Improving Care Coordination to Manage an ACO Population

Greater Baltimore Medical Center

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Background

- Greater Baltimore Medical Center (GBMC)
  - 281 Licensed Beds
  - Standalone Community Hospital with major competitors in the region
    - Johns Hopkins, University of Maryland, Sinai, MedStar
  - Healthcare Landscape:
    - Increasing competition
    - Tighter financial constraints
    - Potential payment system changes
- How can we create value?
  - Focus: Patient-centered care
GBHA

• Greater Baltimore Health Alliance (GBHA)
  • Chartered in 2011 to integrate delivery of both employed and community-based clinical services
    • Network of approximately 400 providers
  • Goal: Improve access for patients and providers, maximize quality, reduce cost of care
  • Approved as an Accountable Care Organization (ACO) through the Medicare Shared Savings program in July 2012
Current Care Coordination Challenges

• Lack of information flow between Primary Care Provider, Specialty Physician, Hospitalist, and Care Coordinator
  • No central repository to lookup patient medical record
  • Leads to redundant testing (increased costs)
• Care Coordinator workflow
  • Paper based: cumbersome and inefficient
  • Nurses burdened with non-clinical tasks
  • No standard process of identifying “high risk” patients across GBHA practices
Burning Platform

• Process Improvement needed to improve results before ACO reporting period in December 2013
• Need to “lean out” Care Coordination process to provide more efficient care to the patient population
  • Reduce rework (both clinical testing and non-clinical duties)
  • Enable more patients to be assigned a Care Coordinator, given limited availability of resources
• GBMC’s Strategy: Workflow redesign leveraging new technology applications
Top Improvement Efforts

• Three new technologies will be implemented to streamline care coordination efforts
  • Health Information Exchange (HIE)
    • Allows providers to view basic medical record from inpatient and outpatient visits
Health Information Exchange (HIE) Implementation

• Current State:
  • Patient brings physical medical records from previous visit
  • ED physician not able to access any outpatient records (allergies & medications are unknown)

• Future State:
  • All physicians on the Medical Staff may access basic patient information
    • Labs/DI reports
    • Progress/Discharge Summaries
  • Encounter notification system (CRISP)

• *Increasing the ability to lookup previous visits allows for better care coordination of the ACO patient population*
Top Improvement Efforts

- Three new technologies will be implemented to streamline care coordination efforts
  - Health Information Exchange (HIE)
    - Allows providers to see basic medical record from inpatient and outpatient visits
  - Care Coordination Medical Record (CCMR)
    - Electronic Medical Record only used by Care Managers and Care Coordinators
    - Pulls information from the HIE
CCMR Development

• Beta-Partner with eClinicalWorks to develop an electronic medical record specific to Care Coordination
• Weekly meetings with vendor partner, care coordinators, nurses, and administrators to design CCMR
  • Content: Expand upon current paper practices
  • Display: Both information and aesthetics
• No time wasted on scanning/transcribing paper records
CCMR Development (cont.)

• Goals:
  • Improve Care Coordinator workflow
    • Patient lookup and documentation
    • Predefined drop-down/checklists for CC questions
  • Totality of care more visible
    • Easier to track patient progress
  • Increased communication between providers and care coordinators
    • Provider-to-Provider (P2P) messaging system
Top Improvement Efforts

- Three new technologies will be implemented to streamline care coordination efforts
  - Health Information Exchange (HIE)
    - Allows providers to see basic medical record from inpatient and outpatient visits
  - Care Coordination Medical Record (CCMR)
    - EMR only used by Care Managers and Care Coordinators
    - Pulls information from the HIE
  - ACO Analytics and Reporting tools
    - Able to generate reports on the population’s quality and health measures
ACO Analytics and Reporting

• Goal: Better manage Care Coordinator resources by targeting “high risk” population

• Current State:
  • No standard work for which patients Care Coordinators target for intervention across practices

• Future State:
  • Standard work to clearly define which patients need to be assigned a Care Manager
    • Target population:
      • Patients with hypertension, diabetes, and BMI >30
      • Patients not meeting CMS ACO quality measures
    • Determine last visit date and primary care provider
  • Benchmark our population against other eCW facilities’ patients for quality metrics
Next Steps

• Rollout of HIE and CCMR to GBHA practices
  • Define daily workflow to ensure maximum Value-Added time
  • Training and change management needed
• Continuous Improvement
  • Feedback will be given back to the vendor to incorporate into system upgrades
• Split current Care Coordinator role into:
  • Care Manager: RN who deals with clinical aspects
  • Care Coordinator: Non-clinician who works to schedule patients and perform administrative tasks
• Create standard work to define process of identifying “high risk” patients and prioritize accordingly
Summary

• Process Improvement through technology roll-outs
  • Health Information Exchange (HIE)
  • ACO Analytics and Reporting tool
  • Care Coordination Medical Record (CCMR)
• These will help facilitate the care management of the ACO population
  • Reduce costs while improving quality
    • Shared Savings difference
    • CMS Quality measures
• Current Care Coordinator workflow needs to change to achieve our ultimate goal of improving patient-centered care
What to Expect in New Orleans

• Status update
  • Implementation progress
  • Workflow redesign
    • Lean/Process Improvement tools used
    • Lessons learned
• Don’t know what we don’t know...
Questions?

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