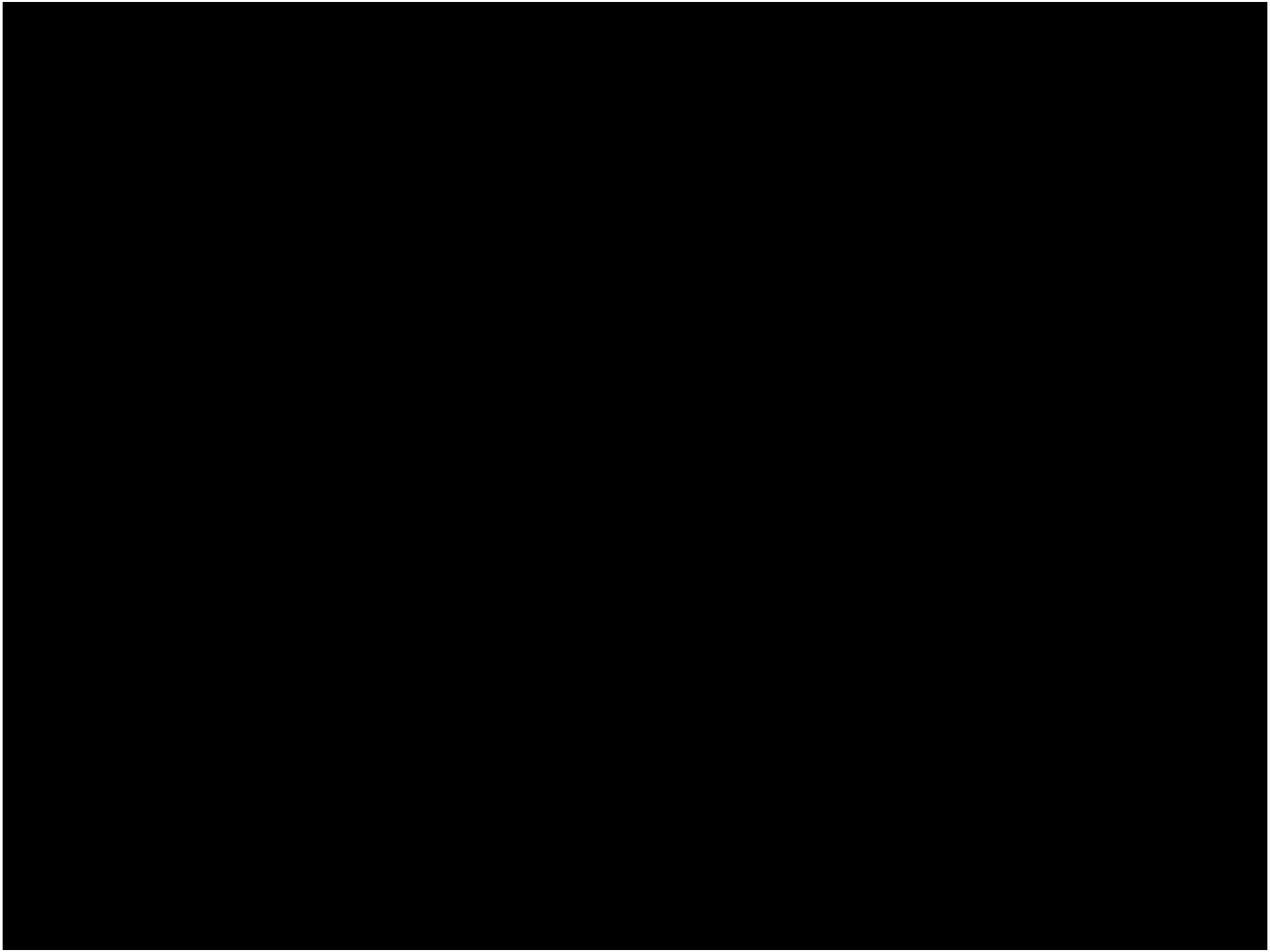
System Failures
misspelling on SS card
slowed paperwork
follow-up paperwork mis-filed
common name compounded
simple mistakes

Driving Diagnoses
Hepatitis C
Hypertension
Congestive Heart Failure

Social Indicators
unemployed
no income
uninsured
homeless
no social support
active drug use



Hospital Utilization
in the 9 months post enrollment:
0 Emergency Department visits
+ 1 Inpatient stays
= 3 days hospitalized
= **Total Receipts $3,955**



Breakout 2