A BRIDGE TO BETTER PATIENT CARE & LOWER COSTS

To truly serve a patient population with compassionate care that leads to better outcomes, you must first understand them. That’s a central issue facing hospitals, health systems, payers and others that are embracing the tenets of population health management (PHM) and its promise to improve the lives of those with certain conditions such as ischemic heart disease.

Christiana Care, one of the nation’s largest health systems, recognized that 20% of their patient populations make up 80% of its healthcare costs. As a regional center for excellence in cardiology, the health system received a $10 million, three-year award from the Centers for Medicare & Medicaid Services’ Center for Medicare & Medicaid Innovation to develop and implement a care management program for ischemic heart disease.

Proven technology is a must
In order to develop protocols to standardize care plans for a certain condition, you first must understand the patient population, involve the right members of the care team and commit to team-based care. Christiana Care identified three foundational components needed to successfully develop a coordinated care model:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of healthcare

- Well-trained care management team
- Strong technology infrastructure
- Stakeholder buy-in

80% of healthcare costs are driven by 20% of patient populations.
Notably, the program received 100 percent support from cardiac physicians. This was achieved by engaging them in the concept of better care for patients — not an easy achievement considering that the initiative demands flexibility with scheduling and an unprecedented level of data integration with the American College of Cardiology’s Pinnacle data registry.

Seventeen months since the program was initiated, more than 2,300 patients have enrolled in Bridging the Divides, with more than 1,200 active enrollees as of August 2014.

As more data comes in, Christiana Care will tweak its processes and use the information learned to inform other PHM-related initiatives within the system. The health system has already received high satisfaction marks from patients and clinicians. Christiana Care also hopes other organizations may benefit from insights gained during its pioneering PHM experience.

Electronic health records, unfortunately, do not provide a sufficiently robust platform to track metrics and provide the analytical support necessary to understand patients and gauge the success of any interventions. Christiana Care Health System chose Medecision’s Aerial Population Health Management platform to pull information from various systems, parse the data and develop workflows to address patient needs with custom interventions divided among care team members.

The system is able to analyze disparate patient data from multiple systems to automatically develop an illness acuity score. This score is evaluated by the system in the form of risk-prioritized patient lists that are presented to care managers for review and intervention. Some patients will receive more attention than with traditional manual care management, while other patients receive less, with the expectation that the specific patient’s findings will trigger the appropriate intervention.

Bridging the Divides aims to enhance the efficiency, quality and care outcomes from the moment a patient arrives in the hospital through release and beyond. For example, upon hospital discharge, a patient may receive a reminder call about a follow-up appointment; a social worker arranges transportation to that visit and a pharmacist ensures that the patient is taking prescribed medications as directed.

PROGRAM FRAMEWORK
A successful population health management program must bring the right service to the patient at the right time. Understanding patients requires a robust technology infrastructure, but a provider network must have a committed staff and the necessary services in place to meet diverse patient needs.
Dedicated care team, stakeholder buy-in essential

In the previous instance, technology triggers touch points at the appropriate times. However, technology alone cannot produce an effective population health strategy. A multidisciplinary care management program is essential to monitor and respond to patient needs, forming the second component.

By design, population health management is proactive, reaching patients where they are in the care continuum. Christiana Care’s PHM strategy allocates resources to support a wide variety of options, including phone consults, patient home visits, device monitoring and even deploying care management professionals embedded within community physician groups.

Team members are tasked with proactive patient outreach and follow-up based on demonstrated health risk and situation. Some patients have extraordinary socioeconomic needs that must be met to avoid a readmission. Others may have difficulty adjusting to new behaviors designed to improve health and prevent readmission.

To gain widespread acceptance, an intensive program, such as Bridging the Divides, requires a change management component that needs stakeholder buy-in, the final component Christiana Care discovered. That buy-in has to come from the top and filter through the organization to be effective, so transparent and timely communications are essential.

Lessons Learned
- An undertaking
- Operational challenges
- Effective leadership
- Team building
- Developing relationships with other groups and agencies
- IT development lagged

Clinical Challenges
- Effectively motivating patients to care for themselves
- The sometimes overwhelming burden of socioeconomic factors
- Mental health and addiction issues among patients
- Developing physician buy-in

Challenges Interacting with Post-Acute Care Partners
- Duplication of effort
- Transitions of care need to be enhanced
- Aligning goals of home health agencies and skilled nursing facilities

ABOUT THE AUTHORS

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Dr. Tabassum Salam, serves as the Senior Physician Advisor for Population Health in the Department of Quality, Safety and Population Health at Christiana Care Health System in Newark, Delaware. She serves as the Medical Director for Care Link, the health system’s longitudinal care management program. One target population being served by Care Link has been patients with ischemic heart disease who are cared for in the first year following their heart attack or heart surgery, with the goal of improving clinical outcomes and adherence to treatment plans and reducing readmissions. Dr. Salam leads an interprofessional group of nurses, social workers and pharmacists in this program.

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Dr. Janine Jordan is the lead physician responsible for developing and implementing a virtual interprofessional team for high risk elective surgical patients. Her work in helping to create patient centered, highly reliable teams has helped transform care delivery and outcomes related to improved quality, safety and efficiency; results of which have been presented nationally at AAMC and SHM. For Care Link, Christiana Care Health System’s longitudinal care management program, she standardized work processes, improved compliance with evidence-based practice across a continuum of care and decreased clinical variance in order to ensure quality and safety outcomes for our patients.
With more than $100 million invested in its Aerial™ solution, Medecision has been providing proven Population Health Management to payers for more than 25 years and to providers for more than 10 years. Its customers’ population health management (PHM) results have been transformative:

- 9% reduction of hospital stays
- 7% reduction of diabetes costs per member
- 20% reduction of utilization review costs
- 96% increase in HCC scores and revenue

Many so-called PHM solutions actually offer just one piece of the puzzle, like niche analytics or patient engagement capabilities. Only Aerial from Medecision offers serious, sustainable PHM solutions designed to drive market advantage.

With advanced tools like tiered data scoring, predictive analysis and customization through flexible modules, Aerial helps Medecision customers stay one step ahead in our constantly evolving healthcare environment. Whether an organization relies upon a fee-for-service or value-based model, Aerial helps to effectively manage risk while ensuring the quality of patient populations.

Medecision’s real-world experience, customer support and flexible modules – built for each organization’s specific needs – help customers reach their goals both now and in the future. To better manage patient populations, Aerial offers:

- Insight to more effectively identify and understand populations.
- Apps that drive care management and care coordination workflow and better educate and engage consumers in their care.
- Tools that connect the entire care team.
- Dashboards and reports for a transparent view of quality, clinical and financial performance.
- Analytics that automatically filter massive amounts of patient, practice and plan data to ensure that just the right information gets to the right people at the right time.