Accountable Care for Low-income and Marginalized Populations

Baylor Health Care System
Office of Health Equity

April 29, 2010
Purpose

• Describe the development of a hospital-linked “Community Care Service Line” and the emerging Accountable Care Organizational (ACO) strategy
  – Expanding Capacity
  – Expanding Access
  – Improving Quality
Overview

• Emergence of the Community Care Service Line
  – A hospital-safety net clinic collaboration strategy for targeted (i.e. chronically ill) low income & marginalized populations

• The Community Care Model
  – Innovation to reduce utilization & costs while reducing disparities and increasing quality (e.g. Accountable Care)

• Market changes demand better alignment
  – Community Benefit Best Practice
    • Stricter 990 reporting requirements
  – Impending growth of Medicaid population
  – Limited Primary & Specialty Care provider capacity
  – Falling hospital reimbursement rates
    • Expanding need for cost reduction innovations
  – Increased competition around hospital quality
Definition

• Accountable Care Organization
  – “A provider-led organization whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population”

• ACO - Multiple forms:
  • Large integrated delivery systems
  • Physician-hospital organizations
  • Multispecialty practice groups
  • Independent practice associations
  • Virtual inter-dependent networks of hospitals, physicians & clinics

“Starting with a vision”

A Community Care Service Line
Conceptual Framework
BHCS Strategy: Community Care Service Line

“Four Key Components Toward an Accountable Care Organization”

1) Developing Patient-Centered Medical Homes
   - Budget: $3.25M
   - Services: New Medical Homes

2) Deploying Community Care Coordination
   - Budget: $725,000*
   - Services: Transitional Care, Disease Management, Education, Rx Access

3) Implementing Electronic Health Record and Health Information Exchange
   - Budget: TBD
   - Services: Information Exchange, Quality Reporting, ePrescribing

4) Linking to Specialty Care Access
   - Budget: PAD Budget = $4M
   - Services: PAD Services

Health Information Technology
“Building community-based ambulatory care capacity”

Strategy #1: Developing Patient-Centered Medical Homes
Community Care’s Asset Map

• Hospital-based residency clinics
• Hospital-based chronic disease clinics
  – Diabetes, Heart Failure, Asthma
• Community-based Primary Care
  – FQHCs
  – Charitable Clinics
  – Private Physicians
• Specialty Care & RX Access Programs
  – Project Access
What is the Service Area for PAD – Health Information Exchange?

6 Major Health Care Systems:
- Baylor
- HCA
- Methodist
- Parkland
- THR
- UTSWMC

2000+ Volunteer physicians

10 Charity Clinics
## Community Care Service Line
### Proposed Budget Increase – FY11

<table>
<thead>
<tr>
<th></th>
<th>FY08</th>
<th>FY09</th>
<th>FYTD 10 (thru 1-10)</th>
<th>FY11 Budget</th>
<th>Commitment from BHCS</th>
<th>Commitment from Outside Organizations</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baylor FM @ Worth Street</td>
<td>$0</td>
<td>$983,667</td>
<td>$720,511</td>
<td>$1,750,000</td>
<td>$1,280,000</td>
<td>$0</td>
<td>$470,000</td>
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<tr>
<td>Central Dallas Ministries</td>
<td>$837,373</td>
<td>$727,754</td>
<td>$444,466</td>
<td>$1,424,000</td>
<td>$800,000</td>
<td>$624,000</td>
<td>$0</td>
</tr>
<tr>
<td>Christ's Family Clinic</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$127,500</td>
<td>$0</td>
<td>$66,160</td>
<td>$61,340</td>
</tr>
<tr>
<td>Hope Clinic of Garland</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$117,200</td>
<td>$0</td>
<td>$97,500</td>
<td>$19,700</td>
</tr>
<tr>
<td>Irving Interfaith Clinic</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$117,200</td>
<td>$0</td>
<td>$97,500</td>
<td>$19,700</td>
</tr>
<tr>
<td>Baylor Diabetes Health &amp; Wellness Institute</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$600,000</td>
<td>$600,000</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$837,373</strong></td>
<td><strong>$1,711,421</strong></td>
<td><strong>$1,164,977</strong></td>
<td><strong>$4,135,900</strong></td>
<td><strong>$2,680,000</strong></td>
<td><strong>$885,160</strong></td>
<td><strong>$570,740</strong></td>
</tr>
</tbody>
</table>
## Community Care Service Line
### Patient Capacity – FY11

<table>
<thead>
<tr>
<th>Service Provider</th>
<th>Projected FY10 Visits</th>
<th>Projected FY10 Unduplicated Patients</th>
<th>Projected FY11 Visits</th>
<th>Projected FY11 Unduplicated Patients</th>
<th>Patients % Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baylor Family Med. Worth Street (3.5 FTEs)</td>
<td>4,170</td>
<td>2,370</td>
<td>2,850</td>
<td>9,450</td>
<td>20%</td>
</tr>
<tr>
<td>Central Dallas Ministries (2.4 FTEs)</td>
<td>8,564**</td>
<td>1,392</td>
<td>1,728</td>
<td>10,627**</td>
<td>24%</td>
</tr>
<tr>
<td>Christ's Family Clinic (0.2 FTEs)</td>
<td>300</td>
<td>75</td>
<td>108</td>
<td>366</td>
<td>44%</td>
</tr>
<tr>
<td>Hope Clinic of Garland*** (0.5 FTEs)</td>
<td>2,927</td>
<td>887</td>
<td>1,175</td>
<td>3,877</td>
<td>32%</td>
</tr>
<tr>
<td>Irving Interfaith Clinic*** (0.5 FTEs)</td>
<td>1,850</td>
<td>1,640</td>
<td>1,968</td>
<td>6,494</td>
<td>20%</td>
</tr>
<tr>
<td>Diabetes Health &amp; Wellness Institute (1.5 FTEs)</td>
<td>0</td>
<td>0</td>
<td>1,230</td>
<td>4,059</td>
<td>-</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>17,811</strong></td>
<td><strong>6,364</strong></td>
<td><strong>9,059</strong></td>
<td><strong>34,843</strong></td>
<td><strong>42%</strong></td>
</tr>
</tbody>
</table>

* Assumes Patient Panel Size of 1,000 patients per FTE Provider: ACMPE Paper, Determining Provider Panel Size in a Staff-model HMO, 2006.

** Central Dallas Ministries has an average of 6.15 visits per patient annually, compared to an HMO benchmark of 3.3 visits per patient.

*** Both Clinics recruit volunteer providers to expand PCP capacity.

~2,700 New Patients get a medical home in FY-11
Community Care Service Line: Increased hospital-to-medical home connections

- Dedicated Project Access Enrollment Coordinators will enroll eligible patients from BHCS hospitals and establish medical homes at partnering charitable clinic.

<table>
<thead>
<tr>
<th></th>
<th>Weekly Hospital Enrollment Capacity</th>
<th>Monthly Hospital Enrollment Capacity</th>
<th>FY-11 Hospital Enrollment Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worth Street</td>
<td>10</td>
<td>40</td>
<td>480</td>
</tr>
<tr>
<td>Central Dallas Ministries</td>
<td>2</td>
<td>8h</td>
<td>96</td>
</tr>
<tr>
<td>Hope Clinic of Garland</td>
<td>6</td>
<td>24</td>
<td>288</td>
</tr>
<tr>
<td>Irving interfaith Clinic</td>
<td>6</td>
<td>24</td>
<td>288</td>
</tr>
<tr>
<td>Diabetes Health &amp; Wellness Institute</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>24</strong></td>
<td><strong>96</strong></td>
<td><strong>1,152</strong></td>
</tr>
</tbody>
</table>

~1,150 Unassigned hospitalized patients get a medical home in FY-11
Productivity: Local Charity Clinic

*Note: Benchmark: 25% MGMA per 1 FTE

- Physician (w/o OB): 3787 per Year / 316 per Month
- Nurse Practitioner: 1590 per Year / 132 per Month
**Productivity: Hospital-Owned Clinic**

*Note*: Benchmark: 25% MGMA per 1 FTE

- Physician (w/o OB): 3787 per Year / 316 per Month
- Nurse Practitioner: 1590 per Year / 132 per Month
Outcomes: Service Excellence

Community Health Services Corps
Patient Satisfaction - Overall Mean Score
Rolling 12 Months: Apr '09 - Mar '10

Overall Mean Score
- Worth St: 89.1% to 97.3%
- CDM: 83.4% to 96.4%
- Christ's Family: 76.2%
- Hope Garland: 100.0%

# of Surveys
- Worth St: 4 to 9
- CDM: 6 to 13
- Christ's Family: 1
- Irving: 1
- Hope: 1 to 6

*Survey Data by Discharge/Service Date
Outcomes: Quality Improvement

Community Health Services Corps
Adult Preventative Services
Percent Opportunity Achieved
July '08 - December '09

*Note:
• Percent Opportunity Achieved (POA) = The sum of the services provided (or completed, i.e. "done") divided by the total services applicable to the patient

Dr. Berry
Dr. Grimson
Dr. Robertson
Dr. Stephen
Dr. Wang
HTPN Average
### Outcomes: Budget Stewardship
#### Community Care Service Line

<table>
<thead>
<tr>
<th>Clinic</th>
<th>FYTD '10 Total Expense(^1) (Thru 2/10)</th>
<th>FYTD '10 Budget (Thru 2/10)</th>
<th>Variance (+ = over budget) (- = under budget)</th>
<th>% Variance (+ = over budget) (- = under budget)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDM</td>
<td>$511,621</td>
<td>$509,769</td>
<td>+ $1,852</td>
<td>+ 0.36%</td>
</tr>
<tr>
<td>Worth St.</td>
<td>$833,099</td>
<td>$1,114,575</td>
<td>- $281,476</td>
<td>- 25.3%</td>
</tr>
<tr>
<td>Christ’s Family(^2)</td>
<td>$38,644</td>
<td>$8,082</td>
<td>+ $30,582</td>
<td>+ 378.4%</td>
</tr>
<tr>
<td>Irving Interfaith(^2)</td>
<td>$42,336</td>
<td>$31,964</td>
<td>+ $10,372</td>
<td>+ 32.4%</td>
</tr>
<tr>
<td>Hope Garland(^2)</td>
<td>$42,336</td>
<td>$31,964</td>
<td>+ $10,372</td>
<td>+ 32.4%</td>
</tr>
</tbody>
</table>

*Note:*

\(^1\) Total Expense from Cash Financials (3380)
\(^2\) Difference Between Expenses and Income
“There is a return on investment”

Impacting Hospital Utilization, Uncompensated Costs & Quality
BHCS Hospital Utilization Analysis for Worth Street Patients
365 Day Pre and Post Initiation of Care
Number of Uncompensated Emergency, Inpatient and Outpatient Services
(n=480 patients)

<table>
<thead>
<tr>
<th></th>
<th># ED Encounters</th>
<th># IP Encounters</th>
<th>IP Avg LOS</th>
<th># OP Encounters</th>
<th>Total Encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before Initiation of Care</td>
<td>464</td>
<td>193</td>
<td>11.9</td>
<td>109</td>
<td>766</td>
</tr>
<tr>
<td>After Initiation of Care</td>
<td>417</td>
<td>94</td>
<td>7.3</td>
<td>360</td>
<td>871</td>
</tr>
<tr>
<td>%Change</td>
<td>-10.1%</td>
<td>-51.3%</td>
<td>-38.7%</td>
<td>+230.3%</td>
<td>+13.7%</td>
</tr>
</tbody>
</table>
BHCS Hospital Utilization Analysis for Worth Street Patients
365 Day Pre and Post Initiation of Care
Total Uncompensated Emergency, Inpatient and Outpatient Costs
(n=480 patients)

<table>
<thead>
<tr>
<th></th>
<th>ED Total Costs</th>
<th>IP Total Costs</th>
<th>OP Total Costs</th>
<th>Total Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before Initiation of Care</strong></td>
<td>$128,769</td>
<td>$3,522,420</td>
<td>$247,087</td>
<td>$3,898,276</td>
</tr>
<tr>
<td><strong>After Initiation of Care</strong></td>
<td>$129,586</td>
<td>$707,199</td>
<td>$398,681</td>
<td>$1,235,466</td>
</tr>
<tr>
<td><strong>% Change</strong></td>
<td>+0.6%</td>
<td>-79.9%</td>
<td>+61.4%</td>
<td>-68.3%</td>
</tr>
</tbody>
</table>
Outcomes: Reduced Uncompensated Hospital Care Costs

BHCS Hospital Utilization Analysis for Worth Street Patients
365 Day Pre and Post Initiation of Care
Total Emergency, Inpatient, and Outpatient Uncompensated Costs
(n=480 patients)*

$3,522,420
$128,769
$247,087
$3,898,276
$129,586
$707,199
$398,681
$1,235,466

Reducing Hospital Care Costs:
~$5,500/patient

* At the end of CY-09, Total Patient Panel = 2,300 x $5,547 saved per patient in first year = $12,758,100 in avoided hospital costs

*Note: Hospital Utilization data provided my BHCS Decision Support / Revenue Cycle. Analysis includes patients with a 1st Date of Service at Worth St. on or before 12/21/08 with hospital utilization data through 12/21/09.
Outcomes: Reduced 30-day Post-Discharge Readmission Rate

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>VPN-CHF Program 30-Day Post-Discharge Readmission Rate from Initial Index Admission (n = 38 total patients)</td>
<td>13.2%</td>
</tr>
<tr>
<td>BUMC Heart Failure Readmission Rate¹</td>
<td>19.8%</td>
</tr>
<tr>
<td>BHVH Heart Failure Readmission Rate¹</td>
<td>15.9%</td>
</tr>
<tr>
<td>US National Readmission Rate for Heart Failure Patients¹</td>
<td>24.5%</td>
</tr>
<tr>
<td>CMS 2004 Heart Failure Readmission Rate²</td>
<td></td>
</tr>
<tr>
<td>25th Percentile</td>
<td>18.8%</td>
</tr>
<tr>
<td>50th Percentile</td>
<td>23.1%</td>
</tr>
<tr>
<td>75th Percentile</td>
<td>27.3%</td>
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</tbody>
</table>

² “Hospital 30-Day Heart Failure Readmission Measure Methodology” Submitted by Yale University/Yale-New Haven Hospital Center for Outcomes Research & Evaluation (YNHH-CORE)
“It’s not all about the clinics”

Strategy #2: Developing Community Care Coordination
BHCS Strategy: Community Care Service Line
Care Coordination: Innovation for ACO Success

1) Community Health Navigation

At-Risk Patient
- PCP Appointment Adherence
- Prescription Adherence

Budget: $523,000
Outcome Metrics:
- Appointment Adherence
- Prescription Adherence
- Satisfaction (% Top Box Score)

2) Community Health Education

Diabetes Equity Project
- Education and Self Management Behavior
- Diet, Exercise and Weight Management
- Prescription Adherence

Budget: $342,653
Outcome Metrics:
- HgA1C
- BMI
- Self-Management Behaviors Performance Frequency
- Satisfaction (% Top Box Score)

3) Community Health Transition

VPN Patients Transitions
- Neurotrauma
- Heart Failure
- CV Disease (AMI)

Budget: $65,000
Outcome Metrics:
- 30-Day Readmission Rate
- Post-Discharge Contact within 14 Days Yes/No
- Post-Discharge Visit within 14 Days Yes/No
- Post-Discharge Rx Adherence Yes/No
- Satisfaction (% Top Box Score)
Community Health Navigation
Adapting Care Coordination: Community Health Navigation

- Utilizing the Community Health Worker (CHW) skill set
  - Adapting CHWs to Community Health Navigation (CHN)
- CHNs establish relationships with patients & clinics
- CHNs use phone calls and visits (home, clinic, hospital, pharmacy, resource center) to coordinate and monitor a patient’s successful navigation of 7 key barriers
- CHNs may provide emergency assistance & then coach their patients on how to better navigate in the future
How do CHNs Help Patients Navigate Health Care Systems?

• CHNs assigned to specific charitable clinics and targeted neighborhoods
• CHNs visits patients’ homes, clinics, hospitals and pharmacies
• CHNs use navigation pathways to facilitate effective care coordination
• CHNs provide patients with bus/light rail passes, emergency funds for prescription co-pays, health information, referrals, emotional support, translation services, etc.
• CHNs facilitate communication between patients, Project Access clinics and the PAD administrative office
Community Health Education
Adapting Care Coordination: Community Health Education

• Utilizing the Community Health Worker (CHW) skill set
  – Adapting CHWs to Diabetes Health Promotion (DHP)

• Use of Community Health Workers to provide chronic disease education and self-management training to diabetic patients within charitable health clinics across Dallas County
  – Conducting one-on-one counseling with patients (7 visits/year)
    • DHP is bilingual/bi-cultural
    – Contextualizes diabetes curriculum & messages
    – Advocates for diabetics & families (meds, referrals, etc.)
    – Serving as an additional point-of-contact for patient/families
### Community Health Education

#### Diabetes Control Study

Community Diabetes Education Project (CoDE)

#### Hb A1C %

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>3 Mos</th>
<th>6 Mos</th>
<th>9 Mos</th>
<th>12 Mos</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Control Group (CG)</strong></td>
<td>8.71 (p=.84)</td>
<td>7.92 (p=.33)</td>
<td>7.77</td>
<td>7.38</td>
<td>7.27</td>
</tr>
<tr>
<td><strong>Experimental Group (EG)</strong></td>
<td>8.92 (p=.53)</td>
<td>8.05 (p=.03)</td>
<td>8.00 (p=.043)</td>
<td>7.82</td>
<td></td>
</tr>
</tbody>
</table>

**Experimental Group = Enrolled in CoDE Program**

**Control Group = Standard of Care – Not enrolled in CoDE**

Mean Age at Diabetes Onset: 42.27 (SD 10.99)

Average Number of Years Since Diagnosis: 4.80 (SD 5.20)
Project Access Dallas (PAD)

PAD DM Patients

Community Care Coordination

DFW Charity Clinics
Community Health Centers
Private Practices

Medicine Home

CoDE* Sites

Juanita Craft Clinic (SSHl)

Diabetes Educator (CHW)

Irving Interfaith
Clinic

Diabetes Educator (CHW)

Hope Clinic of
Garland

Diabetes Educator (CHW)

Healing Hands-
Lake Highlands

Diabetes Educator (CHW)

1st- Based on Patient’s Medical Home

2nd- Based on closest Location to Patient’s Residence

Refer to: CoDE Program

Non PAD DM Patients

DFW Charity Clinics
Community Health Centers
PAD Volunteer Physicians

1st Target Program
Patient Population

2nd Target Program
Patient Population

Diabetes Education
CoDE Curriculum

See Attached Detailed Intervention Protocol

Visit 1: Scheduled ~2 weeks after Enrollment (1 hr. visit)

Visit 2: Scheduled 2 weeks after 1st Visit (1 hr. visit)

Visit 3: Scheduled ~3 weeks after 2nd Visit (1 hr. visit)

Quarterly Visits: Scheduled indefinitely after 3rd Visit (30-60 minute visit)

Clinical Support: Physician

CoDE* Program Manager

Oversight of Program and CHWs

Patient's Data Capture: Diabetes Registry

Web-Based

Demographics, Visits/Utilization, DM Clinical Indicators, Lab Results, DQOL Score, Medications, Foot Complication's Risk Score, Patient Goals

Output

Patient Health Outcome Evaluation (improvement/setbacks)

Patient Reports (Identify DM management priority areas)

Physician Reports

Program Utilization and Effectiveness

Medication Adherence and Utilization Evaluation

5 Community Safety Net Clinics engaged in Community Health Education

*Community Diabetes Education Program
Waiting Area
- Think about this question… “Of all the things that could happen during this visit, what would be the most important thing?” Your DHP will be asking you this shortly.

Your Visit with the Diabetes Health Promoter
- Answer some questions about you and your diabetes
  - Height and weight
  - Blood pressure
  - Blood glucose and A1C
  - Feet
- Check your
- Learn about
  - Diabetes
  - Healthy eating tips
  - Questions that you have
- You’ll be given
  - Information on healthy eating
  - Your diabetes daily reminder sheet
  - Updated information for your wallet card
  - Instructions and appointment for your next visit
  - Patient satisfaction survey to complete today (below)

After your visit
- The DHP will inform your doctor of how you are doing and how we can better assist you.

How long have you been going to the Diabetes Health Promoter (DHP)?
☐ Less than 3 months  ☐ At least 3 months but less than 1 year  ☐ More than 1 year

<table>
<thead>
<tr>
<th>1. Were you treated with respect today?</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
</tbody>
</table>

| 2. During today’s visit, did you increase your understanding of diabetes care for yourself? | o | o | o | o |

| 3. Do you feel that you could call the DHP to ask questions about the care of your diabetes? | o | o | o | o |

| 4. How likely would you be to recommend this program to one of your friends or family members who has diabetes too? | Not at all likely | Very likely |
|------------------------------------------------|------------------|
| Comments: ____________________________________________ |
Diabetes Equity Project
The Diabetes Health Promoter Team

Magdalena, Sayra, Chris, Claudia, Miriam, Martha
Community Health Transitions
Adapting Care Coordination: Community Health Transition

• Utilizing the Community Health Worker (CHW) skill set
  – Adapting CHWs to manage patient care transitions

• Use of Community Health Workers to provide chronically ill hospitalized patients with effective hospital discharge:
  – Post-discharge follow-up medical home care
  – Access to medication, community health navigation, community health education related to chronic disease self-management
  – Contextualizes discharge instructions & follow-up
  – Serving as an additional point-of-contact ("warm" hand-off) for patient/families
  – Support quality goals related to 30-day readmission/mortality reduction
BHCS Community Health Transitional Care Strategy

BMC - Garland

Baylor University Medical Center

BMC - Irving

**Metrics**
1) PCP Appointments within 14 Days
2) Completed Medication List Reconciliation with PCP (see form)
3) Completed Problem List Reconciliation with PCP (see form)
4) Units of Service
   a) Referrals to Project Access Dallas and Project Access Dallas Community Health Navigator
   b) Enrollments to Project Access Dallas

**Metrics**
1) Chronically Ill Inpatient Screened for Medical Home Need (total)
2) Uninsured / Underinsured Referrals to Enrollment Coordinator (% of total)

**Metrics**
1) Contact Home within 2 Weeks
2) % of Patients That Kept First Appointment

**Metrics**
1) New Patient Capacity (weekly)
2) % of New Patient Capacity filled by Project Access Dallas Enrollment Coordinator
3) % of New Patients Seen Within 14 Days of Hospital Discharge

Monitor 30 Day Hospital Readmission Rate / Mortality
Community Health Transitions: Vulnerability Screening Tool

Pre-Screening of Risk Factors for Hospitalization and Emergent Care

Prior Pattern (check all that apply)
- Hospitalizations or ED visits in the past 6 months
- History of recent falls
- History of noncompliance

Chronic Conditions (check all that apply)
- CHF
- Advanced Liver Disease
- Cancer
- Diabetes
- Chronic skin ulcers
- COPD/Asthma
- End Stage Renal Disease
- HIV/AIDS
- “New” diagnosis/problem

Risk Factors (check all that apply)
- 9 or more medications
- More than two secondary diagnoses
- Low Socioeconomic status or financial concerns
- Lives Alone
- Help with managing medications needed
- Confusion (any level)
- Short Life expectancy
- Poor Prognosis
- Dyspnea (any level)
- Urinary catheter
- Open wound (stasis, pressure, diabetic ulcer, open surgical wound)
- Other

Total of Checked Boxes: __________
(6 or more indicates high risk for emergent care)

¹This material was prepared by Georgia QIO, the Medicare Quality Improvement Organization for Georgia under contract with the Centers for Medicare & Medicaid Services (CMS), and agency of the US Department of Health and Human Services. The contents presented do not reflect CMS Policy.
Adapting Care Coordination: Community Health Transitions

• A unique “house-calls” program which utilizes a multi-disciplinary team to provide home-based primary care services to underserved patients with complex medical and social conditions
  – Neuro-trauma and Heart Failure
• Specially-trained CHW supports the care team
  – CHW’s have medical assistant training
  – Utilize clinical and social “Equity care-path” tools
  – Serve as a single point-of-contact for home-bound patients
Community Health Transitions
Impact on Hospital Utilization

BHCS Hospital Utilization for VPN-CHF Patients
Pre to Post VPN-CHF Program Initiation of Care
Percent Change in Number of Encounters Over Time

% Change

-100%  0%  100%  200%  300%

90 Days 180 Days 270 Days 365 Days 450 Days
(n=40) (n=38) (n=35) (n=25) (n=20)

Pre and Post Initiation of Care Analysis Timeframe
- ED  - IP  - OP  - Total

(-) = Reduction in Utilization

*Note: Hospital Utilization data provided by BHCS Decision Support / Revenue Cycle. Analysis includes patients with hospital utilization data through 12/21/09.
Community Health Transitions
Impact on Hospital Utilization

BHCS Hospital Utilization for VPN-CHF Patients
Pre and Post VPN-CHF Program Initiation of Care
Percent Change in Uncompensated Costs Over Time

*Note: Hospital Utilization data provided by BHCS Decision Support / Revenue Cycle. Analysis includes patients with hospital utilization data through 12/21/09.
Community Health Transitions Impact on Hospital Utilization

BHCS Hospitalization for VPN-CHF Patients
365-Day Pre and Post VPN-CHF Initiation of Care
Emergency, Inpatient and Outpatient Uncompensated Cost
(n=25 patients)

*Note: Hospital Utilization data provided by BHCS Decision Support / Revenue Cycle. Analysis includes patients with a 1st Date of Service in VPN-CHF program on or before 12/21/08 with hospital utilization data through 12/21/09.
“We need to communicate better”

Strategy #3: Implementing Health Information Technology
Health Information Exchange
The value for our “medically vulnerable”

• The power of a local HIE - leveraging technology:
  – Longitudinal patient record available across organizations
  – Incremental improvement in health care quality (i.e. decreased morbidity & mortality)
  – Reduction in health care cost (i.e. decreased hospital utilization)
  – Increase efficiency in health care delivery across the local safety-net health care systems
  – Enables the development of Patient-centered Medical Homes
  – Improvement in care coordination for patients
Patients – “Medically Vulnerable”
(Future: Commercially Insured, Medicaid/ SCHIP, Medicare)
“Leveraging Project Access for ACO Development”

Strategy #4: Linkage to Specialty Care Access
Project Access: Our Mission

- A physician-led, community effort to provide health care for low-income, working but un-insured Dallas County residents.
- Managed by the Dallas County Medical Society (DCMS) in partnership with hospitals, business, faith and community organizations, and funded through grants and donations to DCMS’ foundation, the Dallas Academy of Medicine.
Supporting Physicians, Charity Clinics & Hospitals

- PAD Enrollees:
  - Earn < 200% fpl
  - Not Eligible for Medicaid
  - Uninsured
  - Dallas County Residents

- Referred from:
  - Community Clinics
  - Emergency Rooms
  - Hospitals
  - Doctors

- Clinics screen and enroll patients – web-based
A Role for Pharmacy Services

- Patients receive RX thru CVS-CareMark® PBM generic formulary
  - CVS-CareMark® charges costs of medications back to PAD
  - Patient pays a minimal co-pay ($10/Rx)
- Some Patients obtain mail-order through Welvista
- Many Rx filled at Walmart’s $4 formulary.
Outcomes

- Decreased inappropriate ED use and uncompensated hospital care
- Organized physician community service
- Increased capacity & efficiency at community health clinics
- Increased patient co-responsibility in health care, chronic disease management
- Increased community awareness and investment in community’s uninsured problem
Summary

• Community Care Service Line emergence
  – A hospital-linked “Community Care Service Line” for low income & marginalized populations

• Community Care’s model
  – Innovative collaboration for achieving an accountable care organizational vision

• Market changes provide a need for ACO
  – Community Benefit Best Practice
    • Stricter 990 reporting requirements
  – Impending growth of Medicaid population
  – Limited Primary & Specialty Care capacity for low income patients
  – Falling hospital reimbursement rates
    • Expanding need for cost reduction innovations
  – Increased competition around hospital quality