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PATHWAY TO DISCOVERY FOR THE PROFESSIONAL CASE MANAGER

The Triple Aim for Hospital Case Management: Population Health

Linking Inpatient Functions to Ambulatory Care Management

Janet Tomcavage, RN, MSN
Chief Population Health Officer
Geisinger Health System

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Agenda

- Welcome and Introductions
- Learning Objectives
- **Janet Tomcavage, RN, MSN,** Chief Population Health Officer, Geisinger Health System
- Question and Answer Session

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Audience Notes

- There is no call-in number for today's event. Audio is by streaming only. Please use your computer speakers, or you may prefer to use headphones. There is a troubleshooting guide in the tab to the left of your screen. Please refresh your screen if slides don't appear to advance.
- Please use the "chat" feature below the slides to ask questions throughout the presentations. We will pose questions after the presentation and will address as many as time permits.
- A recording of today's session will be posted within one week to the Commission's website, www.ccmcertification.org
- One continuing education credit is available for today's webinar only to those who registered in advance and are participating today.

Learning Objectives Overview

After the webinar, participants will be able to:

1. Describe population health as a strategy, within the context of the Triple Aim for health care: better care, better health and lower costs; and
2. Discuss the types of population health tools used to improve care coordination and care transitions.

Introduction

Patrice Sminkey
Chief Executive Officer
Commission for Case Manager Certification

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PATHWAY TO DISCOVERY FOR THE PROFESSIONAL CASE MANAGER

- **Webinars**
- **Certification Workshops**
- **Issue Briefs**
- **Speaker's Bureau**

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IssueBrief

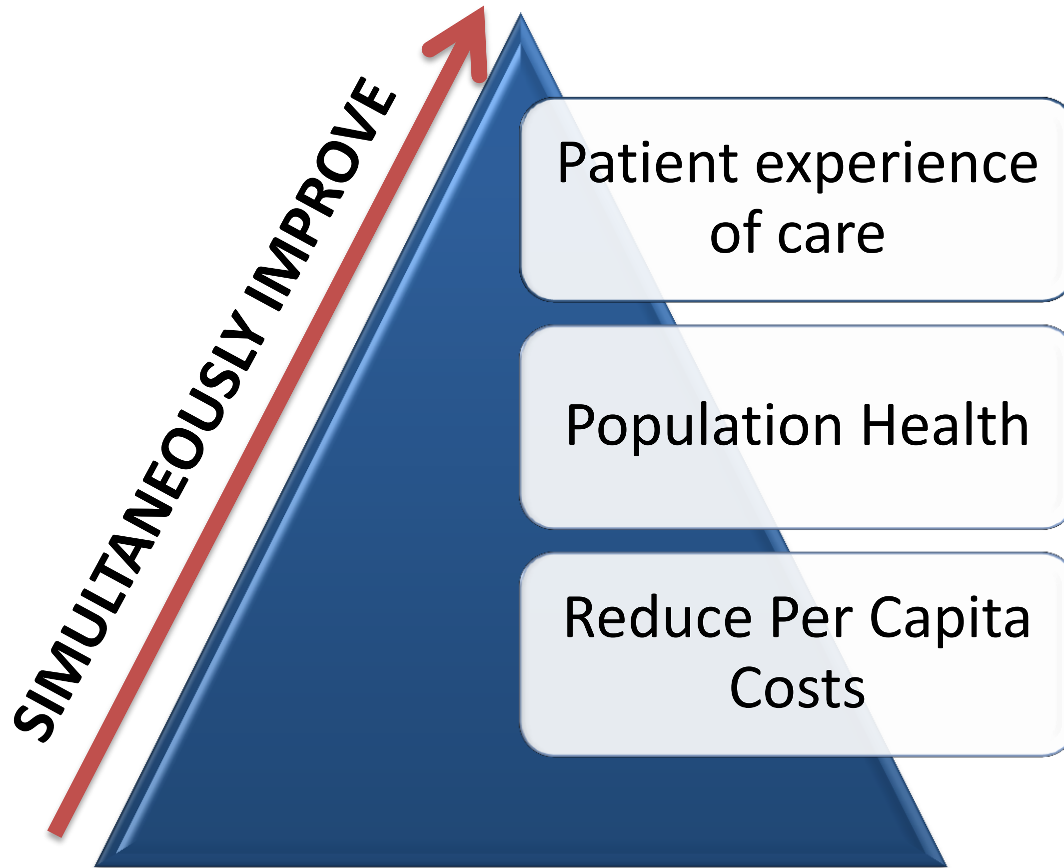
Case managers and the opioid epidemic:
What you need to know, what you need to do

www.ccmcertification.org

The Triple Aim

The IHI Triple Aim framework was developed by the Institute for Healthcare Improvement in Cambridge, Massachusetts (www.ihi.org)

Simultaneous Improvement Focus



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Population Health: The Middle Child?

Portrait of Lady Cockburn and her Three Eldest Sons, by Joshua Reynolds (1773)

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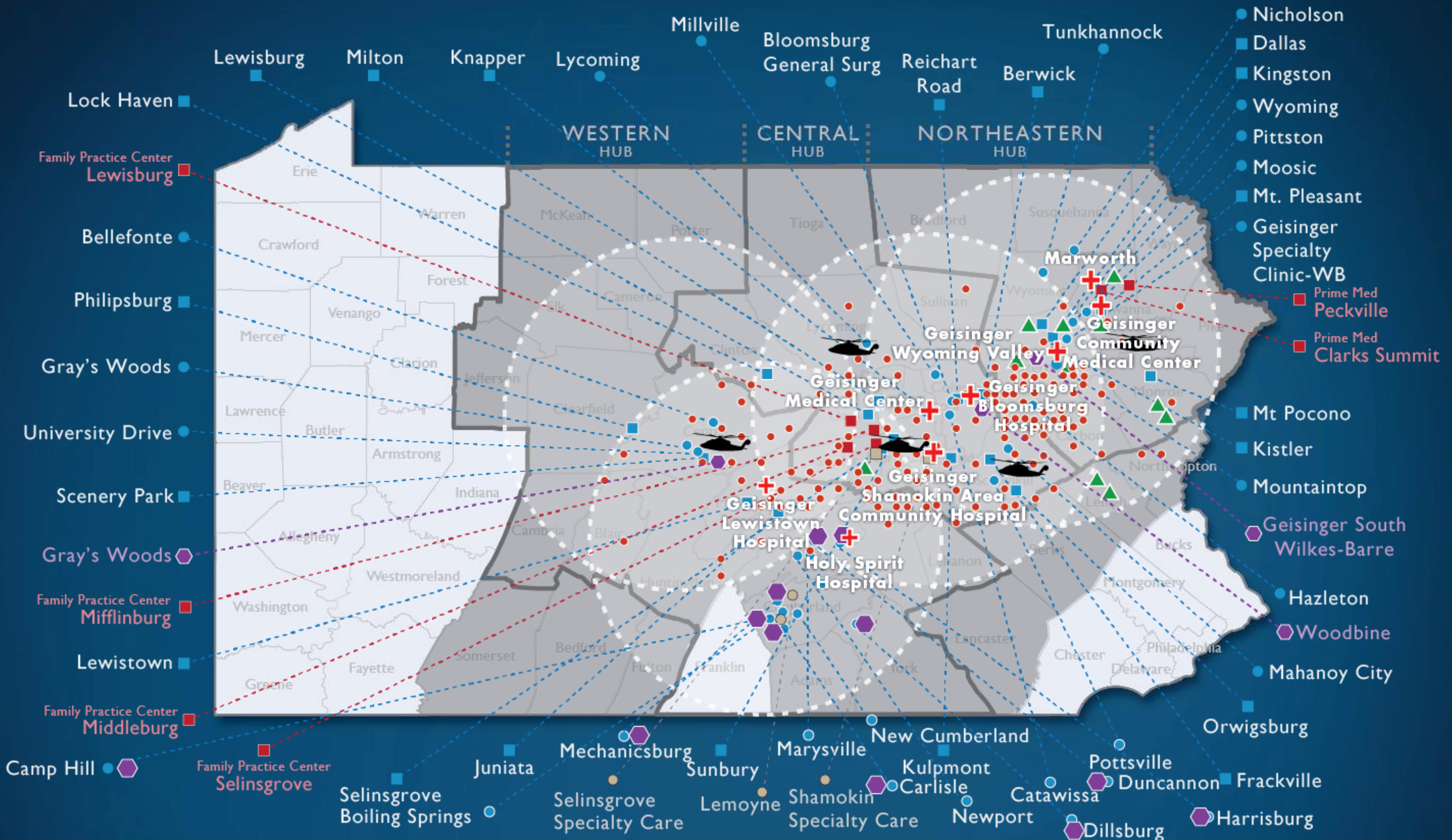
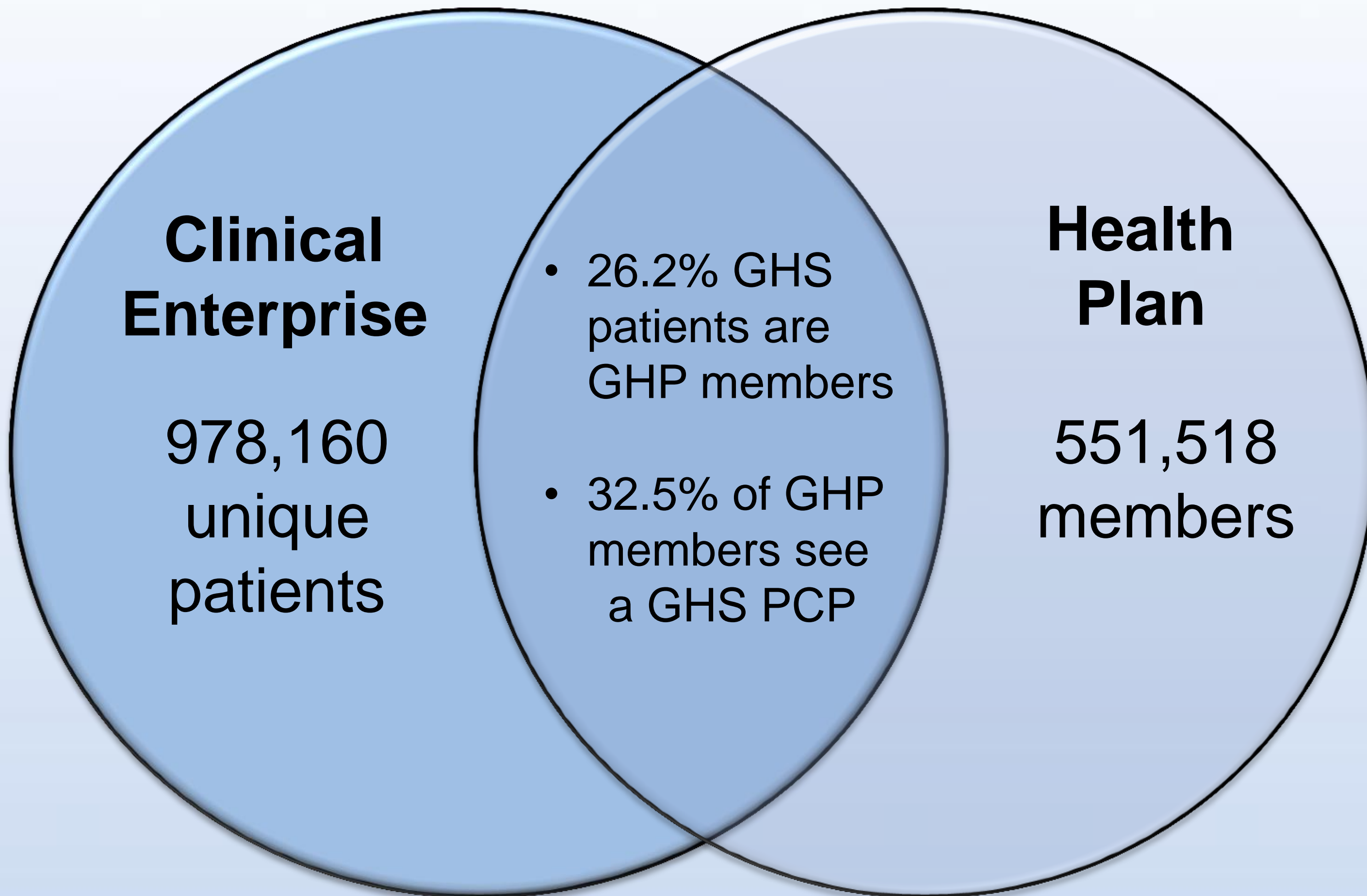
Geisinger Health System Coverage Area



Moving from the "Sweet Spot" to a Population Approach – "One Geisinger"



As of June 2016

Geisinger

Data includes ALL
(PA, AtlantiCare, CCHS, EMHS)

Supporting the Triple Aim*

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*From IHI's Triple Aim

Redesigning alignment of PH core components

Care Management	Utilization Management	Placement Services	Innovation & Alternate Payment	Care Continuum
• Inpt & Ambulatory Case Management • Disease Management • Social Services • Special Needs • Transitions of Care / PHN • Wellness	• Inpatient Utilization Review • Health Plan Medical Management	• Bed & ED Coordination • Transfer Center • Expanded "Air traffic control" capabilities	• Keystone ACO • Proven Wellness Neighborhood • CMMI Bundles • Specialty Redesign • New Payment Models	• Skilled Nursing Facilities • Home Health / Hospice • LIFE Geisinger • VITALine – home infusion

Started with Ambulatory Case Management 2006

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Geisinger's ProvenHealth Navigator®

Managing and Improving Health of Populations

Patient Centered Primary Care	• PCP-led team-delivered care, with all members functioning at "top of the license" • Enhanced access; services guided by patient needs and preferences • Member and family education & engagement
Population Health Care Management	• Population identification, segmentation and risk stratification • Chronic disease and preventive care optimized with EHR, clinical decision support • ***Case manager as core member within care team*** • Automated interventions triggered by gaps in care
Medical Neighborhood	• 360°care systems – SNF, ED, hospitals, home health, pharmacy, etc. • Physician profiling, selective specialty/facility referral • Transitions of care processes, community services integration
Performance Management	• Patient and clinician satisfaction • Cost of care, utilization, efficiency • Quality metrics, addressing variations in clinical care
Value-Based Reimbursement	• Bridging the journey between FFS and pay for value • Embracing payment models that support population accountability – results share, upside risk, global budgets, etc. • Payments distributed on measured quality performance

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Very focused on PC based RN Case Management

High-Risk Identification	Targeted Populations	Comprehensive Assessment	Team Care
• Predictive modeling • EHR data • Medical claims • Pharmacy data • Health Risk Assessment (HRA) data	• HF, COPD, oncology • Special populations—cystic fibrosis, CP, MS, high-risk pregnancy • Multiple trauma • ESRD, frail elderly • TOC	• Driving issue behind case • Physical and psychosocial gaps • Readiness to change • Family/ social supports • Frequent follow-up with patient/ family	• Daily interaction with provider • Active team member • Patient sees CM in practice or with specialist • Pushes access / exacerbation management

Evolution of Ambulatory Case Management Model

Remote Telephonic	Primary Care	Technology - Assisted	Specialty	Facility
- Telephonic based RNs, Social Workers (SW) and Community health assistants (CHA)	- Embedded RN CMs (advanced medical home) - Linked to SWs and CHAs - Access to EHR - Seen as part of the practice care team	- Blue tooth scales for HF and ESRD - Interactive Voice Response (IVR) for TOC Includes blue - - Coming soon: in home video connectivity	- Nephrology for ESRD management - High risk OB - High Risk Pediatrics - "Transitions" for high risk children - Pilot coming for COPD & HF	- Inpatient Hospital - Emergency Department - Skilled Nursing Facilities

New populations and new goals caused us to expand the Population Health team

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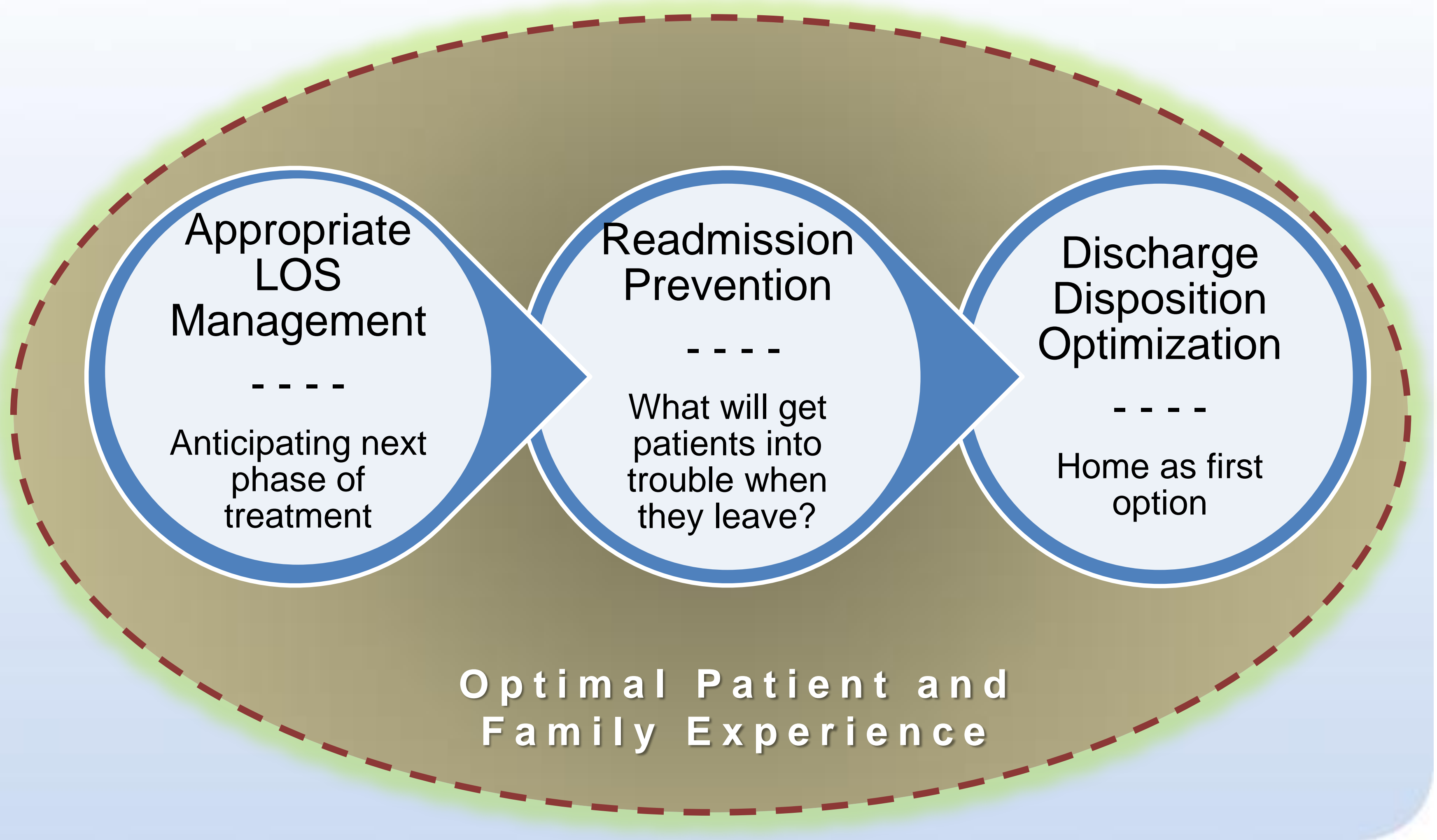
Taking this redesign to Inpatient Care Management

Re-focusing Inpatient Care Management - Driving to a "Triple Aim" for Hospital Transitions



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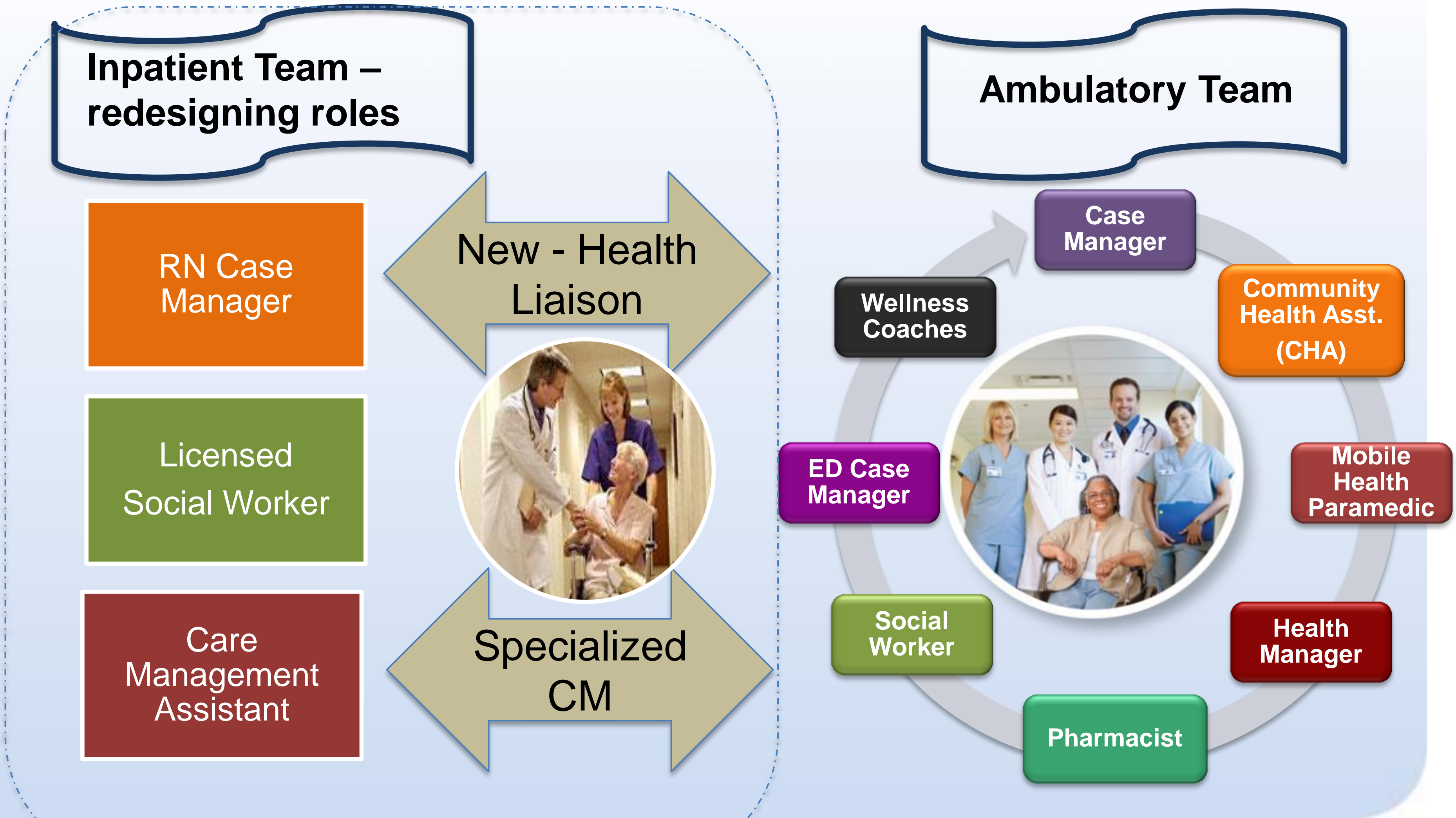
Hospital CM team needs to redefine their roles & be more closely linked to the Ambulatory Team



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Optimizing Transitions Across the Continuum

Ambulatory

- CM 24 - to 48-hr call
- Med reconciliation
- Action Plan
- <7 day follow-up
- IVR and bluetooth scale
- Home visits

SNF

- APRNs
- 24-hr initial assessment
- SNF on-call group
- First week "intensity"
- SNF Log

Hospital

- RN CMs & LSWs
- Intersect prior to admission
- Link to OP CM
- Follow-up
- Assure Discharge Readiness

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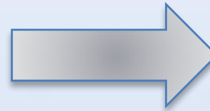
Evolution of ED Case Management:

Specializing our Care Management function

Old ED Case Management Model:

- Focused on ED throughput
- Emphasis on admitted patients
- Limited patient/family education
- Disconnect between OP and ED CM teams



Current State:

- Right care, right place, right time
- Emphasis on diverting admissions & readmissions
- Connection to Medical Neighborhood
- Enhanced patient/family education & engagement

Built an ED CM model that drives impact

Four CMs (RN & LSW) located in 2 large EDs
- Kicked off January 2015
- Average 108,000 ED visits per year

Assess
- Reason for ED visit
- Triggers
- Support system
- Psycho-social needs
- Clinical needs
- Utilization history
- Financing

Plan
- Develop transition plan
- Wrap appropriate resources around patient
- Determine "best" next level of care
- Gap closures

Collaborate
- Patient
- ED Physician
- Family/ care-giver
- Home health
- SNF
- Pharmacy
- OP CM

Educate
- Plan of care
- Exacerbation plan
- Healthcare Resources (PCP, Urgent Care, OP CM)

Handoff
- Communicate plan of care (PCP, Home Health, SNF, OP CM)
- Discuss "red flags" & urgent contact points

Measures of Success
- Reduction of hospital admissions/readmissions
- Reduction of ED high utilizer visits
- Improved patient experience
- Improved hospital throughput

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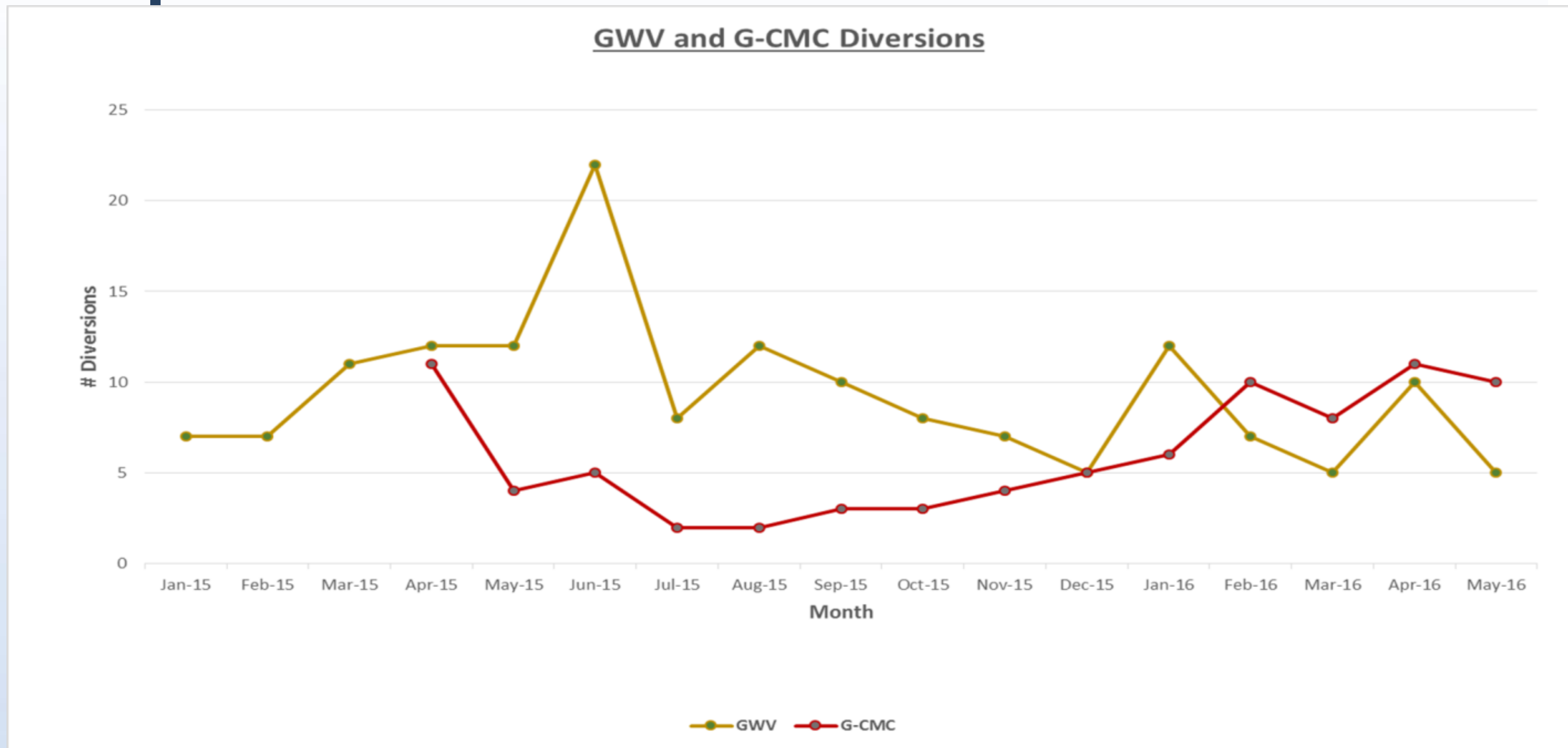
ED program demonstrates significant impact in first 18 months



- Total Diversions = 244
- ~ $2 M in savings
- 41% admitted to Skilled Nursing Facility/Rehab
- 28% returned home
- 20% enrolled in hospice
- 10% admitted to Drug/Alcohol Rehab or Psych facility

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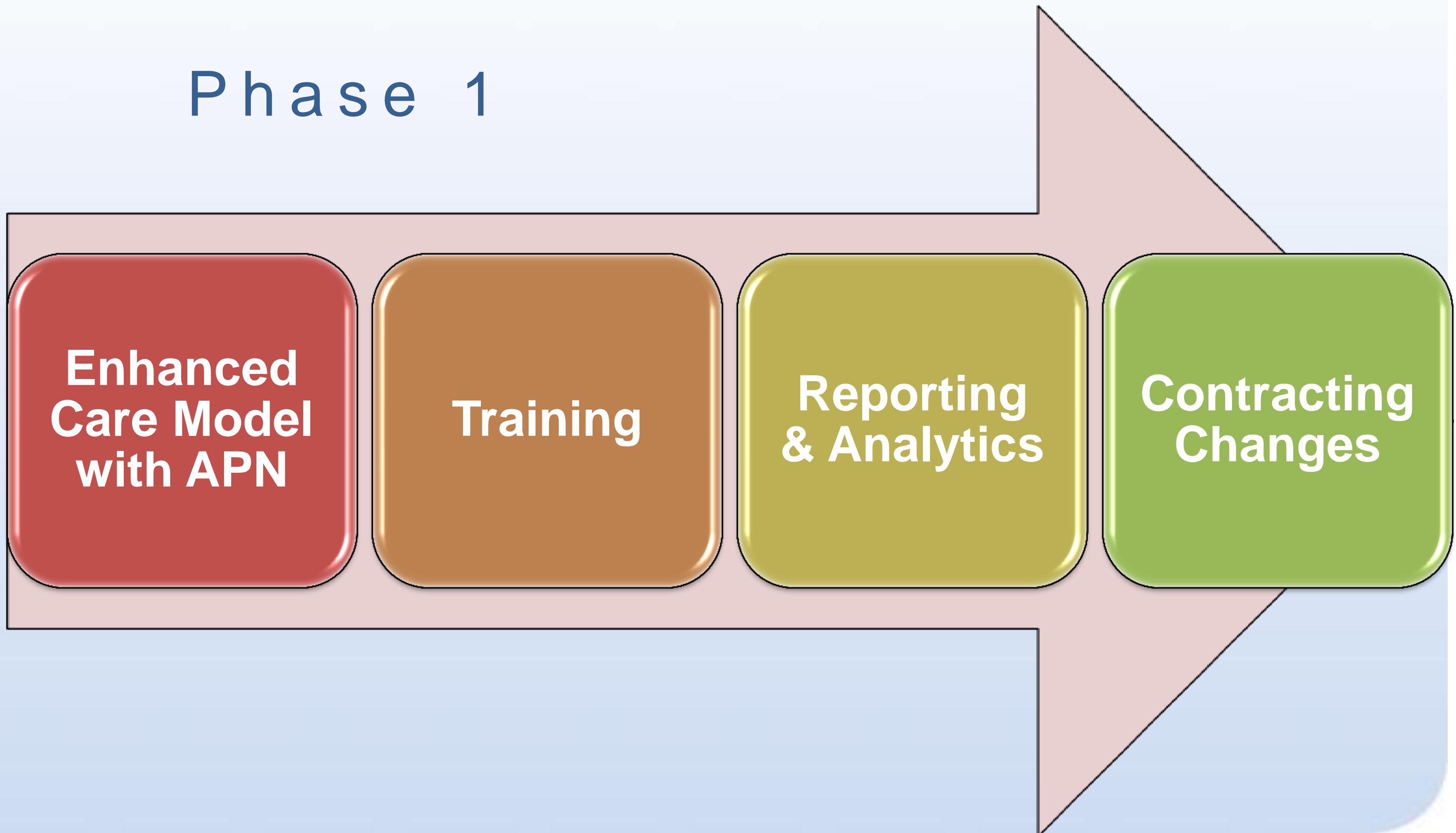
Emergency department visits - January 2015 thru May 2016

Post Acute Care - Creating an enhanced care model in the nursing homes



Expanding the Post Acute Opportunity

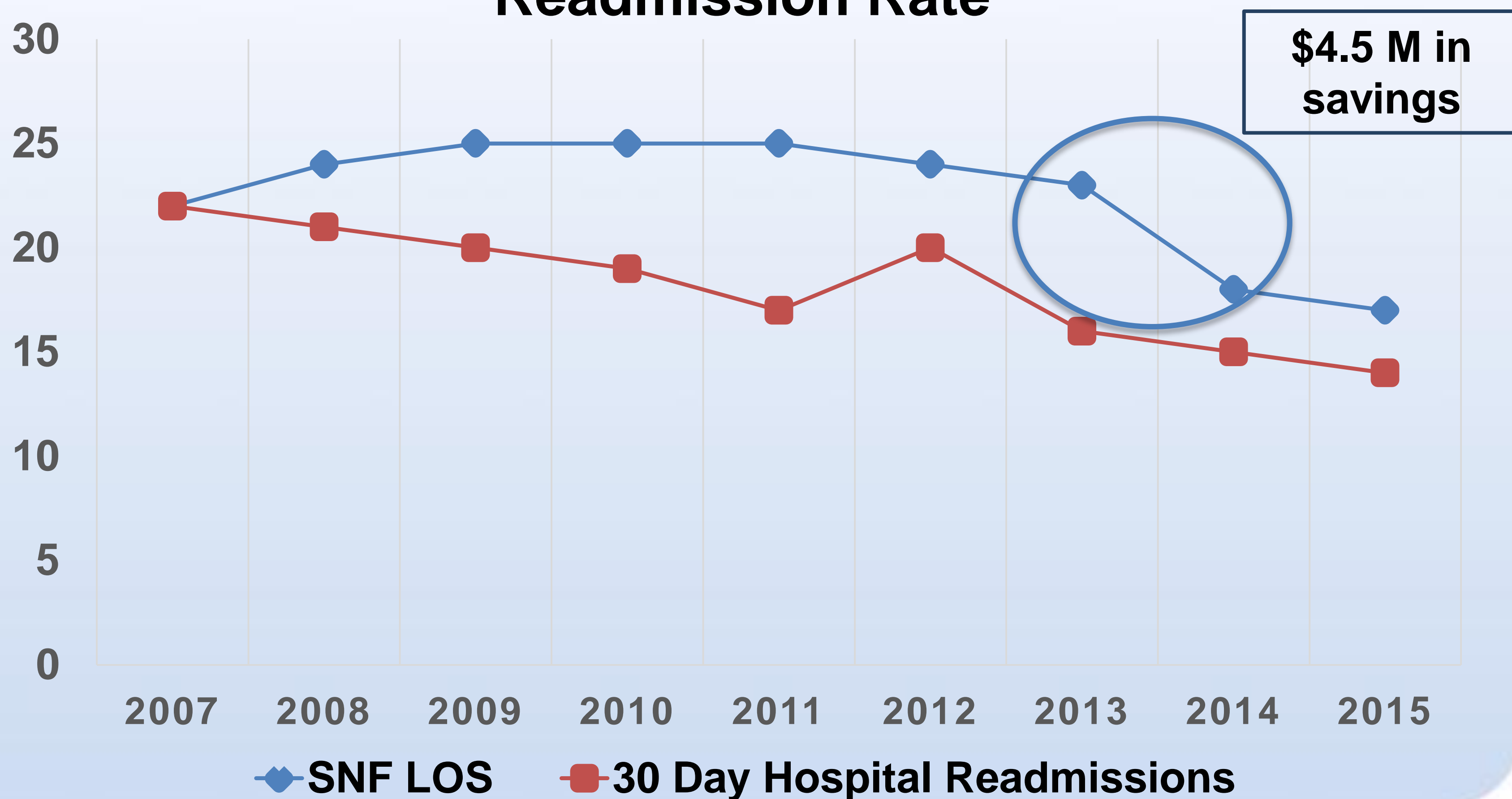
2nd Phase

- GHP UM team moved services onsite in targeted skilled nursing facilities
- Focus on length of stay
- Coordinated discharge preparation

3rd Phase

- ***Creation of Hospital Liaison role***
- Works in hospital with inpt CM team & monitors progress thru post-acute stay
- Serves to replicate HP model for all populations

Impact on SNF Length of Stay (LOS) and 30 day Readmission Rates



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Future Initiatives Underway

Managing Transitions for Members with an Intensive Care Admission

- 1% of our members have an ICU admission
- In 2016, 26% of these admissions are in our own hospitals
- We spend $165M in 2015 on ICU admissions
- 18% of members die w/in 30 days and 26% die within 1 year after ICU admission
- Readmission rate = 19.4%

Strategy

- Collaborating with ICU provider leadership to build a new transitions model
- Specially trained pulmonary RN CM to work directly with Intensivists and Pulmonary Clinic
- Home visits with CHA and targeted follow-up clinic
- Earlier palliative care and hospice coordination

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Question and Answer Session

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Thank you!

- Please fill out the survey after today's session
- Those who signed up for continuing education will receive an evaluation from the Commission.
- A recording of today's webinar and slides will be available in one week at http://ccmcertification.org

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