Rapid Innovations In Care: Building on the Success of a Care Transitions Team.

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Rapid Innovations In Care: Building on the Success of a Care Transitions Team

GWEP: A New Model of Care

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LVHN – Population Health – Management Team

Lehigh Valley Health Network

Who We Are

- 5 Campuses
- 1 Children's Hospital
- 160 Physician Practices
- 17 Community Clinics
- 14 Health Centers
- 11 ExpressCARE Locations
- 81 Testing and Imaging Locations
- 14,361 Employees
- 1,496 Physicians
- 642 Advanced Practice Clinicians
- 3,140 Registered Nurses
- 57,801 Admissions
- 208,882 ED visits
- 1,236 Acute Care Beds

Quality Milestones

2011

- America's Best Hospitals for endocrinology, gastroenterology and geriatrics-*U.S. News & World Report*
- No. 1 and No. 2 Hospitals in the Region-*U.S. News & World Report*
- Magnet Hospital redesignation for nursing excellence- *American Nursing Credentialing Center*
- Top Performer on Key Quality Measures-*Joint Commission*
- Architecture and Design Award for environmentally friendly health care-*GreenCare*
- Top 100 Integrated Health Networks-*Verispan*
- 100 Most Wired Hospitals- *Hospitals & Health Networks*
- 100 Best Places to Work in Healthcare-*Becker's Hospital Review*

2012

- America's Best Hospitals for gastroenterology, orthopedics and pulmonology-*U.S. News & World Report*
- Leapfrog "A" Grade for Patient Safety- *The Leapfrog Group*
- Accredited Chest Pain Centers-*Society of Cardiovascular Patient Care*
- 100 Most Wired Hospitals- *Hospitals & Health Networks*
- NCI Community Cancer Centers Program (NCCCP) redesignation- *National Cancer Institute, U.S. National Institutes of Health*
- 100 Best Places to Work in Healthcare- *Becker's Hospital Review*
- Computerworld Honors Laureate- *Computerworld Magazine*
- VHA Leadership Award for Supply Chain Management Excellence-*VHA*
- HealthGrades Emergency Medicine Excellence Awards (LVH and LVH-Muhlenberg)-***HealthGrades***
- Certified Comprehensive Stroke Center-*Joint Commission*

2013-2014

- America's Best Hospitals in 7 specialties-*U.S. News & World Report - 2013*
- America's Best Hospitals in 10 specialties-*U.S. News & World Report - 2014*
- Magnet Prize®- *American Nursing Credentialing Center*
- Leapfrog "A" Grade for Patient Safety- *The Leapfrog Group 2013 & 2014*
- America's Safest Hospitals - *AARP*
- Most Wired Hospitals- *Hospitals & Health Networks*
- Integrated Health System to Know-*Becker's Hospital Review*
- 100 Best Places to Work in IT-*Computerworld Magazine*

2015-2016

- America's Best Hospitals in 7 specialties-*U.S. News & World Report – 2015*
- America's Best Hospitals in 5 specialties-*U.S. News & World Report - 2016*
- Leapfrog "A" Grade for Patient Safety-*The Leapfrog Group – 2015*
- Circle of Life for Palliative Care-*American Hospital Association*
- Most Wired Hospitals- *Hospitals & Health Networks Group – 2015*
- Most Wired Advanced- *Hospitals & Health Networks Group – 2016*
- "Above Average" In Aortic Valve Replacement- *Consumer Reports*
- Re-certified Comprehensive Stroke Center-*Joint Commission*
- Magnet Hospital redesignation for nursing excellence- *American Nursing Credentialing Center - 2016*

LVHN Vision

We will build on our foundation as a premier academic community health system and become an **innovative population health leader** that creates superior quality and value for the patients and communities we serve.

Population Health

Population Health (PH):

- Health and health outcomes of a group of individuals including how those outcomes are distributed across the group
  - Represents the **Better Health** portion of the Triple Aim

Population Health Management (PHM):

- Design, delivery coordination, and payment of health care services to manage the health and health outcomes of a defined population

Population Health

Establish the infrastructure to support cultural, financial & clinical transformation to become an innovative population health leader

Priorities

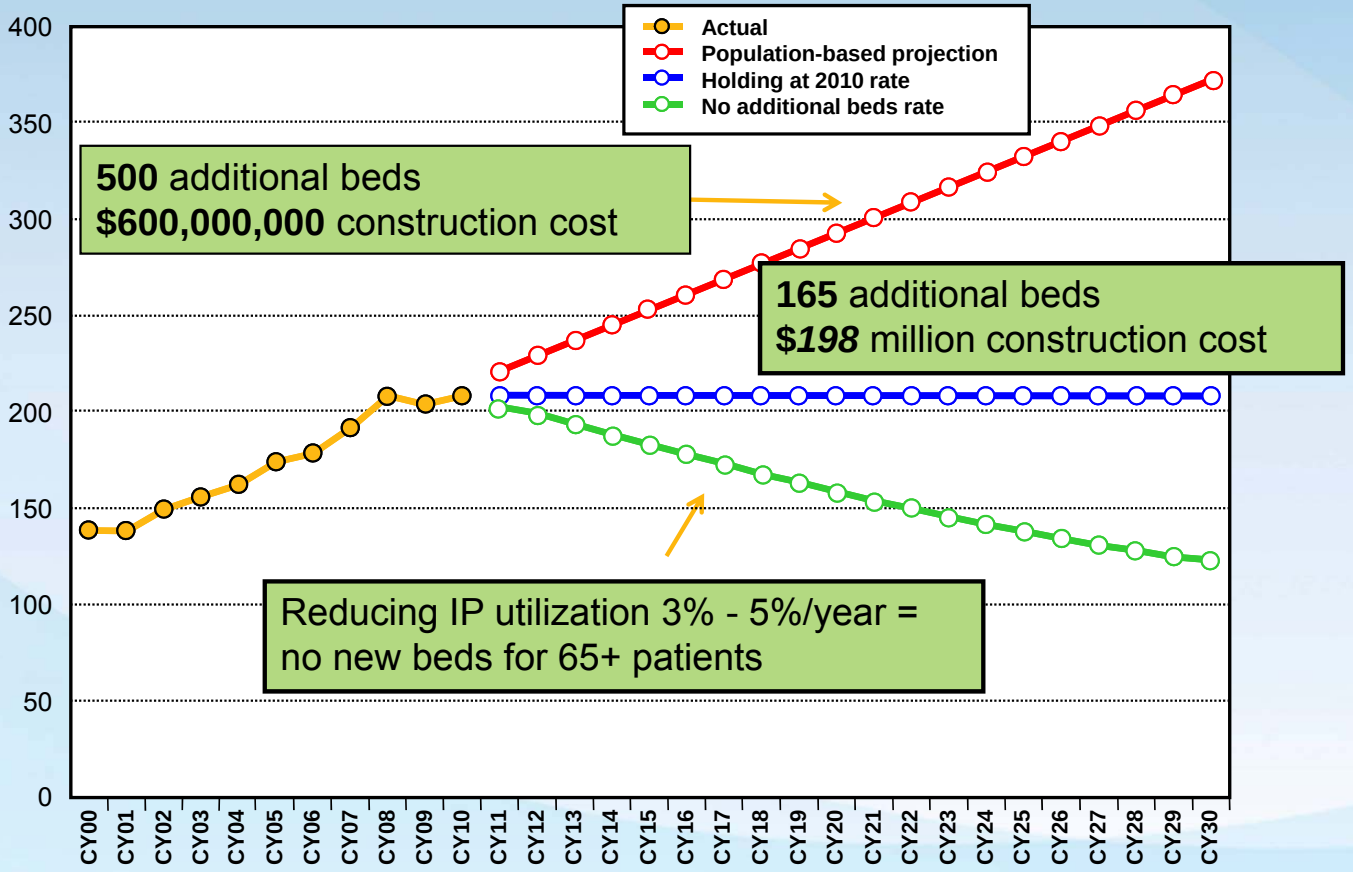
- Continually assess the population through analysis of medical, Rx claims, clinical & quality data
- Identify & prioritize opportunities for quality & financial improvement
- Proactively identify & respond to vulnerable populations

With No Intervention…

- Reliance on fee for service becomes less of a profitable strategy with each passing year
- Medicare/Medicaid/Self Pay will be virtually impossible to project profitability
- Ability to cost shift to commercial payers will disappear
- Risk of payer networks placing you in a different tier

Background

Utilization of LVHN IP Services Per 1,000 65+ Population



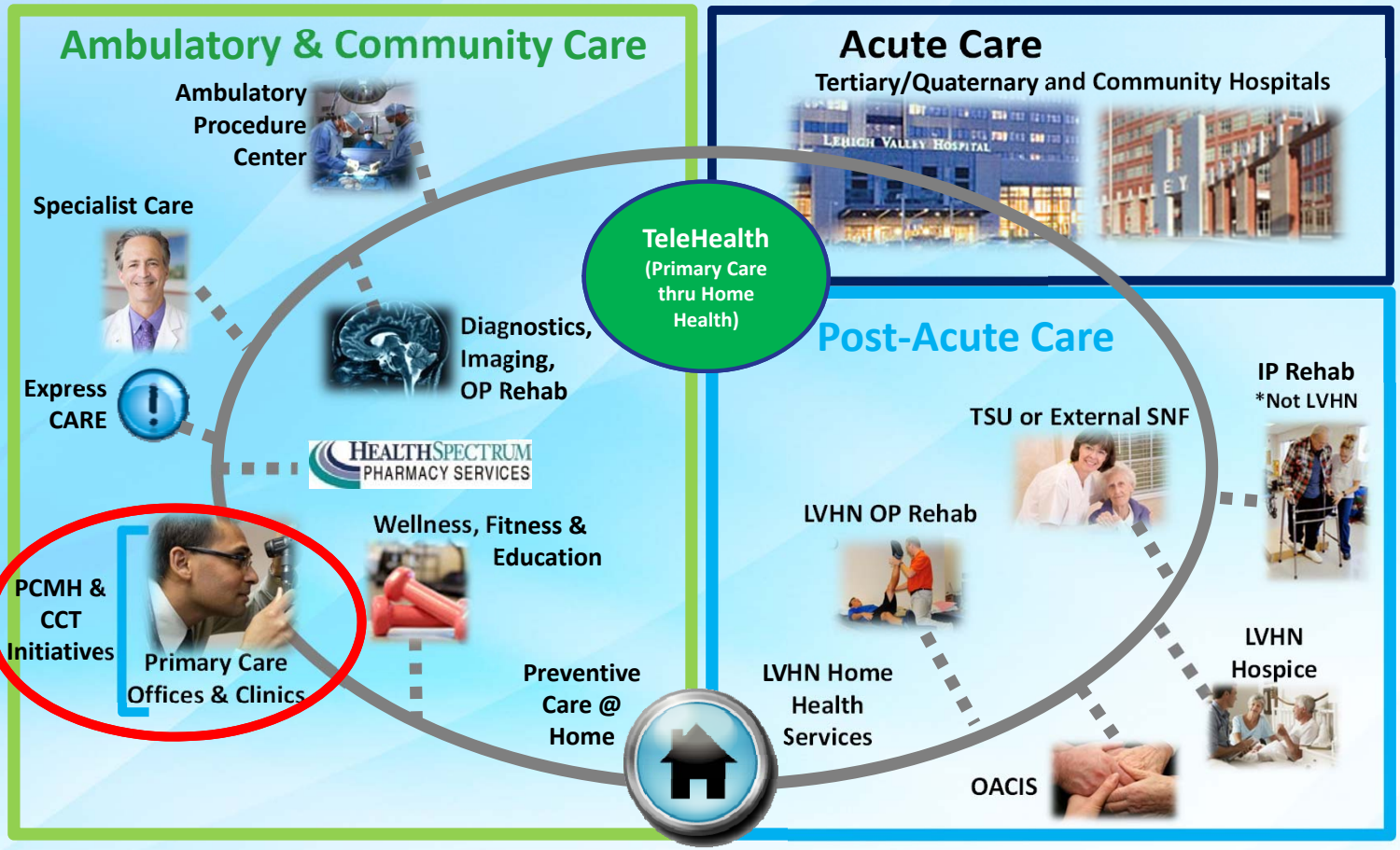
New Era Competencies

- Engage patients: robust care management
- Form effective teams for care delivery
- Coordinate care across settings
- Build in quality, reduce “waste”
- Create & sustain community partnerships
- Develop IT tools, utilize patient data sets
- Focus on health of population, not just disease

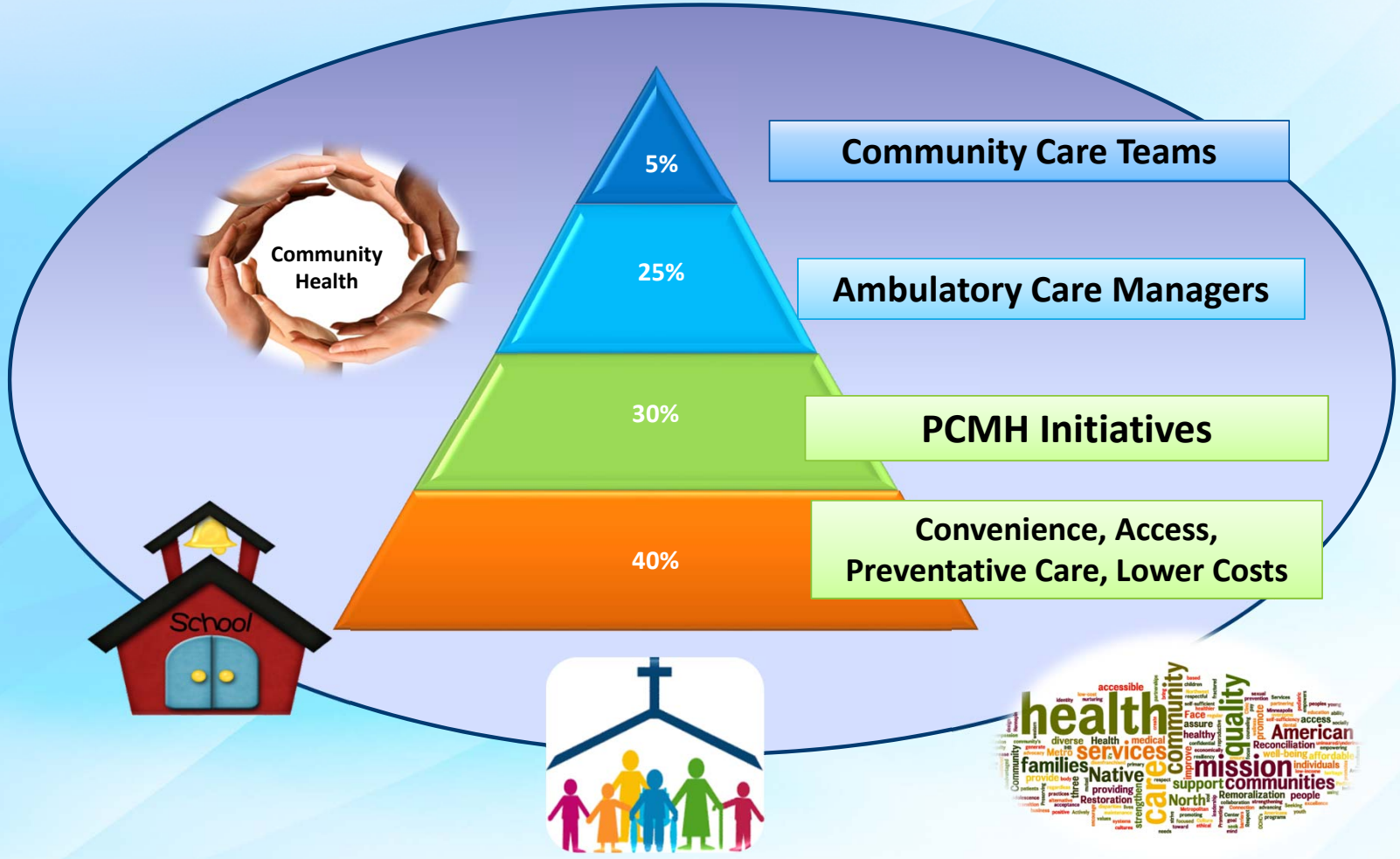
The Journey…

- Primary Care Development Task Force
  - Developed a comprehensive strategic plan for Primary Care at LVHN
- Participation in state-wide initiatives
- LVHN owned and aligned practices participated in Learning Collaboratives
  - 2012 launch of the first Community Care Team

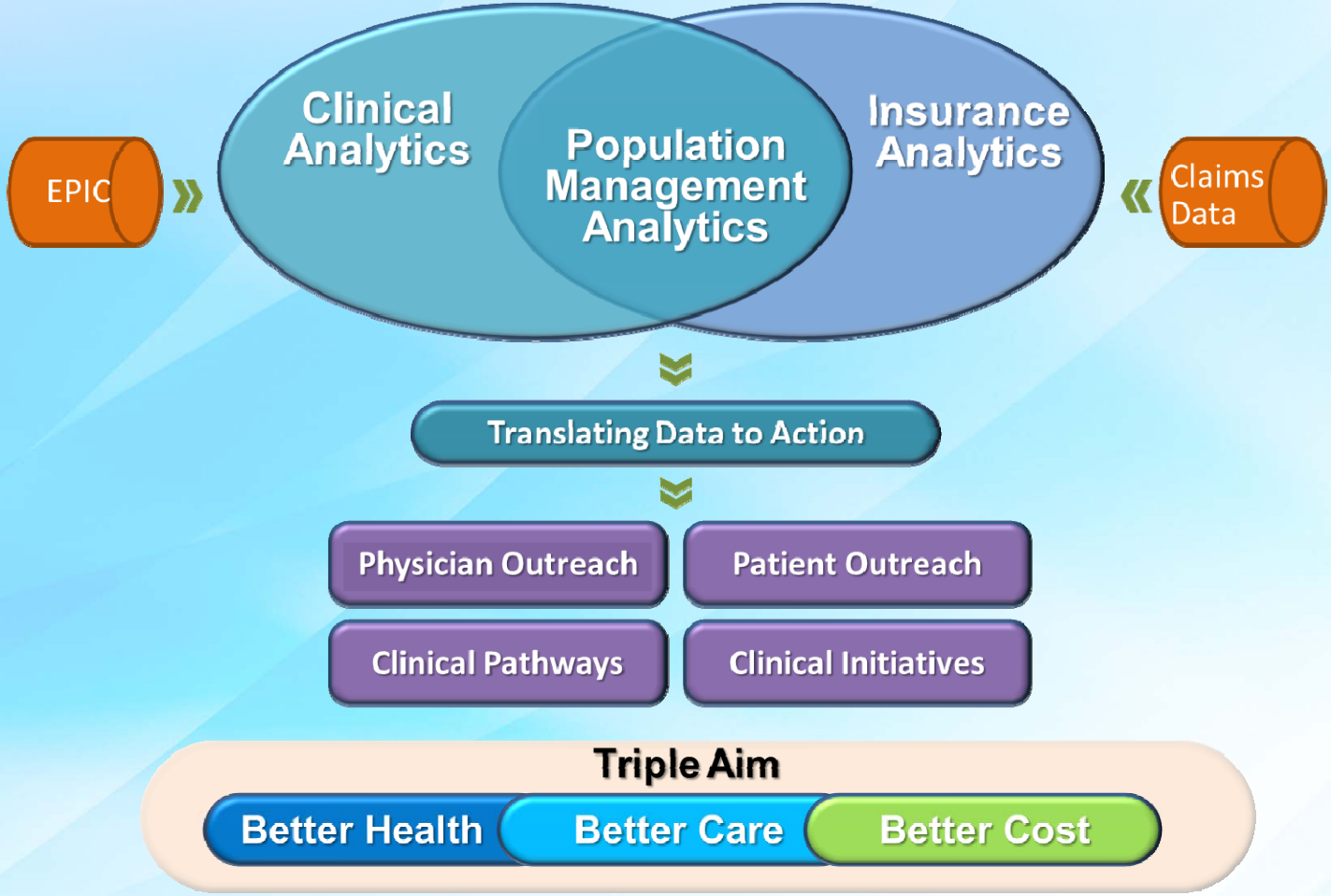
The LVHN Care Continuum



Integrated Population Health Model for a Healthier Community



Translating Data into Action



Overview of our Population Health Department

- Shift in mindset from reactive to proactive engagement of patients
- Systemic changes needed:
  - Patient-centered primary care
  - Care coordination/Shared decision making
  - Infrastructure to manage chronic conditions
  - Reimbursement to reward value, not volume
- Better management of a very large population requires organization and strategy

Integrated Population Work

- Community Care Teams
  - Geriatric Workforce Enhancement Grant
  - Whole Health Grant
- Centralized Care Coordination Model
- Population Health Transition of Care Call Center

Community Care Team (CCT)

- CCTs are interdisciplinary teams working collaboratively with primary care and specialty practices to offer care coordination and management of the high risk patient population

- CCTs are comprised of the following members
  - Nurse Care Managers
  - Behavioral Health Specialists
  - Social Worker/Social Service Coordinators
  - Clinical Pharmacists

- CCTs deployed to 40 practices in 5 counties

CCTs - What We Do

- The community care team members facilitate the care coordination, social, behavioral health, and education needs of the high risk patient population (5%)

- CCTs coordinate and connect patients to additional healthcare and community resources in order to support their health improvement goals, achieve better health outcomes and reduce avoidable costs

Implementation of CCT Work

- Outreach
  - Referral based service, proactive registry outreach, and patients identified from TOC calls
- Transparency
  - Bi-annual practice leadership meetings
    - Discuss team and practice integration, referral volume, data, outcomes, strategies for improvement
  - Monthly interdisciplinary team huddle
    - Practice huddles, department and discipline based

Implementation of CCT Work

- Efficiency
  - Standardized workflows, documentation and outreach expectations across all disciplines to ensure consistent and timely patient outreach.
  - Leverage technology to allow for collaboration with teammates, practice staff and patients even when not physically present
  - Practice assignments geographically organized to minimize travel time

Connecting the dots…

Community Care Team Roles

Nurse Care Manager

- Comprehensive Assessment
- Disease Specific Education
- Medication Review
- Triage Barriers to Care
- Service Linkage
- Home Systems Monitoring
- Nutrition

Social Worker

- Uninsured/Underinsured
- Medicaid, Medicare
- Financial Assistance
- Cost of Medications
- Transportation / Safety
- Placement/Long-Term Care
- Allied Health Services
- SSD, SSI, Food Stamps, Cash Assistance, Unemployment

Community Care Team Roles

Behavioral Health Specialist

- Provide short-term, solution focused therapy while assisting in linkage to appropriate Mental Health/Substance Abuse providers.
- Collaborate with primary care practices as a BH resource and consultant

Clinical Pharmacist

- Disease/Drug Management
- Medication Therapy Management
- CHF,DM,COPD, Asthma, Smoking Cessation, etc.
- Promote patient self management
- Medication education through teach back / Device training

What Characterizes a "High Risk" Patient

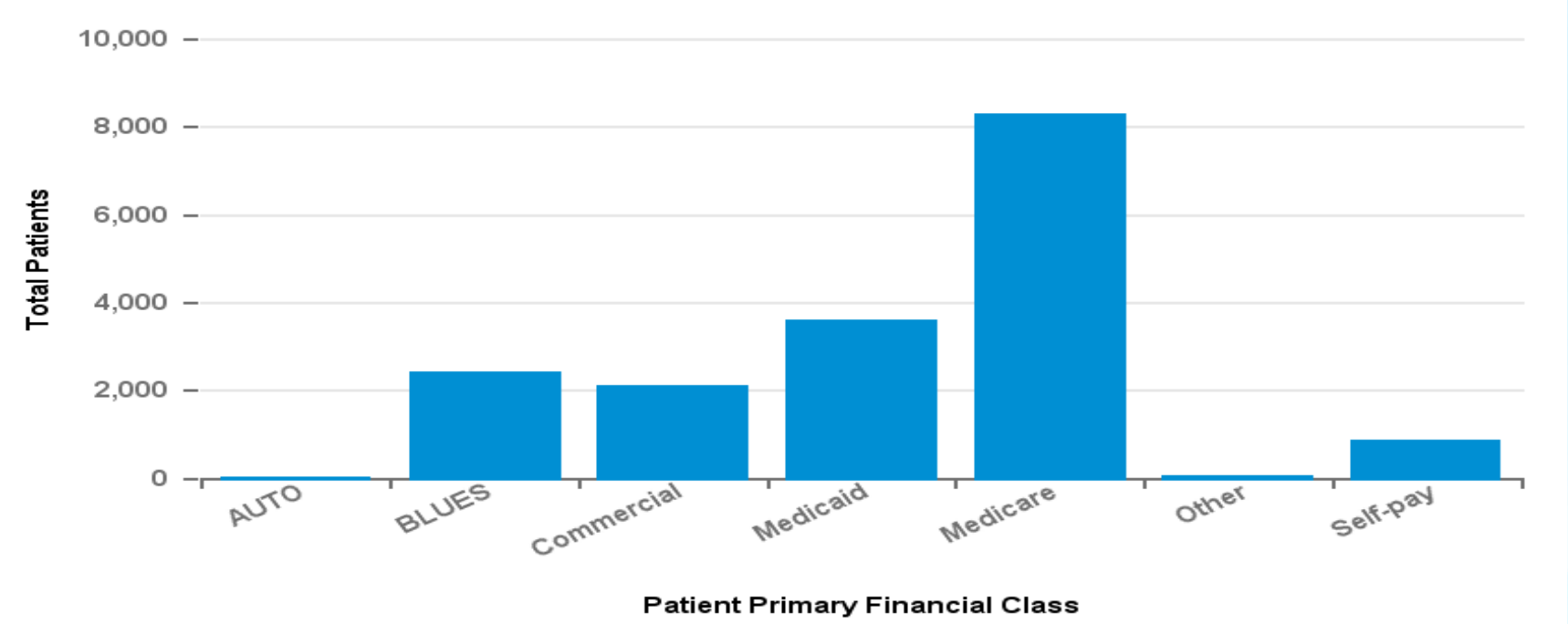
- Clinical indicators
- Chronic conditions
- Multiple medications
- Financial challenges
- Inpatient/ED visits
- High utilization

LEHIGH VALLEY HEALTH NETWORK

POPULATION HEALTH DATA & OUTCOMES

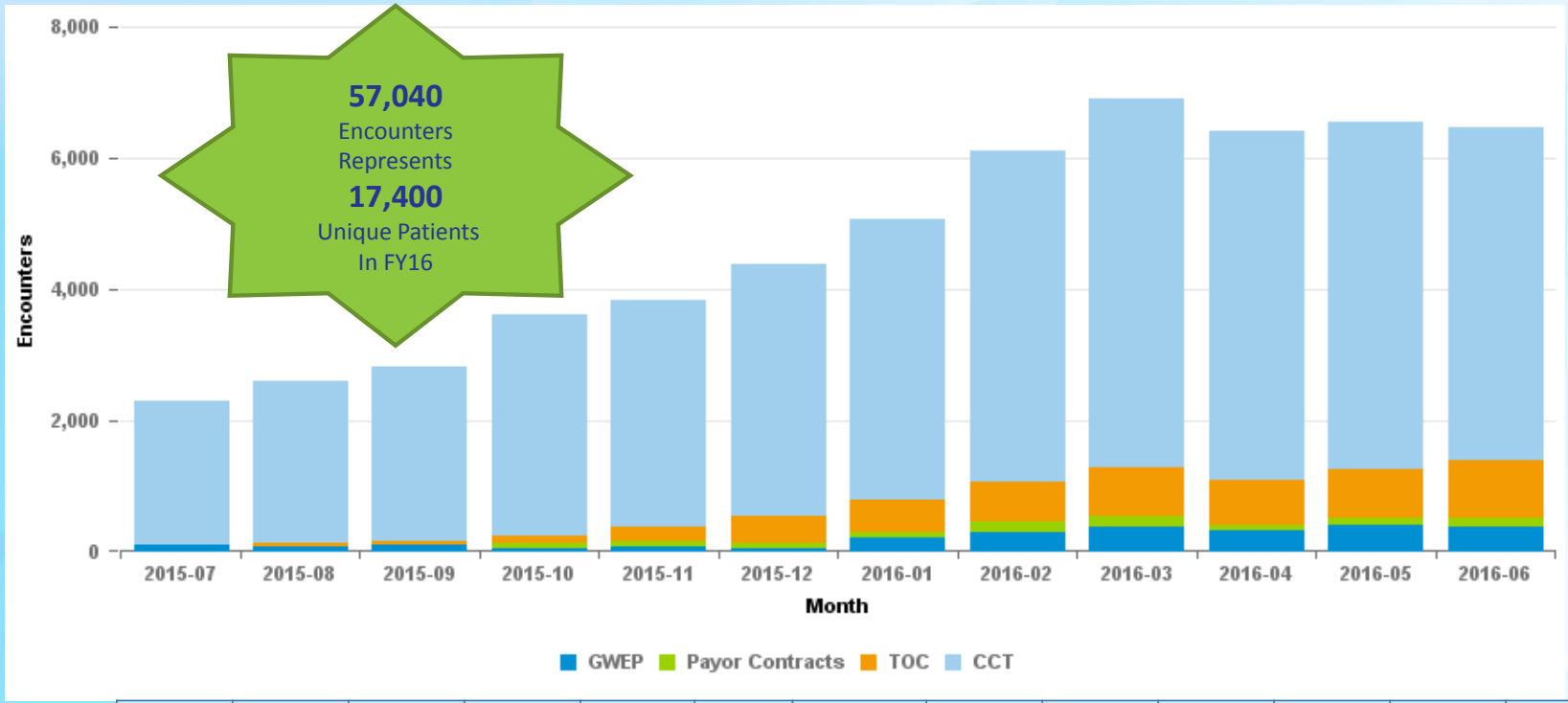
Lehigh Valley Health Network

Population Health
Patient Payer Mix – FY16



Financial Class	AUTO	BLUES	Commercial	Medicaid	Medicare	Other	Self-pay	Total
Total Patients	14	2,430	2,120	3,611	8,296	60	869	**17,400**

Population Health-FY16



	2015-07	2015-08	2015-09	2015-10	2015-11	2015-12	2016-01	2016-02	2016-03	2016-04	2016-05	2016-06	FY16 Total
GWEP							202	285	381	319	408	374	**1969**
Payor Contracts			3	78	73	80	89	165	144	81	96	137	**946**
TOC	10	41	54	13	240	437	479	613	750	682	748	871	**5,060**
CCT	2,281	2,564	2,759	3,3405	3,510	3,859	4,294	5,048	5,638	5,326	5,299	5,082	**48,703**
Total Encounters	**2,291**	**2,605**	**2,816**	**3,618**	**3,823**	**4,376**	**5,064**	**6,111**	**6,913**	**6,408**	**6,551**	**6,464**	**57,040**

Preliminary Utilization Outcomes

- Collaboration with Populytics looking at patients touched by CCTs in CY15, with measurement in the first half of CY16 experienced:
  - 36% fewer ED visits
  - 34% fewer hospital admissions than in the previous six months
- TOC
  - Partnering with EA/LVPG to maximize access and reimbursement


LEHIGH VALLEY HEALTH NETWORK
collaboration
EDUCATION
comfort
INNOVATION
RESEARCH
community
compassion

Paths Diverge

Adaption to Existing Model of Care

- Home based team assessments by RNs and CHWs
- Integration of Community Health Workers (CHW) into team
- Guided Care Model for Nursing framework (Johns Hopkins)
- Enhanced partnerships and communication with community resources

Geriatric Workforce Enhancement Grant (GWEP)

- $2.5 million dollar grant over 3 years from the Health Resources Services Agency
- Grant is based in the Department of Family Medicine
- 4 practices owned by LVHN network
- 2 independent practices who align many of their goals with LVHN's
- All participate in either the Family Medicine or Internal Medicine Residency program

Geriatric Workforce Enhancement Grant (GWEP)

- Core Team Structure
  - Project Director
  - Geriatrician
  - Project Manager
  - 6 Registered Nurses including Manager (total of 4.4FTE)
  - 3 CHWS (Budgeted for 4.0)
  - Practice Coach
  - Research Associate
  - Project Coordinator

Geriatric Workforce Enhancement Grant (GWEP)

- Community Partnerships
  - Aging and Adult Services
  - Alzheimer's Association
  - Health Bureau
  - Cedar Crest College Nursing Program, Social Work Program and Geriatric Certificate Program
  - United Way
  - Local federally qualified health center

GWEP Specific Focus

- Patient Population – Focus is on Geriatric Patients
  - Defined as age 60+ for LVHN
- Patients with Alzheimer's and Related Dementia
- Educational
  - Health care professionals and workforce
  - Community – patients, families, community
- Care Giver Stress
  - Goal is to reduce Care Giver Stress.

GWEP Specific Focus Continued

- Population Health
  - Healthy People 2020 goals
- Leveraging New Technology
  - Beta testing an Avatar program

Enhanced Communication

- Collaborative practice between all team members.
  - CCT, Guided Care RNs, CHW, Physicians, Residents, Workforce
- Enhanced communication with patients, clinicians and staff in Acute/Subacute and post acute care settings
- Interdisciplinary Plan of Care with a Action Plan

Quality Improvement

- Rapid continuous improvement quality cycles - PDSA(s) (Plan, Do, Study, Act)
- Practice Based Efforts
  - Immunizations
- Team Based Efforts – multiple pilots

Program Development

- Creation of Geriatric High risk patient population registry
- Identification and build of applicable geriatric assessments into EMR
- Use of existing CCT Template for documentation
- Creation of additional standard documentation expectations

Program Development
Guided Care Registered Nurses

- Guided Care Course through Johns Hopkins
- Population Health's Care Manger orientation for CCT
- Negotiated understanding of CHW's role
- Facilitated care planning with clinicians and residents
- Leaders of several PDSA projects
- Ambulatory Certification as Certified Care Coordination and Transitions Management

Program Development
Community Health Workers (CHWs)

- Education
  - Initial 100 hours
  - Continued staff development
- Identification of CHW duties
  - Current role expectations
  - Future development
- Development of documentation process for CHWs.
  - Based on CCT Social Workers template and workflow
- Documentation Audits/standard work

Program Development
Community Partners – Students

- Nursing students – curriculum development
- Social Work Interns –
  - Documentation concerns and Network wins
- Classroom presentations for those students unable to be accommodated in clinical with interactive case studies

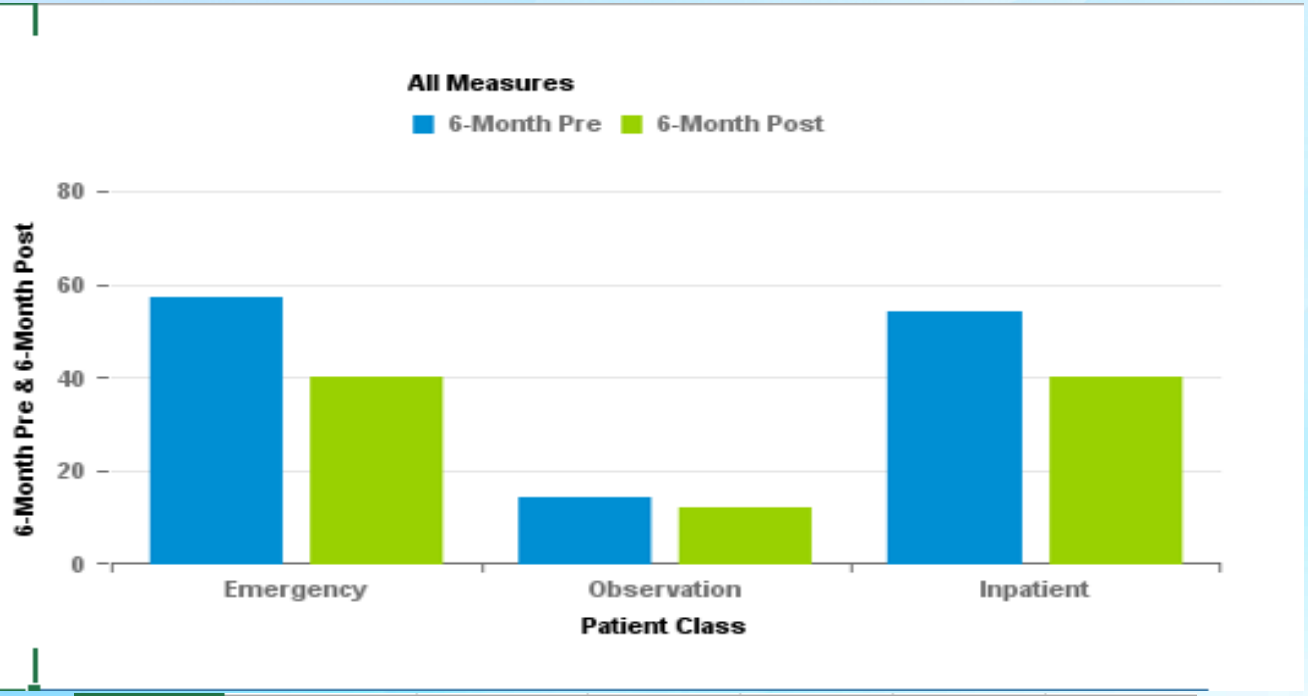
Hurdles

- Team Dynamics
  - Formation and development
  - Integration into existing teams
- Experience of both RNs and CHWs
  - Mixed levels of experience

Hurdles

- Integration of Guided Care Model into LVHN culture
  - Documentation expectations, implementation of the Guided Care Plan into each very different practice
- Staff turn over
- Case loads – variation / expectations
- Significant language barriers

Outcomes

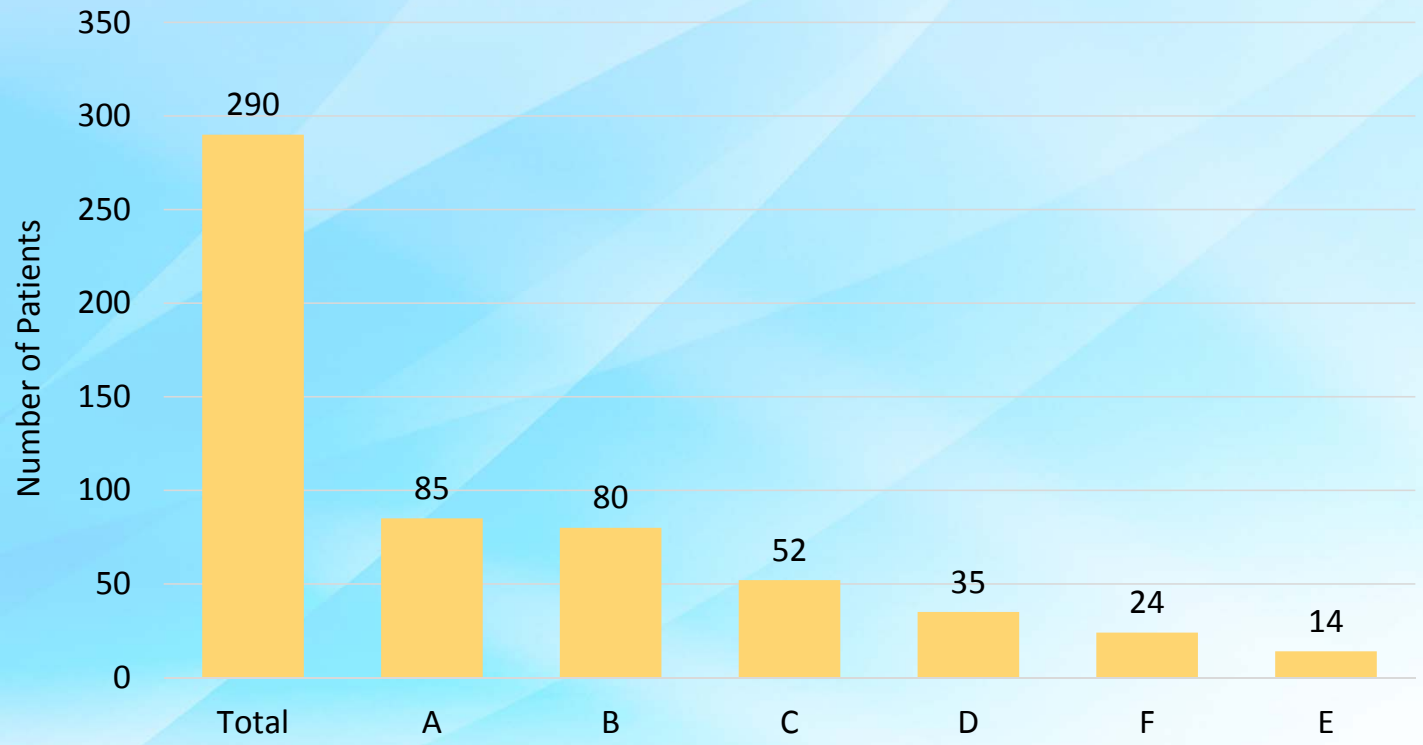


Total Patients	Patient Class	Total Patients	6-Month Pre	6-Month Post	6-Month % Change
107					
	Emergency	78	57	40	-29.82%
	Observation	31	14	12	-14.29%
	Inpatient	63	54	40	-25.93%

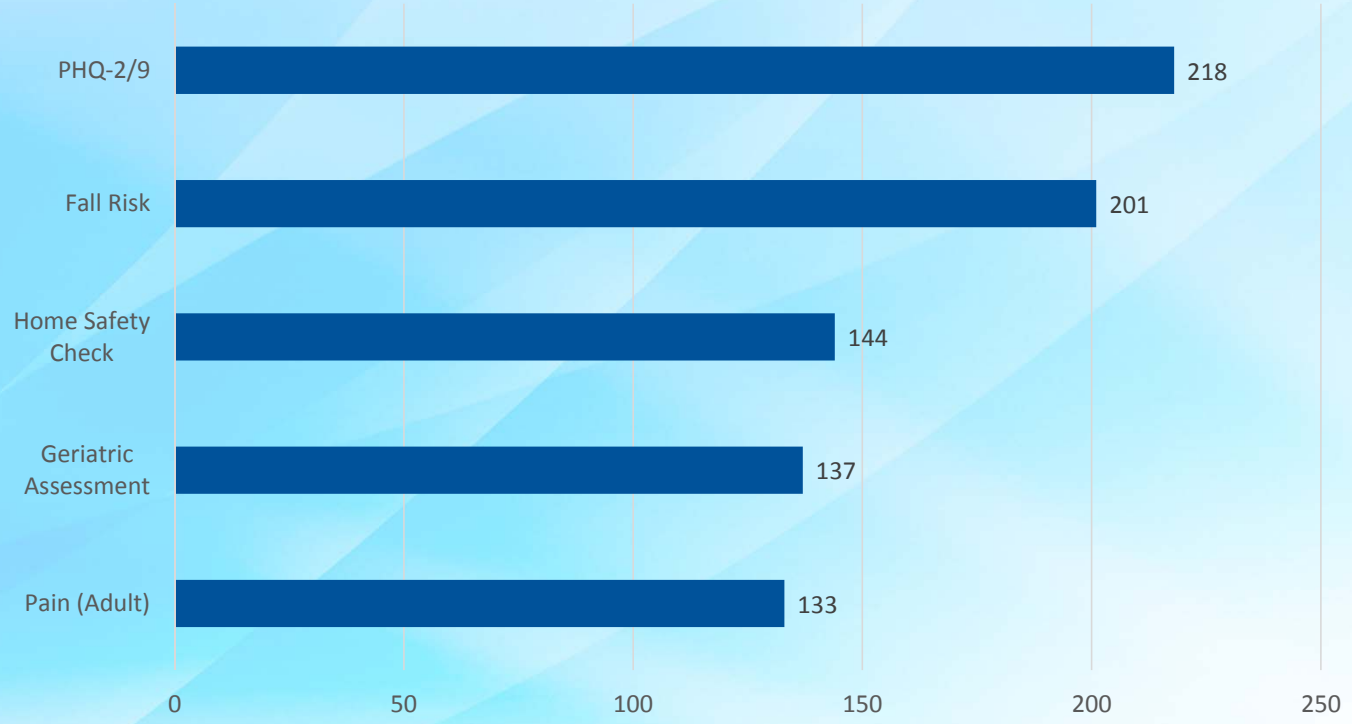
Total Patient Outreach
479
Total Patient Enrollment
290

As of 12/31/2016

Patient Enrollment by Practice



Most Commonly Used Assessments by GC-RNs



Demographic Variable	n (%) or Mean (Range)
Race	
White	339 (70.62)
Ethnicity	
Hispanic/Latino	147 (30.63)
Preferred Language	
English	340 (70.83)
Spanish	123 (25.62)
Other Language	17 (3.54)
Sex	
Female	305 (63.54)
Male	175 (36.46)
Age (Years)	77 (69-84)
Marital Status	
Married	167 (34.79)
Widowed	139 (28.96)
Single	92 (19.17)
Divorced	57 (11.88)
Separated	16 (3.33)

	n (%)
Chronic Conditions	
Diabetes	211 (43.96)
Depression	155 (32.29)
CAD	145 (30.21)
COPD	101 (21.04)
Atrial Fibrillation	98 (20.42)
CHF	92 (19.17)
Obesity	84 (17.5)
ADRD	71 (14.79)
Asthma	63 (13.13)
Chronic Pain	14 (2.92)
Patient Smoking Status	
Former Smoker	196 (40.83)
Never Smoker	217 (45.21)
Current Smoker	45 (9.38)
Passive Smoke Exposure	2 (0.45)
Never Assessed	5 (1.04)

Future Initiatives

- **The Air Products Center for Connected Care and Innovation**
  - Will integrate and co-locate Population Health, Community Health, Telehealth and the community in one space to redesign health care delivery in our community
  - Include key stakeholders in planning how we can imagine, develop and ultimately shape the future of health care

Future Initiatives

- **Centralized Care Management Hub – in development**
  - Located at our multi-practice campus which offers primary care, specialty care, emergency room and diagnostic testing
  - Offering streamlined care management services to the multi-generational families who seek care at this site
  - The patients of this campus are predominately multicultural, indigent, transient with low health literacy and fragemented access to medical services
    - Psychosocial barriers to care
    - The payor mix is predominately Medicaid, Medicare and/or uninsured
  - Co-Located services include RN Care Managers, Behavioral Health, Social Work, Financial Counselors, Community Health Workers, and allied community partners

Questions?

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