Community Memorial Health System

Where Excellence Begins with Caring

COMMUNITY MEMORIAL HEALTH SYSTEM

PERSON CENTERED CARE PROJECT SUMMARY PRESENTATION

March 27, 2019

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Program Focus

- **How we refined our focus and why**
  In an effort to increase referrals

  - Initial focus was hospital inpatients with diagnosis of CHF or COPD
  - Expanded to include AMI and PNA. In January 2019, expanded again to all readmission DRGs
  - Broadened participation to include our Ambulatory Care Clinics and our Alliance partners

About Our Team Members and Structure

- **Which team members (and their roles) in our organization were key to this work**
  - Hospital: Quality VP, Hospitalist MD/residents, Nursing Management, Director Case Management, PT/OT, and later Supervisory for Amb. Care, Care Coordination Program
  - Post acute: Camarillo HealthCare District, Home Health, SNF
- **Which existing hospital committee(s) helped design and direct our efforts**
  - 3 focus groups conducted: physicians, community members healthcare providers
  - Pt Engagement, Board Quality, President's Council, Hospitalist meetings

About Our Post-Acute and Community Partners

- **How we developed shared strategy with Home Health, SNF, CBO providers and Ambulatory Medicine**
  - History of collaboration: Hospital to Home Alliance of Ventura County
  - In Q3 2018, Chronic Care Management Program

What Process Changes We Implemented

- **Processes originating at the hospital**
  - Work flow developed for Pt identification and referral to CHCD post acute case management
  - Revisions to assessments to include WMM questions and documentation
  - PCC referral added to MD standing order set
- **Processes taken on by our post-acute partners**
  - SNF & HH complete revision of their assessments
  - Alliance HH members adopted a performance improvement process focused upon implementing 3 PCC questions
  - CHCD revised their assessment and applied it to all 6 of their programs reaching over 300 pts. This allowed for more robust outcomes reporting

About the Implementation Experience

- Barriers encountered
  - Thomas Fire, Santa Barbara mudslides 12/17, Borderline shooting, Woolsey & Hill Fires 11/18, New hospital move 12/18
  - Turnover in MD, Nursing, Case Management and Rehab champions
  - Difficulty increasing hospital referrals and timely referrals
- How barriers were overcome
  - Expanded our referral base to include Ambulatory Medicine and Alliance partners (This includes other health systems and a managed care organization)
- Executive support
  - VP of Quality, CAO Ambulatory Medicine, CFO and CEO all support continued efforts of the work group to embed PCC in hospital work flows

Quality of Life Assessment

- How did your Person-Centered Care Program address Quality of Life measures and discussions?
  - Quality of life discussions were an integral part of the assessment changes instituted across the continuum.
  - Adopted by Alliance HH members as performance improvement project. Though not all agencies track QOL specifically they all note improved pt. satisfaction and believe this is in large part due to improvement in their QOL.
  - Specific Quality of Life measures were tracked in the post acute environment by CHCD. 53% of pts served noted improved quality of life

What We Have Accomplished

- Quantitative data about the population served with your new person-centered care process

Low Hospital volume did not yield meaningful results: 15/55

CHCD total patients served (306) using a PCC approach:

- Pt. engagement/Pt. activation improvements noted in 100% of pts served with 34% of pts improving by 40% or more
- QOL improved for 53% of pts served
- Functional status improved or maintained by 86.5% of pts served
- Pt satisfaction increased by 16% from 2017 to 2018

Home Health Data

- 3% reduction in readmissions, increased pt. satisfaction scores, increase pt.engagement and
- One agency reported 2% increase in pt. retention ($52,000 in revenue).
- These agencies overwhelming felt that these improvements were driven by PCC approach

Patient Story: Mr. C

- 53yr old African American Male – primarily bed bound. Can with great effort and assistance get up to a wheelchair
- Atrial Fibrillation
- Chronic back pain
- Cellulitis
- Type II Diabetes – uncontrolled
- Hypertension
- Osteomyelitis
- Major Depression
- Congestive Heart Fx, ejection fraction of 25%
- Morbid Obesity

2018 Cost & Utilization

Total Cost of Care $385,000.00
CMHS Unreimbursed costs $119,986.00
Additional MSPB costs attributed to CMHS $89,000.00

- **9 Inpatient Stays** **CMH- 4 admits/32 days** **Other Hospital- 5 admits/29 days**
  53% in Q4 - 7/34 days
- **8 ED visits** **CMH/Ojai- 6** **Other Hospital- 2**
  66% in Q4- 6
- **Swing Bed stay** **CMH- 30 days**
- **SNF Stay** **7 mos.**
- **Readmissions** **5**
- **Readmissions Attributed to CMH** **3**

Social Determinants

- **Housing** – Mr. C lives in a 1 bdrm. Apt. with 3 children and 1 grandchild. He sleeps on a hospital bed in the living rm, Dtr. on a futon with her toddler, and his two sons sleep on the floor. The home was absent of additional furniture.
- **Financial** – Mr. C has Medicare and MediCal. He receives disability and is the sole support of the household. APS and CPS reports have been filed. HHC providers worry that his adult dtr. is abusing his finances. Pt was about to have his electricity turned off for failure to pay his bill.
- **Transportation** – Mr. C depends upon curb to curb public transportation which requires reservation 7 days in advance of need.
- **Caregiver Support** – Mr. C's adult daughter was attempting to become his paid caregiver through in home support. Her ability to follow through and provide appropriate care was poor.

Functional Status Quality of Life

- **Mental Health** – Major depression resulted in pt. apathy and disinterest in participating in plan of care
- **Mobility** – Severely limited, requiring assistance to get to his wheelchair. Mr. C out of bed 1x per day to toilet, unable to shower without major assist
- **Medication** – Did not fill RXs due to lack of transportation. He did not have a glucometer and was unaware of his blood glucose level
- **Nutritional Status** – Poor, secondary to finances, lack of mobility, inadequate caregiver support and access
- **Chronic Pain -** Out of control
- **Chronic Disease Mgmt.** – Pt had not attended a PCP or specialist apt since 1/3/2018. In 2018, pt. had 4 no show and 5 cancelled apts. Pt was not checking his blood sugars or blood pressure at home.

Outcomes Post Person Centered Care

- **Mental Health** – Improved symptoms of depression. Improved self esteem due to increased adherence and sense of control over his health. He is linked with Dr. H and has an apt on 3/1/19 for an evaluation. Pt recently reached out to HR CM to inquire about resources for talk therapy
- **Mobility** – Improved mobility, pt. is walking around his apartment complex daily with a 4ww and attending outpatient PT 3 times/week
- **Medication** – Through frequent HH and HR CM interactions, pt. is checking his blood sugar regularly and taking meds as directed.
- **Nutritional Status** – Pt is doing grocery shopping and accessing food banks with the help of his son and cooking meals at home
- **Chronic Pain** – Pain improved, Dilaudid discontinued, pt. connected to pain management, placed on a pain contract which all providers have access to.
- **Chronic Disease Mgmt.** - Since 12/14/2018, pt. has attended **ALL** of his scheduled appointments including 3 CCM interventions. He has attended 2 PCP appts, 2 pain management appts, 1 GI apt and all of his outpt. PT apts. He is scheduled with his PCP for 2/26, GI on 2/28 and Psychiatry on 3/1. **Pt self scheduled all of the above apts**. He is aware that he is due for his Medicare AWV and is scheduled for that on 3/13/19. Of note, pt.'s last PCP visit note indicated that pt.'s **A1C is at or near goal (8.8 down from 12.6)** and that his glycemic control has been good, his foot pain and numbness are stable, chronic back pain stable. Per PCP, pt. is doing well with his heart failure and DM goals.

The Power of What Matters Most

- Despite 9 months of continuous care in a clinical setting, most of the care team did not know about Mr. C's 13 yr. old son.
- The simple question of what matters to you and Mr. C's answer formed the basis for goal setting care planning.
- The import of being a functioning father kept Mr. C focused on achieving his goals by participating in his plan of care
- Reaching goals that **he set** not only improved his health but his sense of self worth
- Since the end of December Mr. C has had one, 1day hospital stay, NO ED visits and has kept every medical and OP therapy appointments

How Our Organization Has Benefited

- Demonstrated that they already do much of this and that minor adjustments in their approach can yield results
- Increased understanding of SDOH and the benefit of CBO involvement in achieving better pt. outcomes
- The potential of PCC to improve outcomes, lower cost of care and improve pt./caregiver satisfaction
- Joy in work

Person-Centered Care

- How is your organization now better equipped to provide person-centered care?
  - Program structure has been built
  - All champions see the value and wish to continue our efforts. We will continue to more firmly embed the workflow and increase referrals and timely referrals
  - Working with ambulatory medicine allows for a further reach.
  - Our Alliance network is seeing the value of PCC and we will continue to work with this network also expanding our reach.

Contact Information

- Thank you for the opportunity to share with you our journey- which has really just begun! I would be happy to share any of our tools or forms if you would like to contact me…

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