Contact Information

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Physician Organization Name: Genesys PHO
Practice Name: Ascension Medical Group Genesys/Participating Independent Primary Care Physicians
Practice Address: 3495 S Center Rd. Burton, Mi 48519
How many physicians in practice: 116
Description of Care team: The care team consists of a MD/DO, RN, LPN, MSW and MA

Executive Summary:

- In participation with I-MPACT (Integrated Michigan Patient-centered Alliance in Care Transitions) first quarter 2018 Ascension Genesys identified an all cause re-admission rate of 26.7% for patients with primary diagnosis of CHF.
- Follow-up appointments within 7 days of discharge were noted to be 17%
- Analysis revealed patient lack of education and understanding coupled with poor follow-up and self-management skills to be the root cause.
- A dedicated CHF Registered Nurse Health Navigator was employed to meet identified patients at the bedside and begin the education process.
- The CHF Health Navigator worked in conjunction with the PCP office as well as Cardiology offices to scheduled follow up appointments prior to discharge.
- The CHF Health Navigator transferred continuing education to the Health Navigator embedded in the PCP office.
- Metrics to measure success for the PCP, Cardiologist, Health Navigators and patients were identified.
- I-MPACT second quarter 2019 demonstrated the all cause readmission rate of 12.2% with follow-up appointments within 7 days of discharge at 42.6%

Category of Submission:
Reduction in Utilization

Title of Submission:
Collaborative Use of Care Management in the Reduction of Congestive Heart Failure Hospital Readmissions

When did the intervention start and end:
Identified interventions began March 1, 2018 and are ongoing.

Goal of the Program/Intervention:
The goal of this program was to reduce CHF readmissions and increase post discharge follow-up appointments through the collaborative efforts of the PCP, the Health Navigator Care Manager, the cardiac specialist, home health care and other ancillary staff.

Who developed the program/intervention and how?
The program was collectively developed by Ascension Genesys Case Management, Genesys PHO, Genesys Heart Institute and Regional Cardiology. Data related to CHF readmissions was collected, reviewed and metrics to measure success were identified.

Description of the Program/Intervention:
Upon review of the data collected by Ascension Genesys and Genesys PHO it was determined that greater than 50% of CHF readmissions occurred within 15 days of discharge from an acute inpatient admission. Intervention needed to occur prior to discharge. A Registered Nurse Health Navigator was employed to begin intervention at the bedside. Standardized education materials were approved and implemented.

Working in conjunction with the patient, patient's caregiver, the PCP, cardiologist, pharmacy and home health care, the Health Navigator began the discharge process with patient education, follow-up care and self-management goals being the key components. When the patient was stable for discharge, the CHF Health Navigator made a follow-up appointment with the PCP within three days of discharge. If applicable, a cardiology appointment was made within seven days of discharge and a return PCP appointment created for 14 days post discharge. Pharmacy reconciled medications prior to discharge to identify potential medication issues. Home health care was to complete the first home visit within 24 hours of discharge.
The CHF Health Navigator transferred continued care to the Health Navigator embedded in the PCP office. The embedded Health Navigator Care Manager contacted the patient within 48 hours of discharge ascertaining the visit from home care as well as the follow-up appointment. Medication reconciliation was completed, questions answered and additional contact scheduled. Patients were followed for a minimum of 30 days.

How were patient identified for the program/intervention?
Ascension Genesys generated a daily report of all patients admitted for inpatient care who have had a previous admission for CHF or those having a current admission for acute CHF. The diagnosis codes were expanded to include fluid overload, dyspnea, shortness of breath and other diagnoses that could be CHF. The identified patients were visited by a hospital Care Manager and identified as appropriate for intervention. The CHF Health Navigator reviewed the report of identified patients and began the interventions.

How was success measured?
With input from all involved parties, metrics were established and assigned to each party to measure success. Hospitalists/PCP and Cardiology metrics included daily progress notes with anticipated discharge date and discharge medication reconciliation. Care Management metrics incorporated an assessment for discharge, bedside visit by the CHF Health Navigator Care Manager, referral to home health care and appointments for follow-up care scheduled. The embedded Health Navigator Care Manager metrics included contacting the patient within 48 hours of discharge, confirming the follow-up visits and if applicable the home care visit. Each metric was documented in either the hospital EHR or the PCP EHR for data extraction. Patients were tracked and trended for 30 days post discharge with readmitted patients beginning the process anew.

What were the program results?
Data extracted prior to implementation of the program demonstrated an all cause CHF readmission rate of 26.7%. Implementation resulted in a steady decrease in that rate with the unexplainable exception of third quarter 2018. Follow-up visits scheduled within seven days of hospital discharge were somewhat labile. Examination of the data revealed admissions coded as CHF post discharge thus not allowing for Care Management intervention.

Intervention	2018 Q1	2018Q2	2018Q3	2018Q4	2019Q1	2019Q2
No. of patients receiving interventions	NA	93.3%	92.0%	90.8%	89.2%	90.5%
Readmission Rate	26.7%	16.0%	24.0%	15.4%	14.9%	12.2%
Follow-up appointment scheduled	16.7%	30.9%	61.4%	52.2%	33.3%	42.6%

Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention?
Upon identification of lack of patient education as a contributing factor to the readmission rate, a standardized educational program was developed by Ascension, reviewed and approved for implementation by the participating team. It was decided that the patient would receive the educational materials at the time the CHF Health Navigator saw the patient at the bedside. The educational program was shared with home care and the embedded Health Navigators to provide consistency for the patient. The PCPs were educated on the expected process of follow-up visits within 3 days of hospital discharge.

What are you proudest of regarding this submission? Why does this work matter?
The collaboration between the hospital, Genesys PHO, the PCPs, the Health Navigators, Cardiology, and home care is monumental. The patient was the center of the focus and the enhanced quality of life related to staying out of the hospital by involvement of all providers made the work worth the time and effort. Engaging patients in Care Management while they are a captive audience is trend setting. Passing the care between Care Managers in a consistent process provides the patient with a secure feeling of care.

How will your organization use the funds if you submission wins?

- Development of additional educational materials for patients
- Ongoing education for the CHF Health Navigator
- Duplication of this program for other chronic disease states i.e. COPD and ESRD