CSB
CASE STUDY BRIEF

Utilizing Teams to Improve Transitions of Care

MyHealth First Network's Approach

Domain: Care Coordination
Category: Care Transitions
Competency: CC 4.2 - Develop care transition protocols to reduce unnecessary emergency room visits and hospital admissions

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BACKGROUND

Greenville Health System's (GHS) formal care coordination initiatives began in 2012 with a grant-funded disease management program that focused solely on educating frequent ED and inpatient utilizers. Due to the program's success, GHS decided to expand its efforts across MyHealth First Network (MyHFN) to include other atrisk patients over a large geographic footprint, particularly those expected to have high utilization, high costs, and poorer outcomes. Over the next couple of years, MyHFN's care coordination programs evolved as the system identified new areas of need and opportunity. The system developed robust ambulatory care coordination and inpatient case management programs which served as the foundation for its transition of care initiatives (the focus of this brief). While this case study focuses on the implementation of MyHFN's care transition program, the supporting coordination efforts have contributed equally to the network's success.

About MyHealth First Network (MyHFN)

The MyHFN clinically-integrated network includes 11 hospitals and more than 2,000 employed and independent providers across 11 counties. The network's primary resources include the Care Coordination Institute (CCI).

Location: Greenville, SC
Website: www.myhfn.org
VBP Activity:
- MSSP Track 1 (~59k lives)
- Self-Funded Employee Health Plans (~28k lives)

APPROACH

With the financial support of one large hospital (the ACO's sole owner), MyHFN has taken a two-step approach to care coordination: 1) Gather robust, actionable data and 2) develop strong, well-coordinated teams to put the data to work. To identify the high-risk and soon-to-be high-risk patients for which the network is financially accountable, MyHFN gathers data from its health information exchange (HIE) using several disparate information systems. Patient risk scores are calculated using aggregated medical records, claims, demographic, and pharmacy data, as well as socioeconomic data and an analytics vendor-calculated motivation scores. Importantly, the motivation score (described later in this brief), helps MyHFN identify patients with a high level of risk and a high motivation to manage their care.

To operationalize the data, MyHFN has developed a strong, well-coordinated workforce made up of multidisciplinary teams on both outpatient and inpatient sides. To better create nimble and focused ambulatory care teams, the network divided its large geographic footprint into five regions, assigning each region a nurse care manager leader with the support of a disease manager/health coach, and a social worker to co-manage high-needs patients. Additionally, MyHFN has assigned ambulatory care managers (26 RNs and 3 social workers) to all primary care practices within the network, providing them with lists of risk score-ranked patients within the FFS Medicare (MSSP), Blue Choice Medicaid, and self-funded employee populations. These ambulatory care managers engage the high-risk, highly motivated patients, conducting additional assessments, creating care plans, and setting goals.

While pleased with its independent care management programs in both the outpatient and inpatient settings, MyHFN saw the need to better coordinate the transitions of care post-discharge. In 2014, the network added transition coordinators to the ambulatory care teams, and stationed those coordinators in acute care facilities to act as a bridge between outpatient and inpatient care management. These transition coordinators work collaboratively with both teams to identify high-risk patients in need of careful attention post-hospital discharge and to facilitate smooth transitions home. During an inpatient stay, transition coordinators conduct additional assessments, including readmission risk score (LACE index) calculations and other transition-specific assessments. The transition coordinators then facilitate a warm, face-to-face handoff with the ambulatory care nurse responsible for the patient on the outpatient side.

After team-based care transition protocols were established between acute and ambulatory care (in 2015), MyHFN began including transitions to post-acute care (PAC) following an inpatient stay. To coordinate these transitions, MyHFN developed a program with select PAC providers, including skilled nursing facilities and inpatient rehabilitation facilities, which connects the ambulatory care manager and the PAC provider overseeing the patient to improve care transitions. Ambulatory care managers round with the PAC provider over the phone to discuss the care plan and address any concerns about the patient's discharge. Each PAC partner is also assigned a MyHFN nurse, who works closely with the PAC providers to identify areas for improvement. Each quarter, PAC partners receive score cards on MyHFN-assigned metrics. Importantly, before the network began this post-acute transitions initiative, it conducted a thorough evaluation process to select the highest value partners.

RESULTS TO DATE

Due to leadership foresight and expertise, MyHFN has aligned and integrated its efforts across its ACO, bundled payment, and PCMH models. This synchronization has allowed MyHFN to utilize the strengths of each model to better optimize many aspects of care, including care transitions. As a result, MyHFN generated $17.3 million in savings during its first year in Track 1 of the MSSP, which is particularly meaningful given its low per capita expenditure benchmark of $9,299.

With the addition of the care transitions program, MyHFN noticed a decline in readmissions for COPD and asthma by 17%, CHF by 11%, and pneumonia by 12%, and heard positive feedback from interdisciplinary care teams, who felt more confident managing high-needs patients across multiple settings.

TOOLS & VENDOR PARTNERS

MyHFN partners with several vendors, including Caradigm as its care management data partner. Through Caradigm, MyHFN is working with a well-known predictive modeling engine that calculates the motivation score, a critical element across all of the system's care management initiatives. The motivation score incorporates frequency and type of physician visits, certain utilizations, and other proprietary factors to predict a patient's motivation to become more involved in self-management. MyHFN is currently piloting a program where the interdisciplinary team, including the inpatient case manager, transition coordinator, outpatient care coordinator, and other needed providers (e.g., pharmacist, physical therapist, home health) connect using a fully secure, Skype-like app called Vidyo for meetings and handoff needs at discharge.

CHALLENGES WITH IMPLEMENTATION

In order to meet the needs of the care coordination programs, existing staff was re-organized and additional staff added. Two years ago when MyHFN began hiring for these positions, it was difficult to find nurses and social workers with case management experience. Improvising, the system hired staff with home health or skilled nursing backgrounds, having developed various skills associated with care management. Still, executing system-wide coordination programs required significant education and training for new staff, physicians, and everyone involved. At the beginning of the coordination initiatives, MyHFN organized a two-day training orientation for all case management staff in the network, teaching the CMSA's Standards of Practice and core competencies for case and care management. The system continues an extensive orientation process, during which new staff must shadow all levels of the interdisciplinary care team before managing patients. Also important to the training process has been communicating the mission of value-based care and educating care management staff on the triple aim.

In addition to the time-consuming training efforts, MyHFN has had to overcome challenges associated with inter-setting relationship building. Fostering cooperation and trust between groups who have traditionally been separate, even territorial, has required significant effort.

KEY LEARNINGS

- **Engage leadership** – To foster meaningful cross-setting collaboration, gain the commitment of system and physician leadership. Staff will more readily collaborate if seeing it patterned by setting and system leaders.
- **Provide care managers with data** – Engage and empower the care managers with robust, real-time data with point-of-contact data feeds.
- **Identify the right patients** – When developing care coordination programs, start small and scale over time. Rather that targeting many patients, first focus on identifying the right patients.

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