Jackson Health Network

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Physician Organization Name: Jackson Health Network
Practice Name: Practice Address: NA
How many physicians in practice: NA
Description of care team (number of care team members and their degrees/qualifications): NA

Executive Summary (5-8 bullet points, must include summary of results)

- Case Conferences are a joint effort between inpatient, ambulatory, and community care services that allows for a review of complex patients, communication of challenges and the creation of a consistent care plan.
- This team consists of a multidisciplinary group with representation from approximately twelve areas. Case Conferences occur monthly with multiple high-utilization patients at each conference.
- Including Performance Analytics in the project allowed for a list of not just patients with high utilization, but a rank of risk based off total number of comorbidities (physical and mental health), appointment tracking (completed/canceled/no-show), and demographics called the Top 50 List.
- The goal of these Case Conferences is to follow the success of each patient presented and find a reduction in ED utilization and/or readmissions to the hospital, an increase in appointments kept at their ambulatory appointments, as well as favorable changes in other population health metrics.
- At this time, the results have shown an overall reduction in the patients' risk score. Additionally, based on historical trends, there is a reduction in inpatient stays and readmissions.

Category of Submission (see page 1):
Reduction in Utilization

Title of Submission:
Reduction in Utilization as a result of Multidisciplinary Case Conferences Across the Continuum

When did the intervention start and end? (1-2 sentences)
The implementation of Case Conferences began by assembling a multidisciplinary team with inpatient and ambulatory representation from approximately twelve areas on January 28, 2019 to discuss objectives, process and expectations. Case Conferences have occurred monthly since then, and are still ongoing, with presentations occurring on multiple high-utilization and high-risk patients at each conference.

Goal of the Program/Intervention: (1-2 sentences)
The goals are to improve clinical outcomes, optimize the health care delivery system across the community, and reduce readmissions and healthcare costs. This is accomplished by bringing together members of the comprehensive care team and providing a space to review complex patients, communicate challenges, and create a consistent plan of care.

Who developed the program/intervention, and how? (2-4 sentences)
Case Conferences were initiated by Jackson Health Network leadership in conjunction with Henry Ford Allegiance Health Targeting Readmissions team. The development team was comprised of representation from Population Health, Care Management, Case Management, Comprehensive Clinical Care, Behavioral Health, Performance Analytics, and the Graduate Medical Education program.

Description of the Program/Intervention (2-3 paragraphs):
Evidence has shown that collaboration across organizations (healthcare, mental health, and community agencies) for a select group of patients is an effective way to stabilize care, decrease overutilization, improve healthcare delivery, and reduce costs (Hardin, 2016); Hardin, Kilian, & Spykerman, 2017). This is a best practice because Case Conferences are a joint effort between inpatient, ambulatory, and community care services. This monthly assembly is a forum that allows the care team to review complex patients, communicate challenges and create a consistent plan of care.

Patients are presented on by a member of the care team that is familiar with the patient's situation. The case is presented using the SBAR format and includes demographics, number of ED visits and admissions, medical and mental health conditions, social needs/barriers and any other pertinent information. Once patients are presented on, the team works collaboratively to generate ideas and resources for addressing barriers and concerns with patient engagement and/or the progression of the plan of care. What makes this unique is that each patient has representation from multiple parts of the care team. Each entity has a voice and ideas that are formulated into a comprehensive and unified plan with incremental steps to help move the process forward successfully.

How were patients identified for the program/intervention? (1-2 paragraphs)

Patients are identified for Case Conferences in a few different ways. Early on, the Performance Analytics team completed a data review on what patient information was pertinent and how the information could be presented in the most functional and concise way. This led to the creation of Top 50 List. This is a list of not just high utilization, but ranks risk based on total number of comorbidities (physical and mental health), appointment tracking (completed/canceled/no-show), and demographics. This Top 50 List was how patients were first identified for Case Conference review.

From there, the interest grew from those that participate in the monthly reviews. This resulted in participants bringing forward patients that had evidence of significant utilization and social needs. These cases often correlated with the Top 50 List but had not yet been presented on by anyone on their care team. At this time, the program has evolved to use this data in conjunction with the readmission data for congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). This decision was made in part to a system initiative to reduce overall CHF and COPD readmissions at Henry Ford Allegiance Health by 5% in 2019.

How was success measured? Please delineate whether metrics were process-based or outcome-based (2-3 paragraphs)

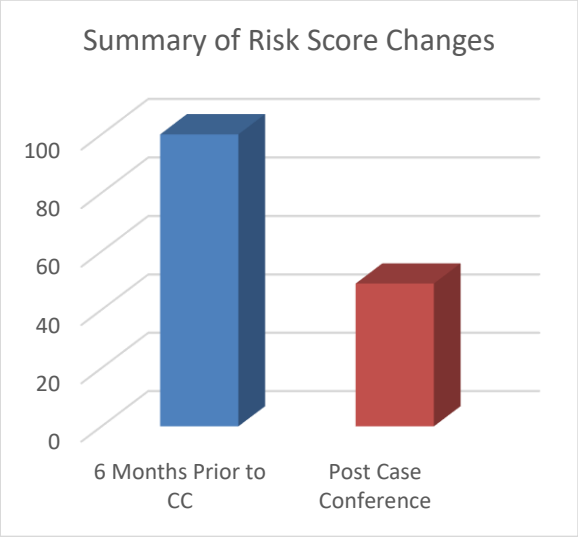
The overall goal of this project is to follow the success of each patient presented at Case Conference and find a reduction in ED utilization and/or readmissions to the hospital, an increase in appointments kept at their ambulatory appointments, and favorable changes in population health outcomes.

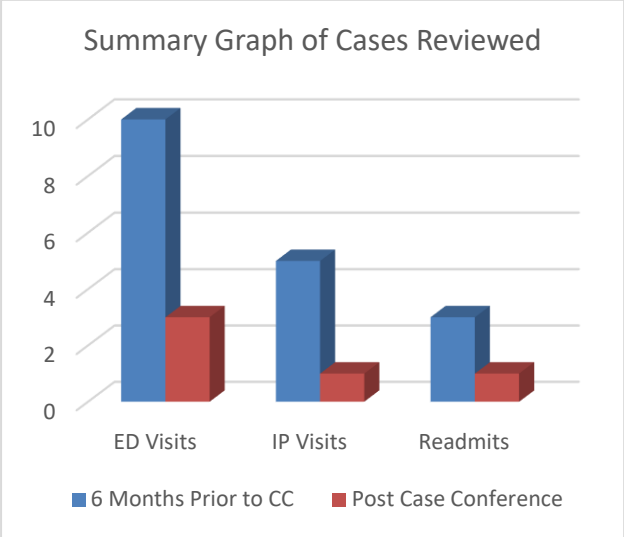
Due to the nature of the patients that are presented at Case Conferences, these results are not available immediately. While the success is outcome-based, it often takes time to see changes and be able to trend the reduction in utilization after case conferences. Due to this, it takes two months after their case is presented to have the ability to start assessing these trends.

What were the program results? Include qualitative data/graphs (2-3 paragraphs)

In the first five months that Case Conferences occurred, eighteen patients were presented on by their Care Manager, Primary Care Provider or Disease Educator. The results have shown an overall reduction in the patient's risk score identified on the Top 50 List. In addition, based on historical trends, there has been a reduction in inpatient stays and readmissions. There is evidence that ED usage continues to remain variable, but this was anticipated and better than resulting in an avoidable admission. Prior to being reviewed as part of Case Conferences, the mean risk score was 100 (out of ~250) for the eighteen cases reviewed. In the months following the comprehensive review of their cases, the mean risk score for those patients dropped to 49. Below is this information broken down for each set of patients reviewed in Case Conferences in that month.

Data from 18 Cases Reviewed at Case Conferences (CC)





Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention? (1-2 paragraphs)

While smaller case reviews had occurred in pockets throughout both organizations, Jackson Health Network and HFAH had not had a cross-continuum platform for reviewing patients previously. This drove the need for new processes for the project to be successful. One advantage was the use of EPIC across both entities. This allowed for a work pool to be created, where all entities could communicate.

In addition, a process and timeline were required to collect and distribute the information before all Case Conferences. This includes analytics submitting the Top 50 Report to the lead, which is then leads to choosing cases and determining who will present. One week before the Case Conference occurs, participants are emailed a list of patients that will be presented on, at which time preparations can be made by reviewing case.

What are you proudest of regarding this submission? Why does this work matter? (1-2 paragraphs)

For every patient that is deemed high-risk or a high-utilizer, there are a multitude of factors affecting their situation. To work individually with patients that have so many concerns and issues will only scratch the surface in assisting patients to stabilize their unique situation. In bringing together a group that crosses the continuum, there is a unique opportunity to work together as a care team where each entity has unique experiences and knowledge about the patient and their situation. Not only is this project having an impact on reducing readmissions and ED visits, as reflected in reduced risk scores, but this is having an impact on the quality of life for patients. This best practice allows for an improvement beyond their mental or physical health, but to also include their social supports and the quality of the care they receive.

How will your organization use the funds if your submission wins? (1 paragraph)

If Jackson Health Network receives funds through this submission, it would be optimal to have improved reporting and enhanced information technology capabilities to show outcomes for these patients. At this time, reporting is a heavily manual process and limited in nature. Improved capabilities in this reporting can allow for more data points and a more in-depth analysis of patient outcomes regarding this best practice. Additionally, funds can be used to support the use of innovative technologies that support patient engagement and follow-up.