holland pho
Physician Hospital Organization

Gina Schutter
Quality Manager
gschutter@hollandhospital.org
616-355-3899
Holland Physician Hospital Organization
175 S. Waverly Road
Holland, MI 49423
9 Primary Care Practices representing 42 Physicians, 24 Care Managers (14 Registered Nurses, 4 Certified Diabetes Educator, 6 Behavioral Health Specialists), and 8 Care Coordinators (MA, LPN, other)
Care Transitions Team: 4 Registered Nurses

Holland PHO
Blue Cross Blue Shield Value Partnerships
Care Management Recognition Awards – Best Practice

Reduction in Utilization – Dedicated Care Transitions Team

Coordinating high quality patient care across a hospital system and several independent physician practices on disparate Electronic Medical Records is no easy task. As the case for care management as a means to improve utilization and health outcomes continues to grow, physician practices and hospitals alike are eager to add trained staff to their care teams increasing the risk of duplicating efforts for the same targeted population.

A top priority for both the hospital and primary care physicians is hospital readmissions. As both parties are pressured to keep readmission rates low, both deployed resources to help bolster their performance. The result was several care managers overlapping efforts, and in many cases calling targeted patients on the very same day, asking many of the very same questions in an effort to prevent readmission.

To mitigate the risk of duplicating efforts, Holland PHO and Holland Hospital worked together to clearly delineate the scope of the care manager's work within the clinically integrated network. In 2016, a Care Transitions Team was formed out of Holland Hospital as a means to improve hospital readmission rates for patients discharging with specific diagnoses that put them at highest risk for readmission. What began as a team of two very part-time registered nurses re-purposed from the hospital's heart failure program has grown to three full time equivalents, and been reorganized within the system to better meet Holland Hospital's strategic essentials of optimizing patient care, improving quality results and being good financial stewards of our resources.

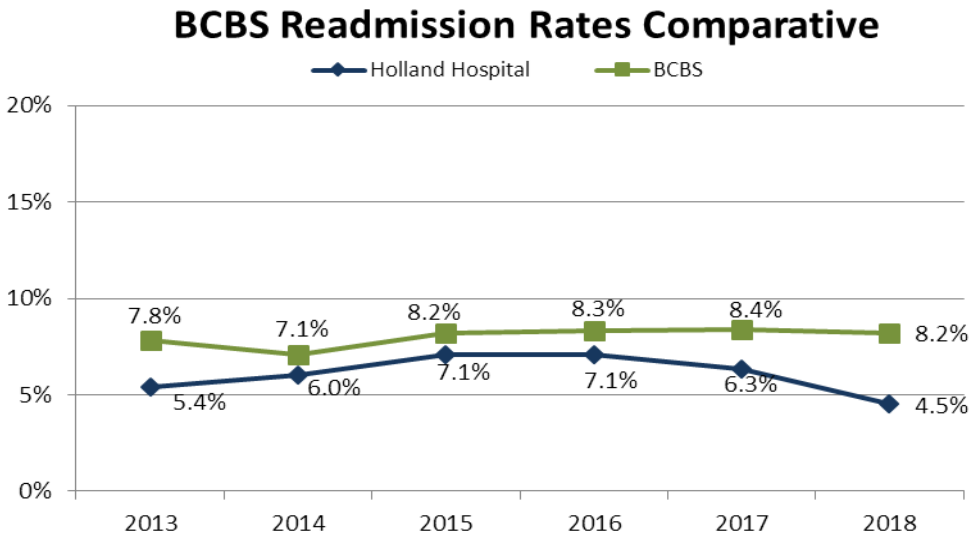
The formation and refinement of the Holland Hospital Care Transitions Team (CTT) program included;

- Implementing the Readmission Prevention Solution BOOST tool within Cerner, Holland Hospitals Electronic Medical Record. The BOOST tool provides automated early identification of specific readmission risk factors and corresponding interventions, preparedness checklists and discharge instructions, including patient "teach-back" instructions provided at bedside prior to discharge.

- Providing remote access and training for staff on the various Electronic Medical Record systems, primarily Cerner, eClinical Works, and Allscripts, for improved accuracy in medication reconciliation.
- Clearly delineating the CTT targeted population, and communicating their scope and process across all primary care practices. Buy-in from primary care was extremely important in order to reduce the duplication of services as the CTT team often met with the patients first at bedside prior to discharge.
- New documentation standards for CTT and a clearly defined hand-off process when CTT "discharges" a patient after 30 days of surveillance for the PCP Care Manager to take over.
- Development of a regional Care Management Contact List, which includes the names of all care managers working for Holland PHO, Spectrum Health Medical Group, and Answer Health physicians for purposes of case conferencing.
- Development of a shared condition-specific patient education toolkit available behind secure login on Holland PHO's website to ensure that ambulatory care managers have access to utilize the same resources and teaching materials provided to the patient at time of discharge.
- Workflow redesign and enhanced case conferencing with Holland Hospital Home Health staff, particularly telemonitoring for heart failure patients.
- Identification of key Skilled Nursing Facility nurses or social workers to serve as a point person for case conferencing while targeted patients reside in their facility.
- Initiating quarterly performance reporting and review meetings with Skilled Nursing Facility stakeholders.

Holland Hospital Care Transitions Team Scope	
Targeted Population	Patients discharging from Holland Hospital with a primary diagnosis of CHF, COPD, Acute MI, Pneumonia, or Sepsis w/pneumonia
Duration	30 day surveillance, including any time spent in a skilled nursing facility
Process	1. Target patients based on scope and risk score using Cerner BOOST tool. 2. Introduction to CTT, patient education at bedside prior to discharge 3. Telephonic assessment within 2 business days of discharge and at determined intervals for at least 30 days, or longer if needed. 4. Discharge patients from CTT program after 30 days, or longer if needed, using a fax notification to ambulatory care manager with pertinent information relative to patient's CTT care plan and readmission risk factors. 5. CTT and ambulatory care manager to case-conference as needed.

Holland PHO's ongoing engagement of a targeted readmission prevention team working in close coordination with ambulatory care managers has helped keep readmission rates for Holland Hospital well below Blue Cross plan-wide rates, and contributed to continued improvement since the program's inception in 2016. As such, favorable performance on Holland Hospital readmissions can help sustain Holland PHO performance overall.



If Holland PHO was rewarded the Best Practice award in the amount of $125,000, funds would be used to further the sustainability of the Care Transitions Team program as it has shown to be successful in improving hospital performance on readmissions. It is important to note that CTT encounters are not reimbursed as the CTT team cannot bill for care management encounters under the auspices that they are a hospital-based program.

- $12,500 (10% of funds) would be retained by the PHO for the oversight and coordination activities within the clinically integrated network
- $2,500 to fund Self-Management Care Management training through MiCSSI ($450 each) and travel fees for MICMT Complex Care Management training. Care Management training would provide professional development and further context into how ambulatory care managers function as to improve the working relationship between them.
- $10,000 to further Telemonitoring capabilities for patients discharged from Holland Hospital with a readmission reduction index diagnosis
  - Hardware costs x 130 kits: $2,000
  - Monthly Maintenance Fees (Software, Data): $8,000
- $100,000 towards operational expenses for calendar year 2020, which may include but are not limited to;
  - Educational Summit to showcase demonstrated successes of the CTT program
  - Staffing expense associated with hiring additional FTE to expand the scope of the program to additional targeted diagnoses
  - A pass-through incentive opportunity to encourage Skilled Nursing Facilities to perform better on targeted readmission metrics