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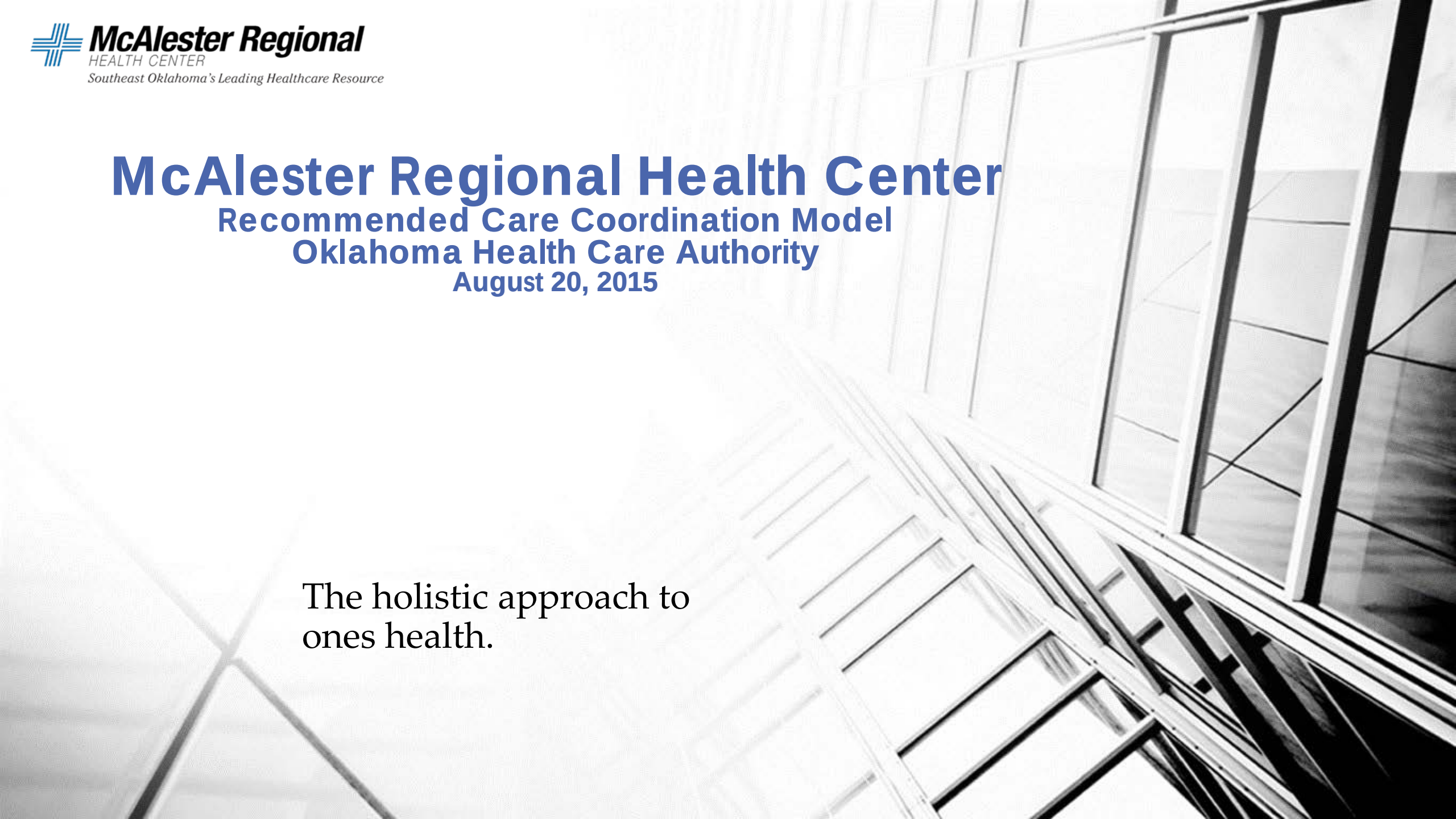
Southeast Oklahoma's Leading Healthcare Resource

McAlester Regional Health Center

Recommended Care Coordination Model
Oklahoma Health Care Authority
August 20, 2015

The holistic approach to ones health.



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Who is McAlester Regional

- McAlester Regional is a non-profit, city owned, regional medical center.
- We serve a large majority of Southeastern Oklahoma (Region 5)
- We offer
  - Residency Program
  - Multidisciplinary inpatient and outpatient services
  - We strive for excellence in our treatment of Stroke, wound care management, and Diabetes
  - Inpatient and outpatient rehab services
  - Home health
  - Hospice (in contract negotiations for this service line)
  - Nationally certified rural health clinic
  - Urgent care clinic
  - Line of Specialist to include, OBGYN, Orthopedic Surgeons, Cardiologist, Interventional Cardiologist, General Surgery, Urology, Internal Medicine, Family Medicine, and Pulmonology

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Vision Statement

- Establish a comprehensive primary care management and coordination program that will provide patient centered comprehensive care across the health care continuum, improve continuity of communications, reduce risk of readmissions, increase patient and family engagement, ensure effectiveness of clinical processes, provide patient specific care, and increase the overall efficiency of health care provided and resources utilized.

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Goal and Objective

- Provide preventative healthcare while also decreasing our percentage of reaction medicine.
- Establish a system of health care treatment that ensures the quality and safety of care provided to our patients in a ambulatory/home setting.
- Reduce the over utilization of resources.
- Educate and empower patients and caregivers to take accountability for ones own health.
- Ensure the patient and caregivers have the correct contact information for any questions and/or concerns following discharge.
- Rebalance the highly fragmented system to align our multidisciplinary team.
- Redirect our culture to a patient centered care environment.
- Support an organization that is information driven.
- Provide the highest quality of care while ensuring safety within the organization.
- Collaboratively align strategies with acute and post-acute services.
- Appropriate transparency with providers and patients.

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Delivery Model

- Partially-Capitated Care Transitions Management Clinic (CTMC)
- Identify high risk patients to be appropriately routed through the clinic
- CTMC will provide patient specific/centered primary care
- Provider led solution

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Focus of Care

- Health Literacy
- Patient and family engagement
- Care coordination across the continuum
- Population/Public health
- Patient safety
- Efficient Utilization of healthcare resources
- Clinical process of care and the effectiveness

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Care Coordination

- Predictive modeling
- Prevention
- Wellness
- Chronic care management
- Ongoing care management
- Medication adherence
- Coordination with non-clinical entities

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Pittsburg County Facts

- High school graduate or higher, % of persons age 25+, 2009-2013=83.3%(86.4%)
- Bachelor's degree or higher, % of persons age 25+ 2009-2013=15.3%(23.5%)
- Median household income, 2009-2013 = $41,252 ($45,339)
- Persons below poverty level, % 2009-2013= 18.5% (16.9%)
- Half of Pittsburg county residents live in homes built before 1970.
- Pittsburg County still has houses being heated by wood, kerosene, fuel oil, etc.
- Pittsburg County rates 62 in overall health out of 77 counties.

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Target Population

- Dual eligible
- Two or more chronic illnesses
- 65 or older
- Hospitalization twice in a 6 month period
- Literacy level
- Receive SSI
- Behavioral health problems
- LACE

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Examples of chronic conditions include, but are not limited to, the following:

- Alzheimer's disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Autism spectrum disorders
- Cancer
- COPD
- Depression
- Diabetes
- Heart failure
- Hypertension
- Ischemic heart disease
- Osteoporosis

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LACE

- LACE index scores for every patient on admission, and discharge on the following parameters:
  - Length of Stay (0-7)
  - Acuity of the admission (3)
  - Co-morbidities (5)
  - Emergency Department visits in the previous 6 months (4)

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Comprehensive Care Plan

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions and identification of the individuals responsible for each intervention
- Medication management
- Community/Social services ordered
- A description of how services of agencies, and specialists outside practice will be directed/coordinated
- Schedule for periodic review, and when applicable, revision of care plan

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Outcomes

- Raise operational efficiency
- Deliver better outcomes
- Increase patient satisfaction
- Longitudinal performance
- Goal-directed, patient-centered care planning and implementation
- Shared decision making
- Systems to coordinate acute care, long-term services that supports nonmedical community resources
- Beneficiary sense of control/autonomy/self-determination
- Psychosocial needs
- Community integration/Inclusion and participation
- Optimal functioning

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Care Team

- Residency Clinic (9 physicians/ within 5 years we will have 24)
- Nurse Practitioners
- Licensed Social Workers
- Licensed Nursing Staff
- Care Managers

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Provider Network

- Midlevel providers, care management specialist, RN, Case Management, and Health Coaches. While we will not be at risk for services other than primary care, we will attempt to minimize costs by utilizing specialists and other providers that are affiliated with MRHC whenever possible.
- Meet the need for continual education of our Residents, continual care for patients.
- Creating more capacity for primary care long term.
- Recruiting and retaining more physicians within the state.

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Provider Payment Structure

- Capitation per member per month for Primary Care
  (minimum of 2500 lives-$125.00 PMPM)
- Fee for service based on the Medicaid fee schedule.
- 10% withhold, distributed as bonus to providers based on outcome scores.

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Impact of Model

Column1	Year 1	Year 2	Year 3	Year 4	Year 5
HOSPITAL SAVINGS	$222k	$234k	$268k	$241k	$217k
OTHER SAVINGS	$25k	$25k	$25k	$25k	$25k
REDUCED ED	140	154	169	152	137
REDUCED ID	40	44	48	44	39

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CMS Quality Measures

- CMS2v1: Prevention Care and Screening: Screening for Clinical Depression and Follow-up Plan (CMS, CQMs).
- CMS68v1: Documentation of Current Medications in the Medical Record (CMS, CQMs).
- CMS69v1: Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow-Up (CMS, CQMs).
- CMS50v1: Closing the referral loop: receipt of specialist report (CMS, CQMs).
- CMS90v1: Functional status assessment for complex chronic conditions (CMS, CQMs).
- CMS165v1: Controlling High Blood Pressure (CMS, CQMs).
- CMS156v1: Use of High-Risk Medications in the Elderly (CMS, CQMs).

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State Identified

- Tobacco cessation and education.
- Increase access to Primary Care providers.
- Recognition and screening of behavior health issues.
- Participation is health care prevention by establishing regular interval visits with health care provider.
  - Healthy- Encourage healthy lifestyles.
  - At Risk- Intervene risk and keep from becoming chronic.
  - Chronic- Prevent disease progression and avoid unnecessary complications.
  - Catastrophic- Mange benefits, controls costs, provide dignity through end of life.
- Nutritional support and education to decrease obesity.

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MRHC Identified Benchmarks

- Accessibility to see patients same day and/or within 24 hours of request.
- Decrease in ER visits.
- Increase in patient and provider satisfaction.
- Community involvement in providing a better environment for all residents.
- Number of visits to Primary Care Provider, ER, Hospital Stays, and/or any other health care service provided.
- Disease management and care coordination.

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Value Based Purchasing Measures

1. Efficiency:
    a. Decrease the overall spend amount for the patients indicated above.
    b. Increase appropriate utilization of individual's time.
2. Reduce Readmissions
    a. Proactively manage the health of those who have chronic conditions to prevent the acute exacerbation episodes.
    b. Provide education to increase the overall knowledge of disease specific indications and decrease knowledge deficit.
    c. Encourage participation in local support groups to provide the ability to network with others with similar chronic conditions.

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Claims Based Outcomes

- Reduction in our overall Medicare Spend for beneficiary from 1.002625 in FY 2015, to 0.952399 in FY 2016 value based purchasing score.

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Why

- Health care organizations across the United States and the world recognize that a small percentage of the population generates a disproportionately large portion of health care costs. In the United States, 5 percent of the patient population generally represents 50 percent of total cost across all payers. This portion of the population is complex and dynamic. These patients may struggle with factors such as chronic physical and mental illness, poverty, social isolation, and they may move in and out of high-need categories as their circumstances change. High utilization rates coupled with poor outcomes tell us that the standard care system is not working for these individuals (IHI, 2015)

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Future trends in transparency

- Providers and consumers will demand price transparency from insurance companies and hospitals.
- Non participants over time will not be getting business.
- Price will be part of every patient, provider interaction.
- Consumer movement empowered by the devices and use of big data.
- Rise of different service models that are inherently transparent.
- Value-Based care will drive lower cost interventions to achieve better outcomes.
- Value based care integrated more seamlessly.

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Quality

- ISO 9001 Certified (Quality Management System)
- LEAN hospital with various employees certified at different levels
- Leapfrog Hospital Safety Score of B
- Certified Healthy Oklahoma Business Excellence
- Certified Diabetes Center
- Certified Urgent care

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Telemedicine

- Current
  - Stroke
  - Radiology
  - EEG
  - Remote Pharmacy Support
- Future
  - Inpatient Neurology
  - Dermatology
  - Home Health
  - Psychiatry

HealthCare's most wired™ WINNER 2015

Hospital List | Ambulatory List

Filter by stage | Oklahoma | Hospital or Health System

Oklahoma	Health System	Stage	City	Beds	Case study
Duncan Regional Hospital	Duncan Regional Hospital	Stage 6	Duncan	151	
HealthPlex	Norman Regional Health System	Stage 6	Norman	136	
Jane Phillips Medical Center	Ascension Health	Stage 6	Bartlesville	140	
McAlester Regional Health Center	McAlester Regional Health Center	Stage 6	McAlester	171	
Mercy Hospital Ardmore	Mercy	Stage 6	Ardmore	190	
Mercy Hospital Oklahoma City	Mercy	Stage 6	Oklahoma City	380	
Norman Regional Hospital	Norman Regional Health System	Stage 6	Norman	324	

Health Portal

https://mymrhcpatientportal.mrhcok.com/00jw62fk00001s4mc7.mthd

Apps | MRHC Sign On

Change Person | Log Off

MRHC
McAlester Regional Health Center

Tracy Locke


Health Record


Medications


Appointments


Billing


Profile

MRHC Links

Online Payment

MRHC Web Site

Recent Visits

Wed, Mar 27, 2013	9:05 am	Referred Outpatient	LAB
Thu, Dec 01, 2011	8:37 am	Surgical Day Care	AMBULATORY SURGERY
Tue, Nov 29, 2011	10:10 am	Clinical Outpatient	RADIOGRAPHY

Contact Us | Preferences | Terms & Conditions

Health Portal

https://mymrhcpatientportal.mrhcok.com/00jw62fk00001s4mc7.mthd

Apps MRHC Sign On

McAlester Regional Health Center

Home Log Off

Tracy Locke's

Health Record

Select an item below or a button to the right to view more details. Select Health Summary to view, print or download a summary of your care.
Learn More

Allergies

There are no allergies for this patient.

Conditions

There are no conditions for this patient.

Medications

There are no medications for this patient.

Contact Us

- Health Summary
- Allergies & Conditions
- Results
- Medications
- Reports
- Visit History

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Anticipated Overarching Timelines

- Development: Development began with a research into Population Health in October of 2014. The research derived was put into business proposal form. The business proposal was presented to the Administrative Executive Team and the Business Development Committee for the Board of Trustees in February 2015. MRHC is actively recruiting for mid-level providers at this time.
- Transition/Readiness Activities: The MRHC nursing leadership and IT have worked tirelessly for months to redesign our discharge routine within our Electronic Health Record. It is now going to be a multidisciplinary care transitions model for all areas of care to document and communicate with one another. This will go live the middle of August.
- Implementation of member enrollment: Patients will have to meet the criteria as identified under **Population Served**.
- Implementation of member service delivery: Please see time line below.

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Timeline

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Market Feasibility

- Environment: Pittsburg County has 10% of the entire State's Medicaid population.
- Conditions unique to the Oklahoma market: High percentage of Medicaid population, high population of diabetes and CHF. Our patients have significant issues with access to healthcare service due to living in rural areas (i.e.: drive time can be excessive and gas is very costly).
- Conditions not unique to the Oklahoma market: Oklahoma is mostly rural with two areas of urban residency. Access to health can be difficult for those living in rural communities.
- Availability and range of community resources: We have after hour's availability through our urgent care center, we participate with many organizations such as Oklahoma Project Women.

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Market Feasibility cont....

- Existing and proposed Federal regulations: This model will inevitably effect the pay-for-performance measures that hospitals are already accustom too. With the passing of the Impact Act the post-acute world will soon follow suit. Bundled payments are knocking on our door so the responsibility to provide patient centered continuum of care is more important than ever for organizations to continue to thrive and market sustainability.
- Data attainment, cross-walking to Medicaid, and use: MRHC has presented a Data Analytic software to our Finance Board and will take it forward to our Board of Trustees on August 5, 2015 for final approval. This will give our hospital and physicians clinic EMRs the ability to talk to one another, along with many other features to stratify our data for study and analysis. Thus allowing for substantial increase in real time accurate data that can be utilized to identify areas of weakness and strength. The software will also allow for MRHC to measure, monitor, and analyze almost any indicator one can think of. It will also allow for us to monitor all ABD, dual eligible, and/or any other identified high risk patients that have entered into our ER, acute care, in-patient rehab, and/or our skilled unit.

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Market Feasibility cont....

- Coordination of benefits and services between Medicare and Medicaid: Strategic development of patient-specific plan of care will allow for alignment of benefits and services to increase efficiency as it relates to utilization, time management, medication reconciliation, prevention, participation in outreach, etc.

- Alignment of payment structures and goals: MRHC will be able to control costs by aligning patients with primary care providers, emergency after hours care through our urgent care centers and emergency room, when appropriate. By aligning patients with primary care providers, MRHC can assist them with appropriate follow up care and prescription management to prevent them from finding themselves in an emergency situation. Our 24/7 availability offers reasonable cost when patients are able to follow up with their primary care providers or be seen in our urgent care centers, avoiding emergency room visits and hospitalization whenever we can.

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Approach to integration with Medicare

- Considerations, observations and potential opportunities and threats related to
- Existing and proposed federal regulations: McAlester Regional Health Center is a community owned regional hospital, that serves many surrounding rural towns, and is financially strong.
- Data attainment, cross-walking to Medicaid, and use: MRHCs EMR and practice management software is fully capable to report and derive data directly from CMS, Medicaid, and all other payers.
- Coordination of Benefits and services between Medicare and Medicaid: Strategic development of patient-specific plan of care will allow for alignment of benefits and services to increase efficiency as it relates to utilization, time management, medication reconciliation, prevention, participation in outreach, etc.
- Alignment of payment structures and goals: MRHC will be able to control costs by aligning patients with primary care providers, emergency after hours care through our urgent care centers and emergency room, when appropriate. By aligning patients with primary care providers, MRHC can assist them with appropriate follow up care and prescription management to prevent them from finding themselves in an emergency situation. Our 24/7 availability offers reasonable cost when patients are able to follow up with their primary care providers or be seen in our urgent care centers, avoiding emergency room visits and hospitalization whenever we can.

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Private Label TPA Services

- Program enrollment management
- Customer service line
- Care management technology platform

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Effective Care Coordination

- Assessment of a patients care coordination needs
- Information exchange across care interfaces
- Interventions that support care coordination
- Monitoring and adjustment of care
- Evaluation of outcomes, including identification of care coordination issues

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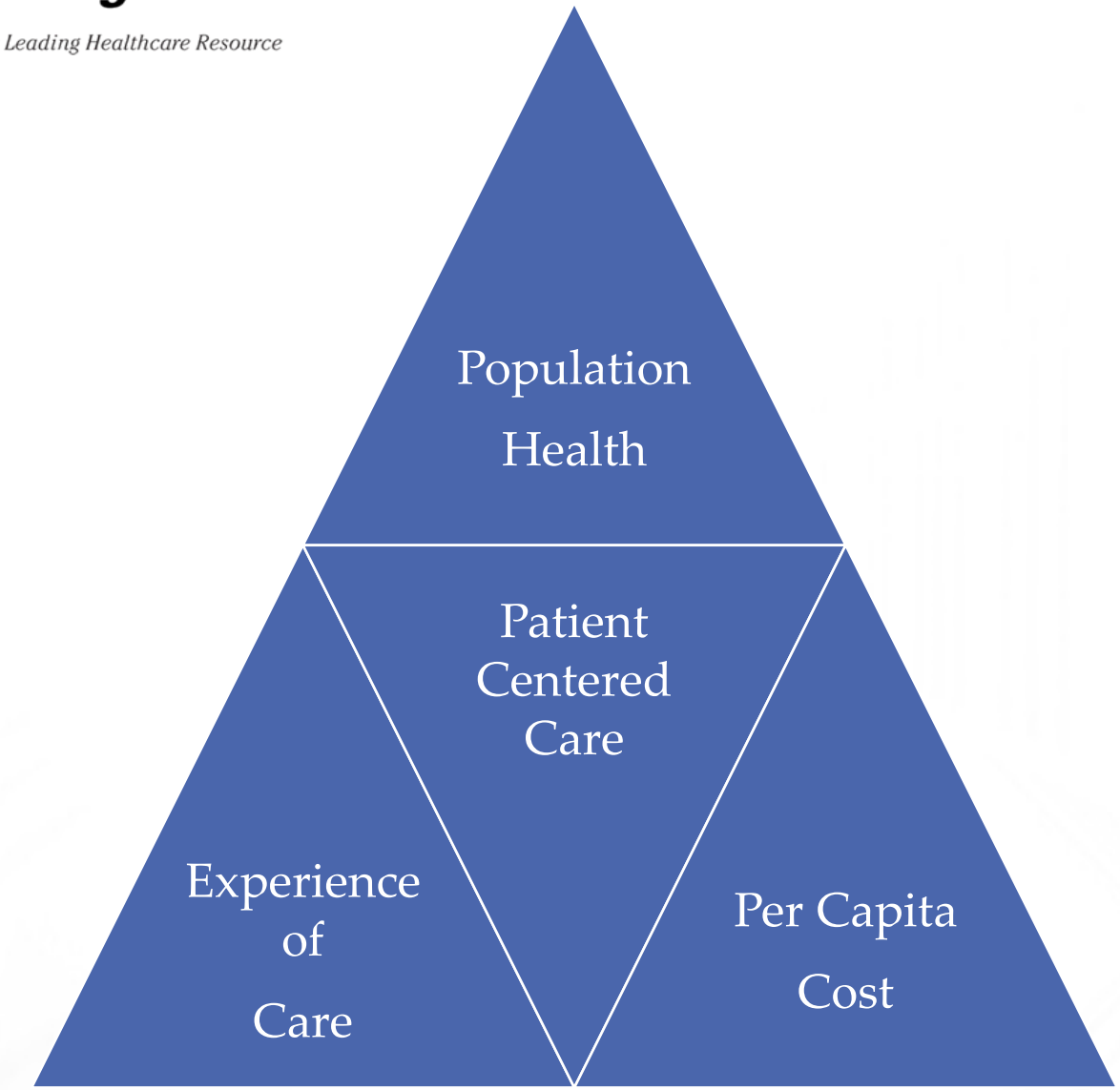

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DAY 1

- Patient is discharged from hospital
- Transition Team contacts patient by phone

DAY 2

- Patient is seen in the clinic by a mid-level provider
- Patients unable to be seen in the clinic will be seen in the home

DAY 5

- Transition Team will contact patient by phone
- Team will follow an approved form to direct the call

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DAY 8

- Transition team will visit with patient in the home
- Documentation format will be provided

DAY 14

- Transition team will contact patient by phone
- Team will follow the approved form to direct the call

DAY 20

- Transition team will contact patient by phone
- Team will follow the approved form to direct the call

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Day 30

- Transition team will contact patient by phone
- Team will follow the approved form to direct the call

Follow-up 60

- Transition team will follow up with all patients 60 days post discharge

Follow-up 90

- Transition team will follow up with all patients 90 days post discharge

McAlester Regional Health Center and the Pittsburg County Health Department embarked on a comprehensive community health needs assessment in December of 2014, to achieve the development of a comprehensive strategic plan for Pittsburg County. This processes time line indicates the successful completion of this project to be December 2015.

MAPP

Mobilizing for Action through Planning and Partnerships

MAPP
MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP)

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Community Outreach

- Monthly lunch and learns at our wellness center that are open to the public
- Outreach education to all the senior living centers
- Host at least two health fairs a year and participate in many
- Alter G, gravity defining treadmill for individuals who are partially weight bearing disadvantaged
- Sitter service to decrease the need for restraints
- Meals on Wheels
- Assisted living/Residential living
- Partner with our local school system as a BLS training site with AHA