



Finger Lakes Health Systems Agency

Using ED and Readmissions Data to Develop Strategies that Reduce Cost and Improve Care

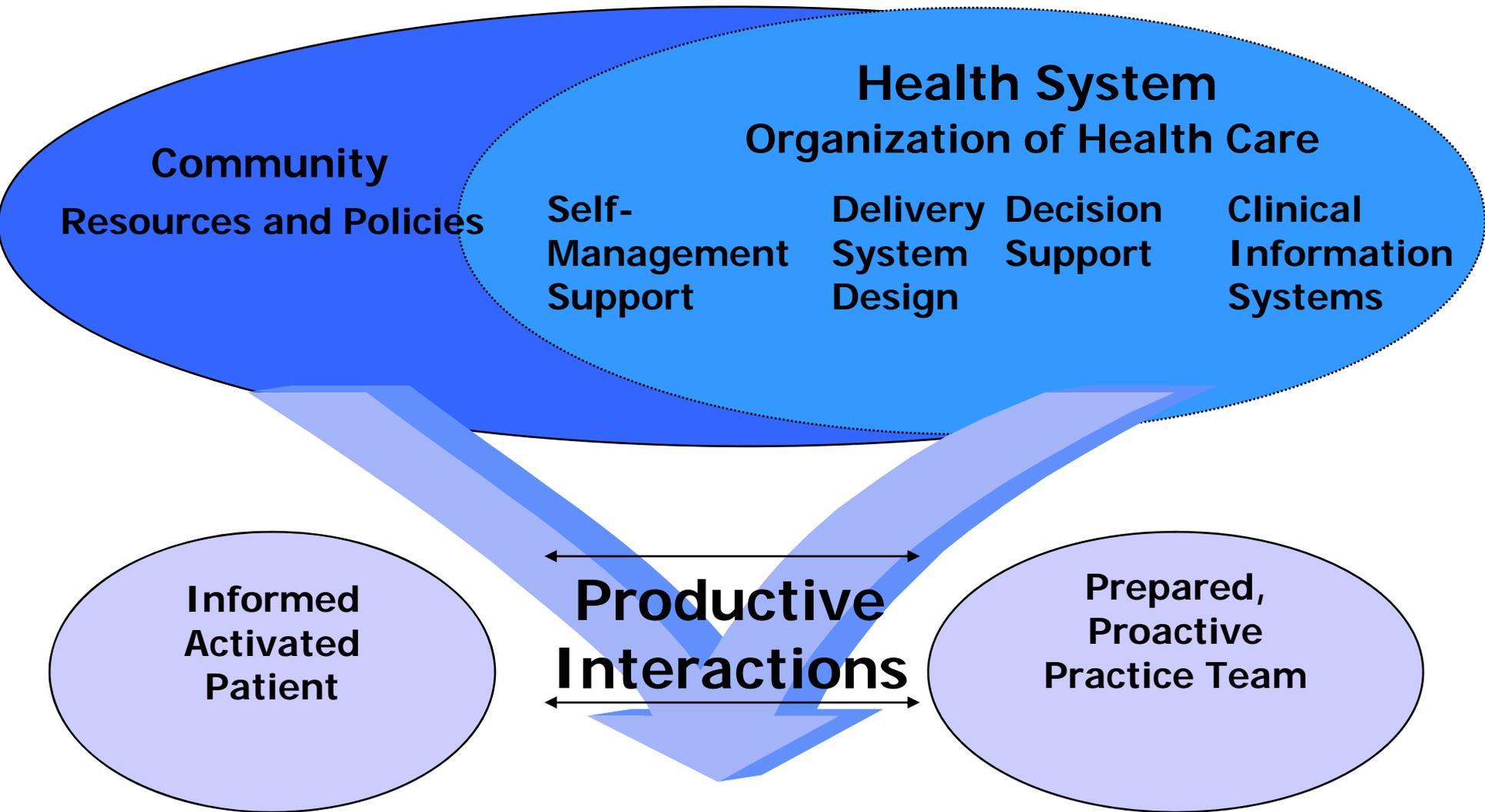
FLHSA: Vision, Mission & Strategy

Vision: A local health-care system that makes people healthier and saves money, by delivering the right care, in the right place, and at the right time for everyone in the community.

Mission: We are an independent organization working to improve health care in Rochester and the Finger Lakes region, by analyzing the needs of the community, bringing together stakeholders and organizations to solve health problems, and measuring results.

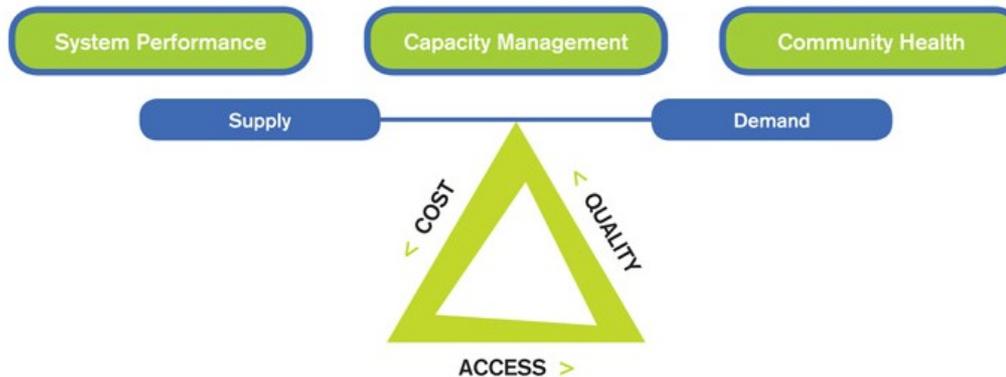
System Performance	Capacity Management	Community Health
<i>Quality and efficiency—</i> Making the best use of health-system resources	<i>Infrastructure optimization—</i> Achieving the right number and type of facilities	<i>Patient responsibility—</i> Educating and engaging consumers to improve their own health and require less care
The right care.	In the right place.	At the right time.

Wagner Model



FLHSA's Role: Redefining Community Health Planning

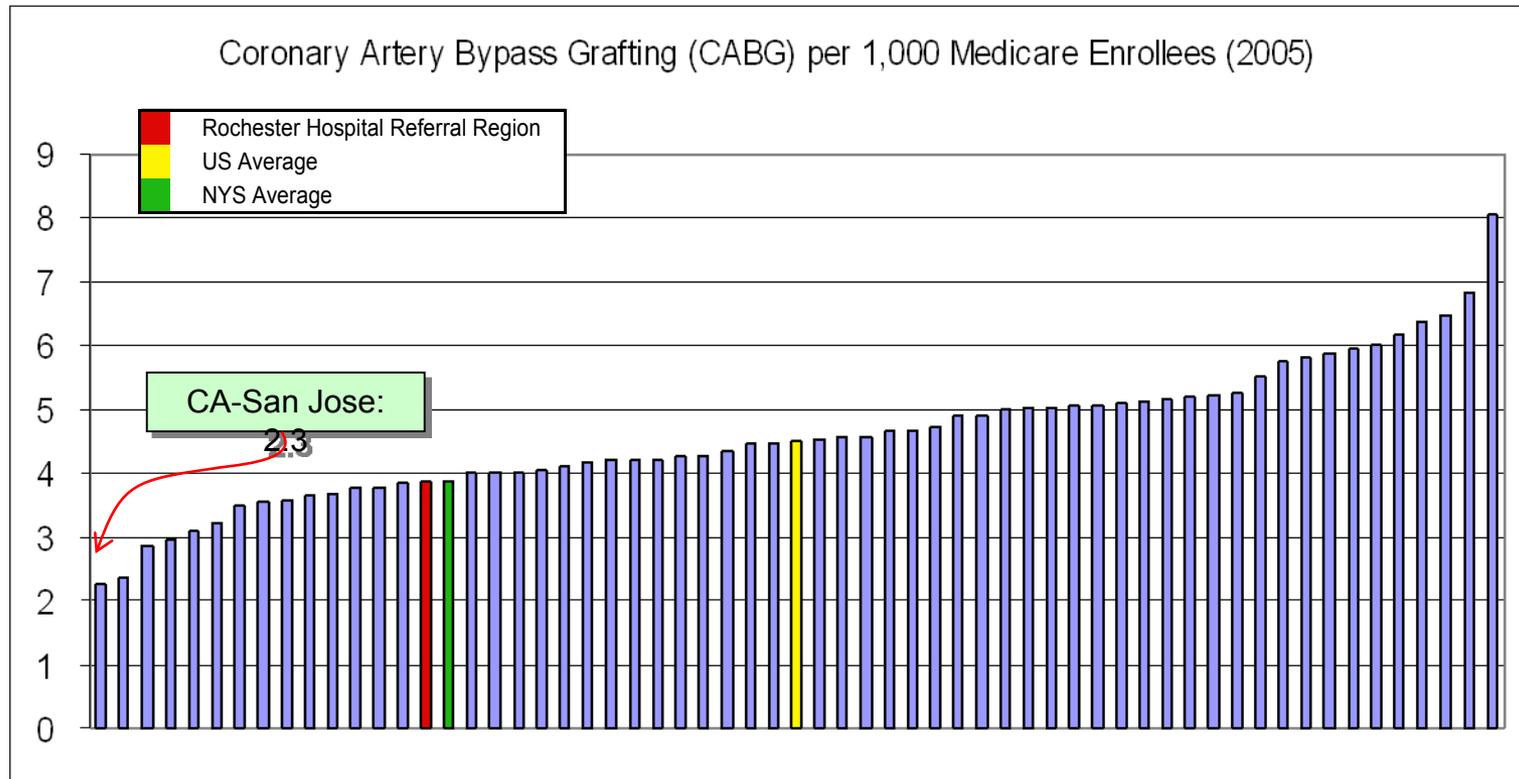
- Objective, collaborative and community-oriented
- Design solutions and set priorities
- Move the performance needle
- Report progress



Data Analysis on Hospital Capacity

- Characteristics of High Performing Health Systems
 - Rochester Region Comparisons
 - Use rates
 - Impact of utilization drivers on future capacity requirements
 - Population and Demographics
 - Disparities
-

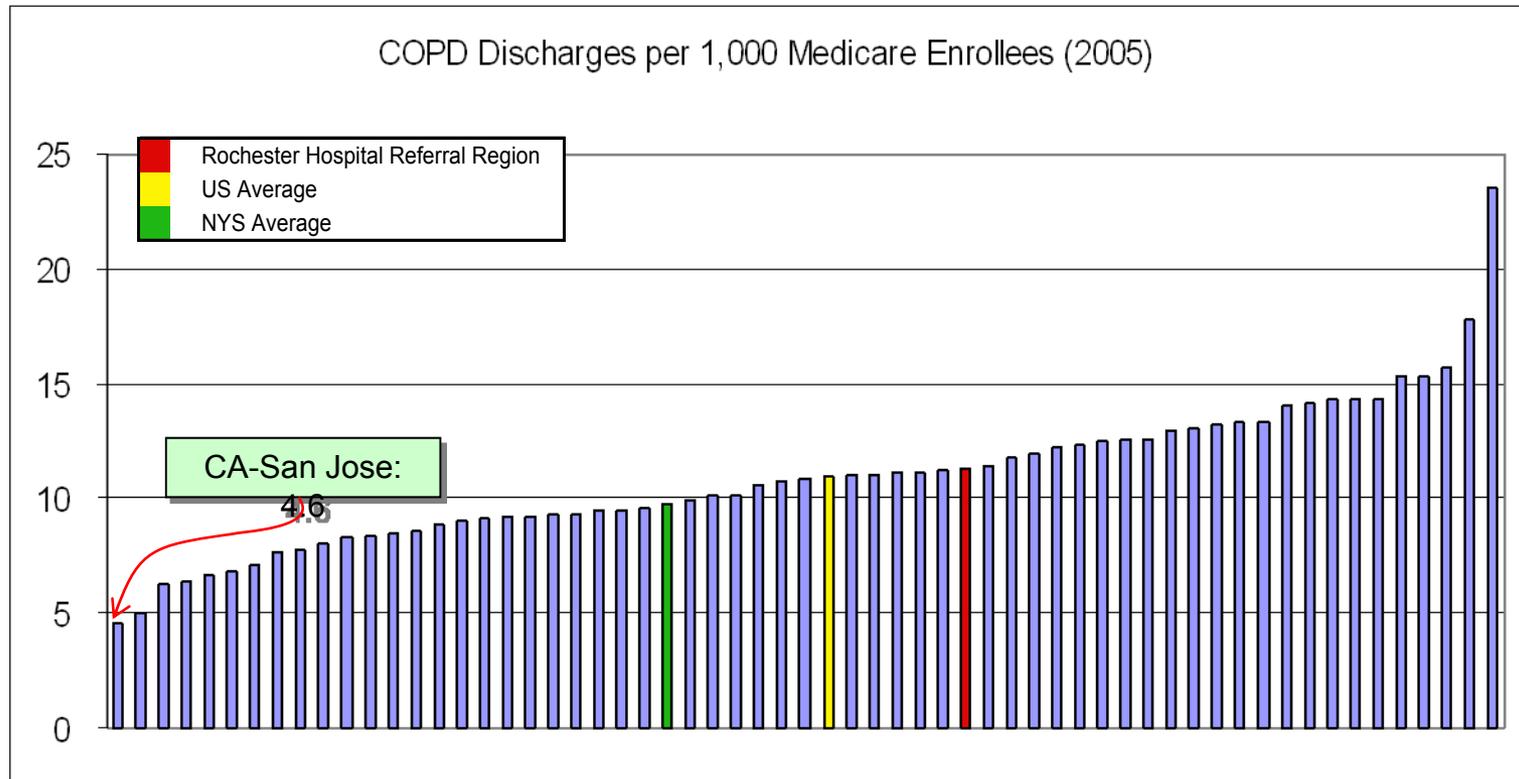
Characteristics of High Performing Health Systems



Source: Dartmouth Atlas of Health Care, Hospital Referral Regions with Medicare populations between 80,000 and 135,000 (n=58)

Rochester HRR	
Actual	3.9
Percentile	25
Rank (n of 306)	78

Characteristics of High Performing Health Systems

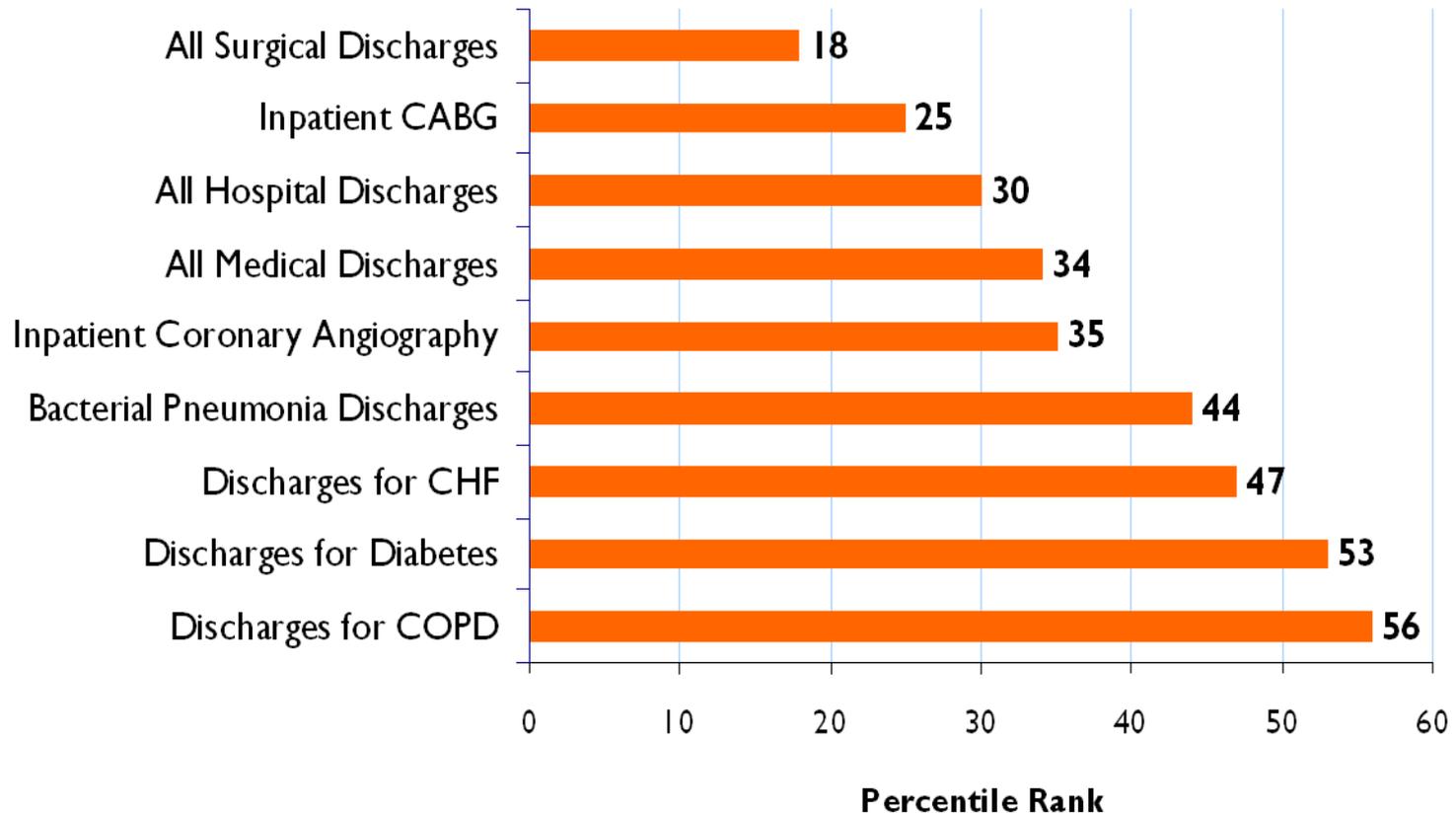


Source: Dartmouth Atlas of Health Care, Hospital Referral Regions with Medicare populations between 80,000 and 135,000 (n=58)

Rochester HRR	
Actual	11.3
Percentile	56
Rank (n of 306)	171

Characteristics of High Performing Health Systems

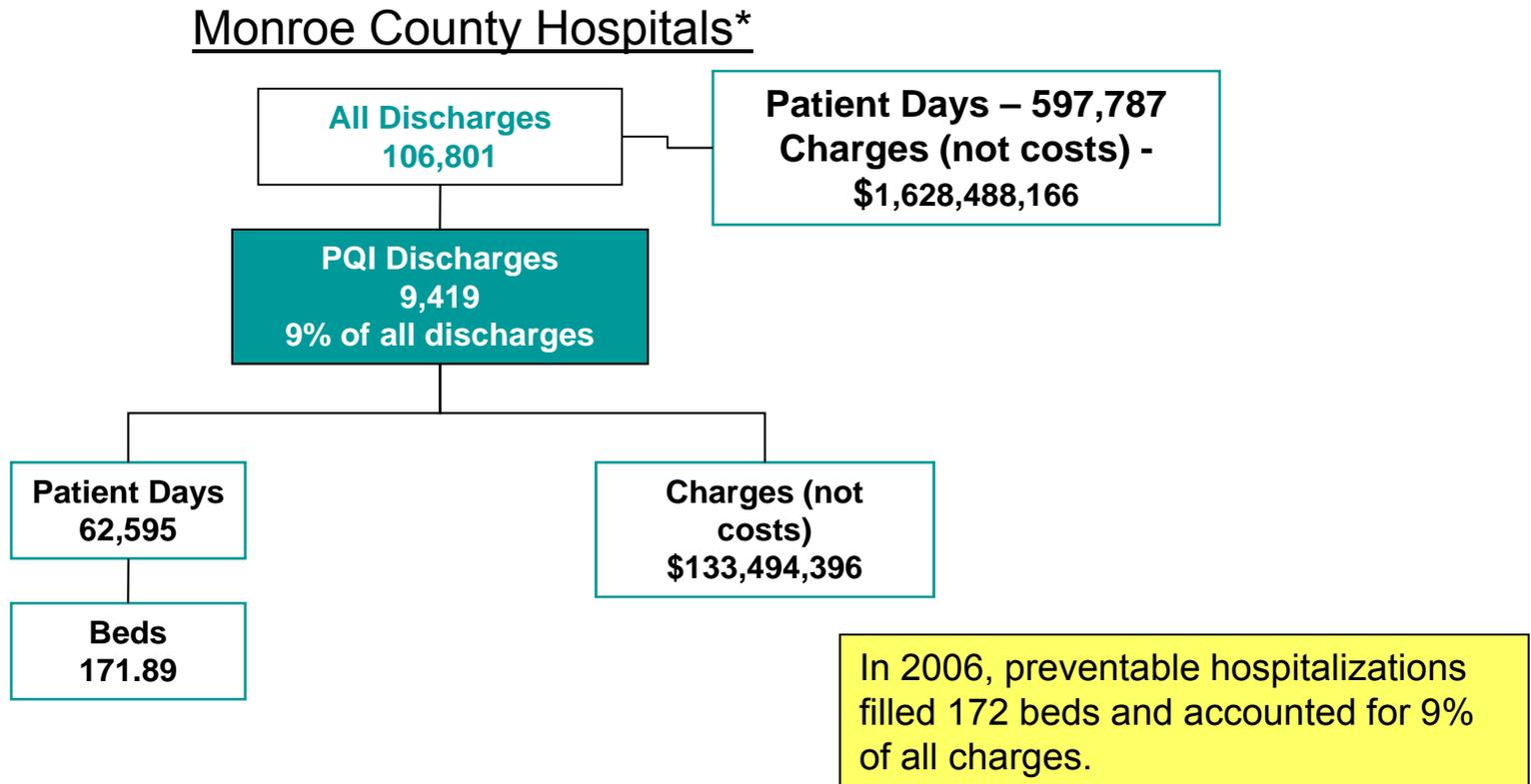
Medicare Utilization Profile for HRR Rochester, N.Y. (2005)*



*Source: Dartmouth Atlas of Health Care

Prevention Quality Indicators

All PQI Hospitalizations – Discharges, 2006



AHRQ Prevention Quality Measures, 2006

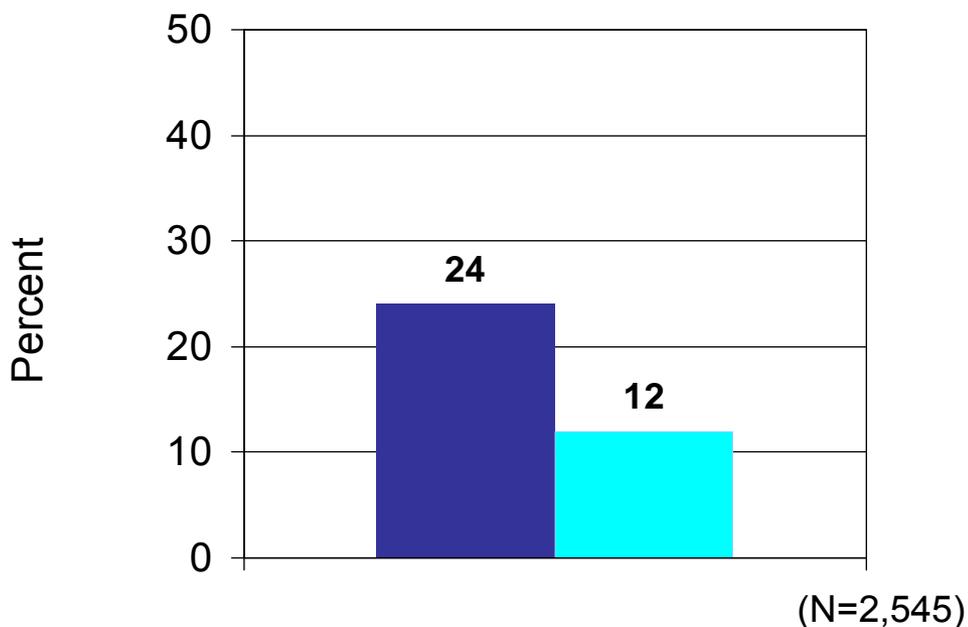
*Includes HH, RGH, Unity, SMH, Lakeside

Disparities

Health Status by Race

Fair or Poor Reported Health Status by Age Group and Race

Adults 18+, Monroe County, 2006

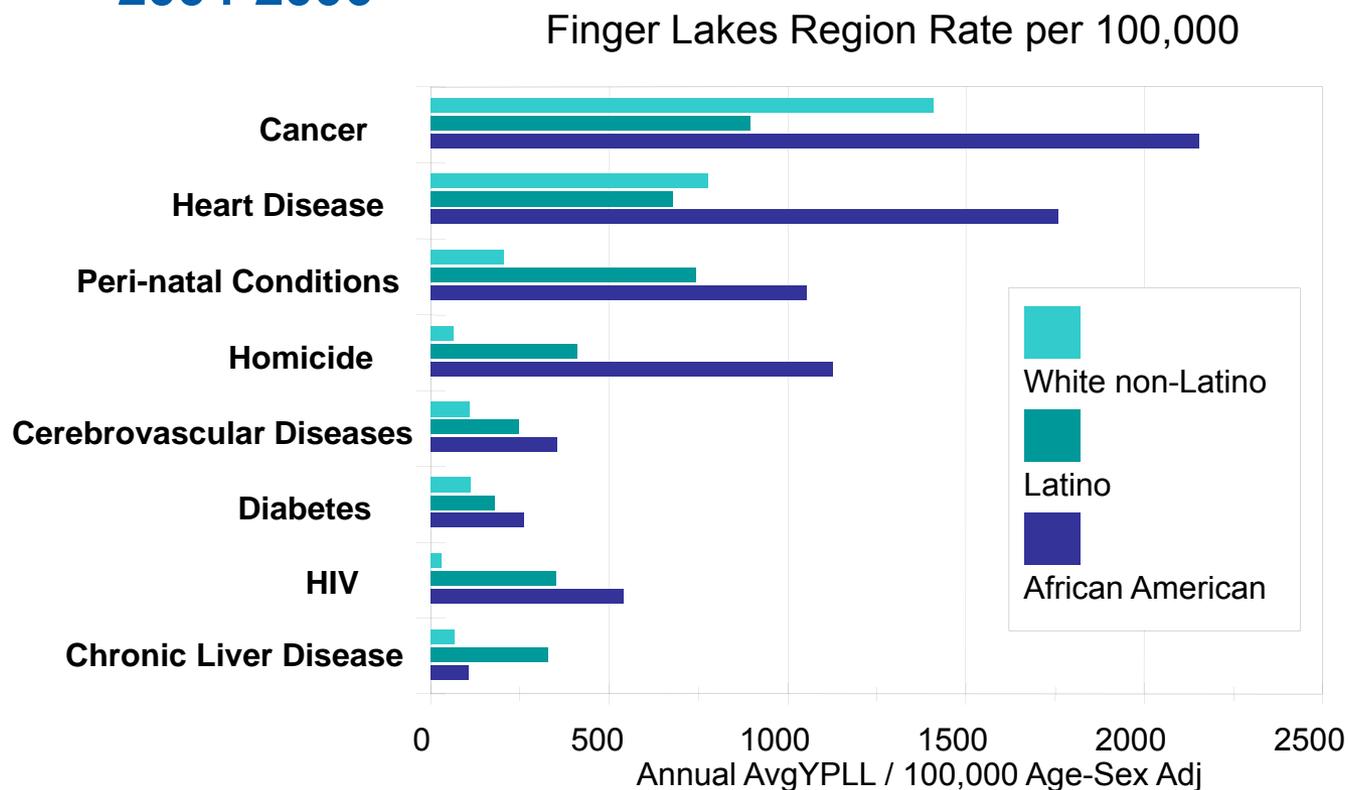


African Americans are twice as likely to rate their health as fair or poor than whites.

Monroe County Adult Health Survey Report, 2006

Disparities

Years of Potential Life Lost (YPLL) by Race/Hispanic Origin, 2004-2006



As a measure of premature mortality or early death, the YPLL data reflect African Americans die at younger ages significantly more than whites and Latinos due to many leading causes of death. YPLL is also a measure of lost productivity or contributions to society, and suggests economic loss as a result of early mortality.

The 2020 Capacity Recommendations

- The 140 bed recommendation is based upon ***anticipated changes in the drivers of inpatient utilization*** realized through targeted demand management/reduction initiatives:
 - Improvement (reduction) in use rates to move the Rochester region closer to the best practices observed in other, similar regions
 - Impact on 2017 need: -70 beds
 - Improvement (reduction) in average length of stay
 - Impact on 2017 need: -60 beds
 - Improvement (reduction) of in-migration of low acuity cases
 - Impact on 2017 need: -18 beds
 - **Total improvement (reduction) due to demand management:**
 - **Impact on 2017 need: -148 beds**

Why This Is Important

If inpatient demand at the three Rochester systems is not able to be reduced, the new capacity recommended by the 2020 Commission and approved by the NYSDOH will be insufficient to meet the needs of the region when it becomes available

Community Investment Goals

To catalyze change in the regional health care system

- In order to drive these changes, the Commission created specific goals for the community
 - A decrease of 15% in the number of low acuity (non-urgent) visits to emergency rooms
 - A decrease of 25% in the number of admissions for Ambulatory Sensitive Conditions that are manageable in outpatient settings
 - A decrease of 20% in the number of low acuity admissions to Monroe County hospitals of residents from outlying communities
-

Community Investment Recommendations

To address the establishment of collaborative initiatives on community-wide issues

- Understanding that such changes are not under the control of any one institution or stakeholder group, the Commission recommended collaborative approaches to achieving the community goals
 - Hospitals, payers and other community stakeholders will develop and initiate processes and programs in response to the goals
 - Resources will be obtained commensurate with the scope of the initiatives related to these recommendations to ensure their long-term success
 - Community stakeholders will engage collaboratively to address community-wide issues
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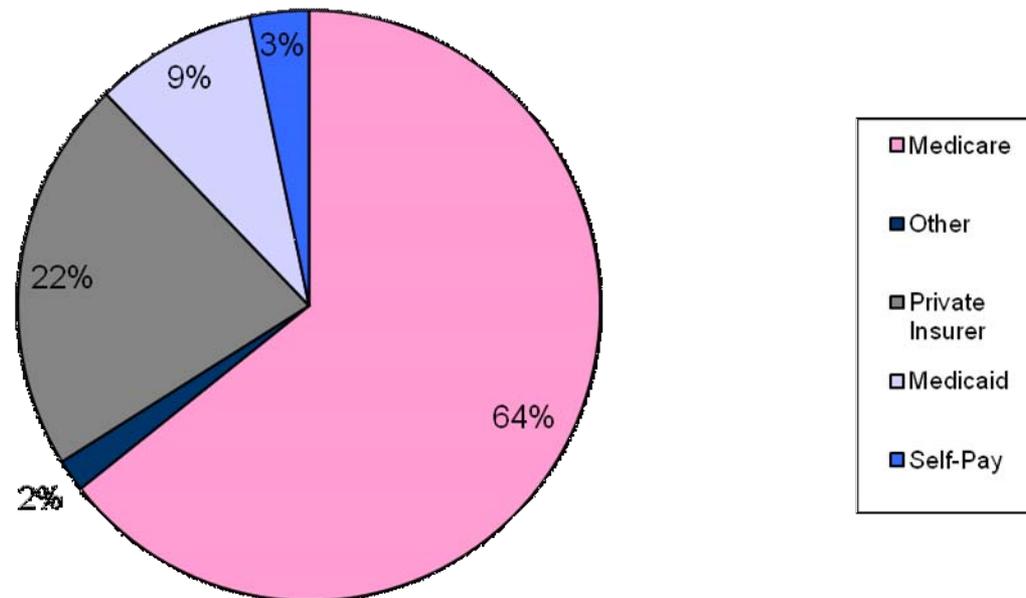
Reducing Avoidable Admissions

- PQI – Prevention Quality Indicators – The condition causing the admission is sensitive to the ambulatory care provided (i.e., the hospitalization is potentially avoidable)
- Scope (yearly average)
 - 2004-2006 – 15,689 PQI discharges (12.7%)
 - 2004-2006 - 86,198 PQI hospital days
 - 2004-2006 - 295 hospital beds in region filled with PQI admit
 - 2004-2006 - Hospital charges for PQI admits - \$157 million

TARGET – Eliminate 3,922 PQI Admissions by 2014

Reducing Avoidable Admissions: Insurance status as a variable

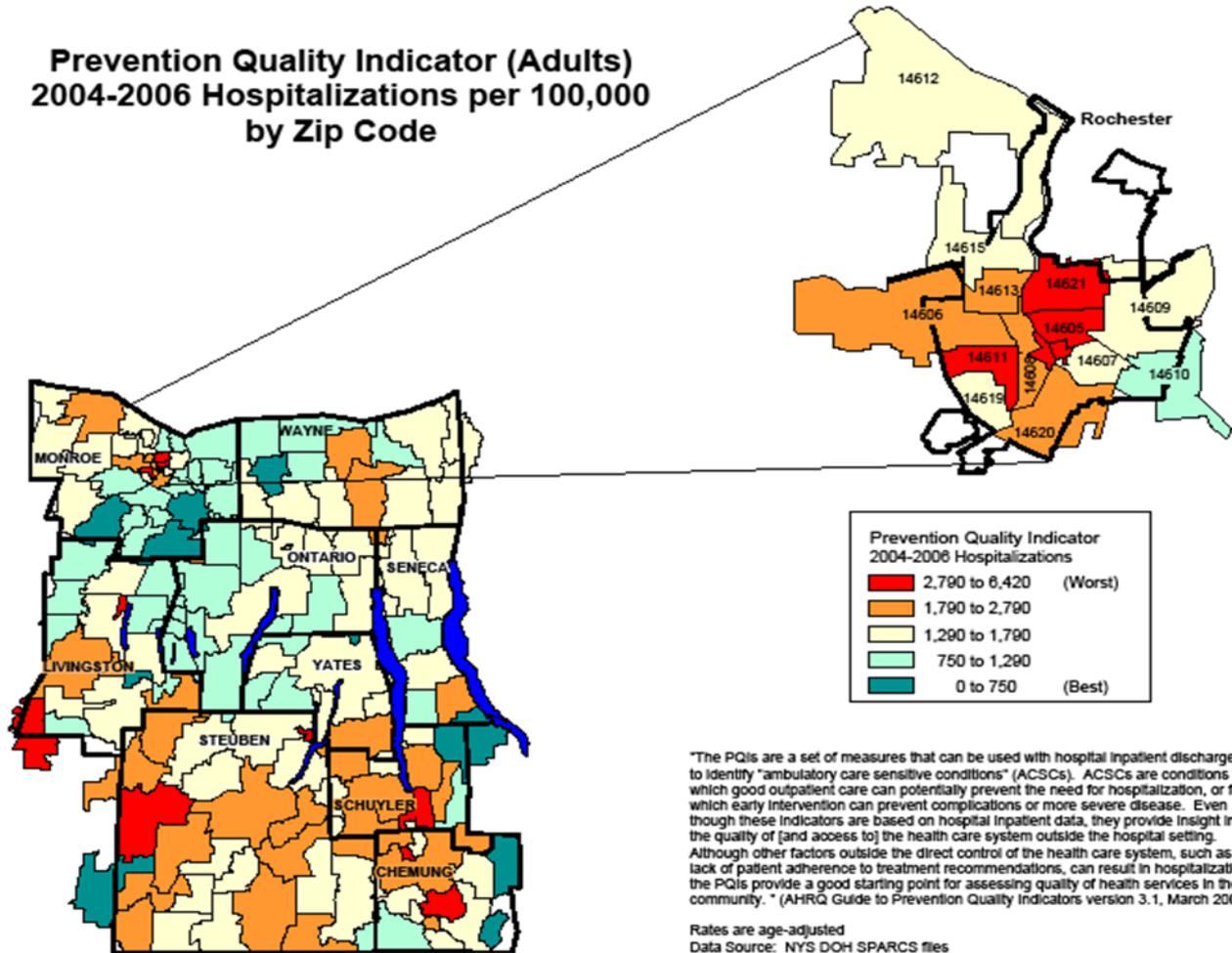
All PQI Hospitalizations by Insurer, 6-County Finger Lakes Region, 2004-06



Data Source: NYS Dept of Health, SPARCS

Reducing Avoidable Admissions: Geography as a variable

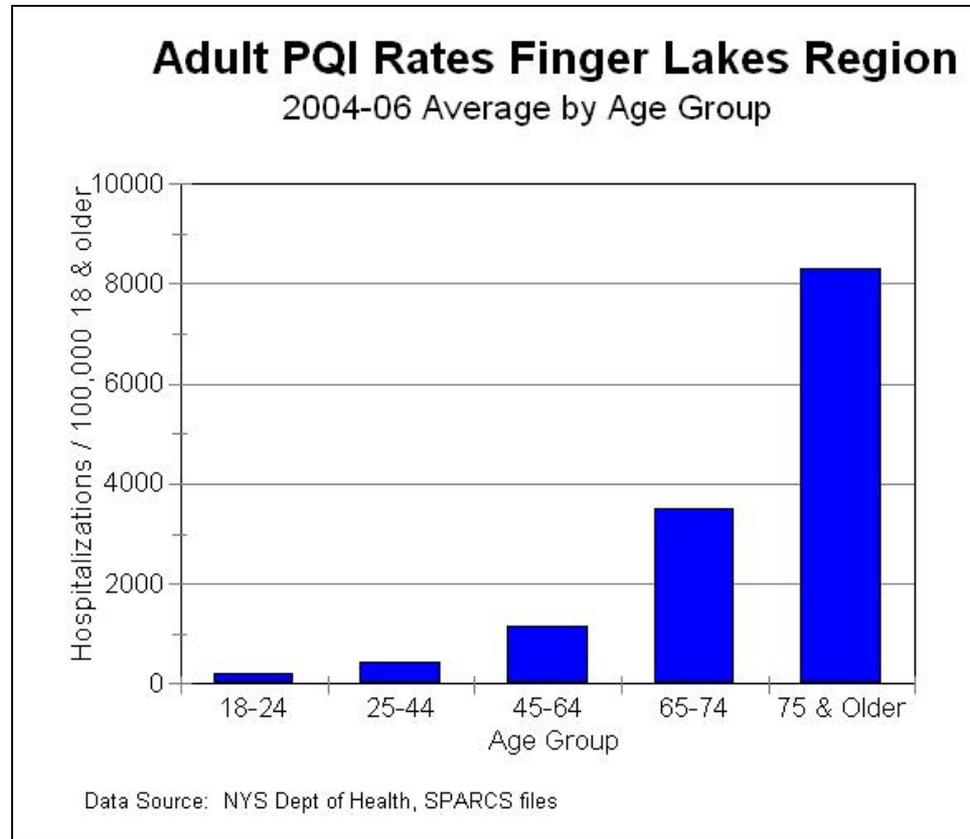
**Prevention Quality Indicator (Adults)
2004-2006 Hospitalizations per 100,000
by Zip Code**



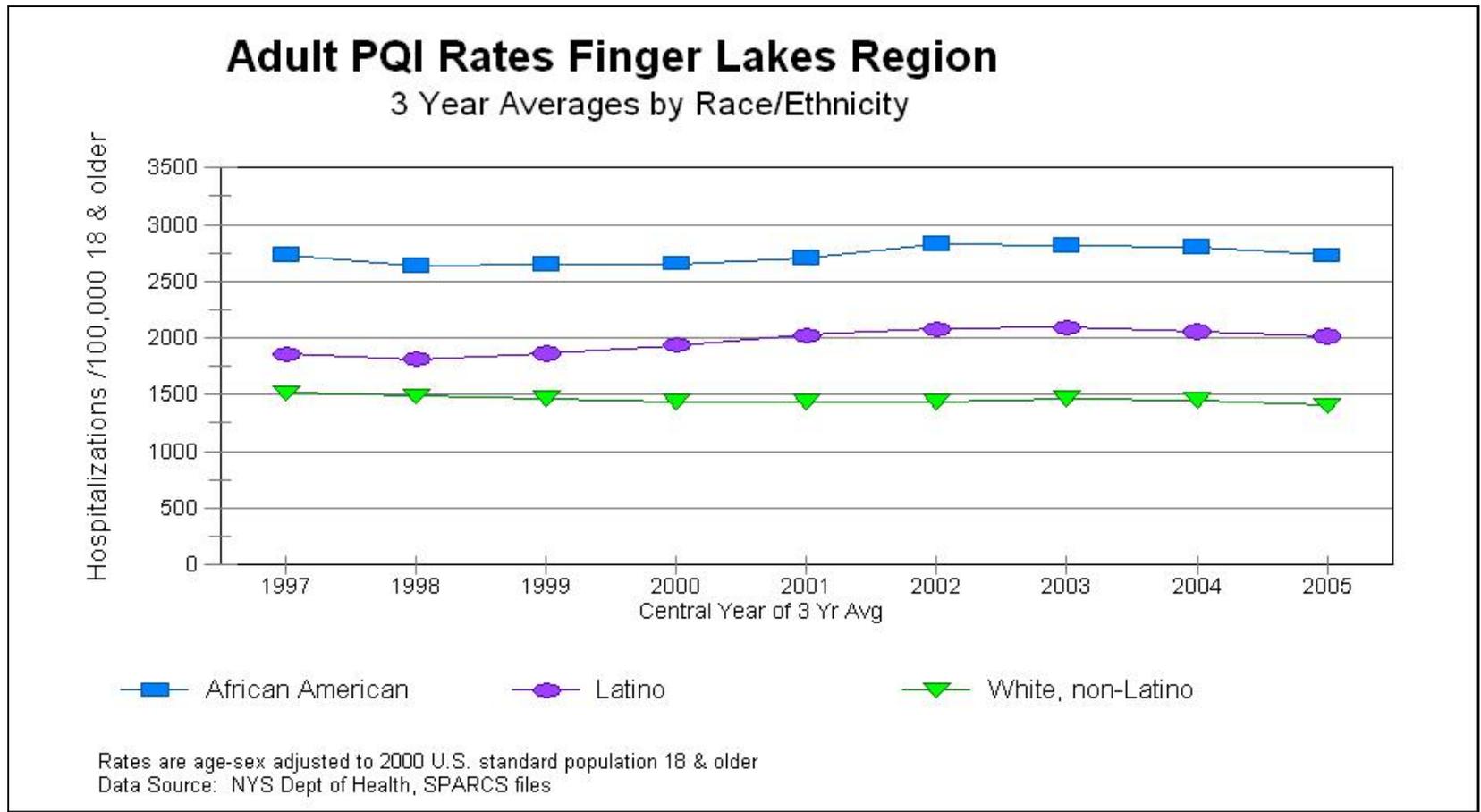
"The PQIs are a set of measures that can be used with hospital inpatient discharge data to identify "ambulatory care sensitive conditions" (ACSCs). ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. Even though these indicators are based on hospital inpatient data, they provide insight into the quality of (and access to) the health care system outside the hospital setting. Although other factors outside the direct control of the health care system, such as lack of patient adherence to treatment recommendations, can result in hospitalization, the PQIs provide a good starting point for assessing quality of health services in the community." (AHRQ Guide to Prevention Quality Indicators version 3.1, March 2007)

Rates are age-adjusted
Data Source: NYS DOH SPARCS files

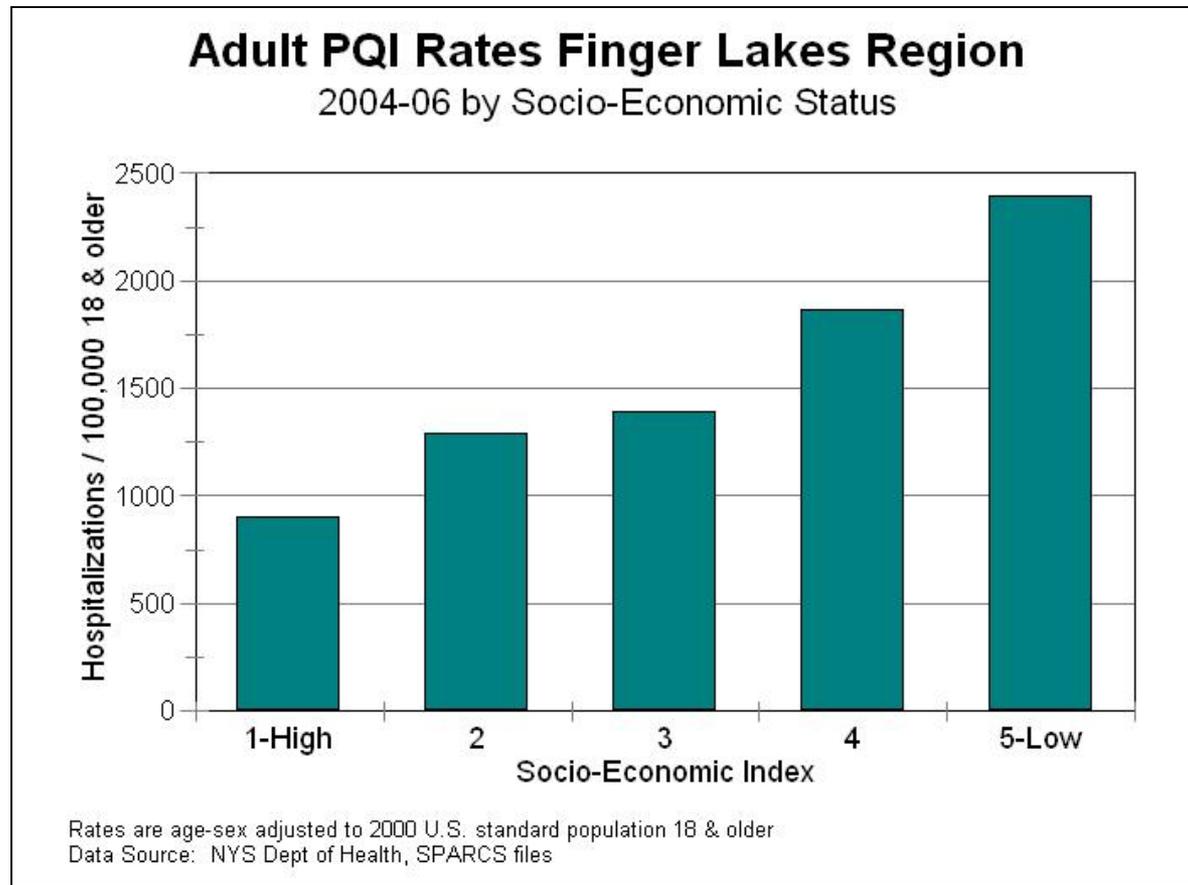
Reducing Avoidable Admissions: Age as a variable



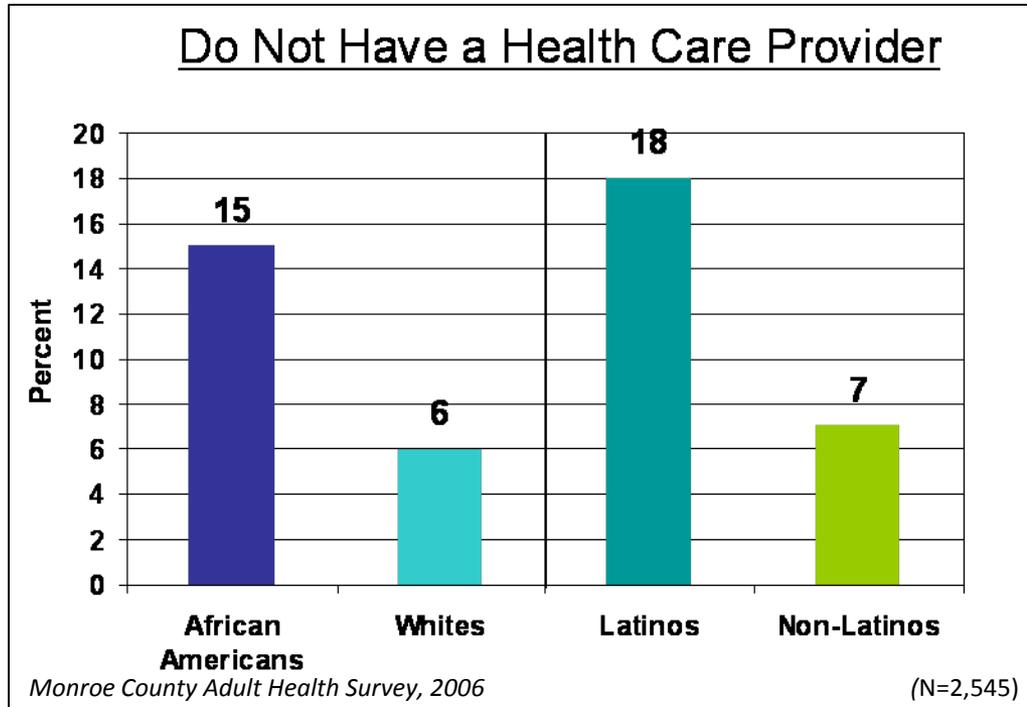
Reducing Avoidable Admissions: Ethnicity as a variable



Reducing Avoidable Admissions: SES as a variable



Reducing Avoidable Admissions: Having a doctor as a Variable



- Access as a variable
 - 18% of Latinos do not have access
 - 15% of African Americans do not have access
 - 6% of Caucasians do not have access

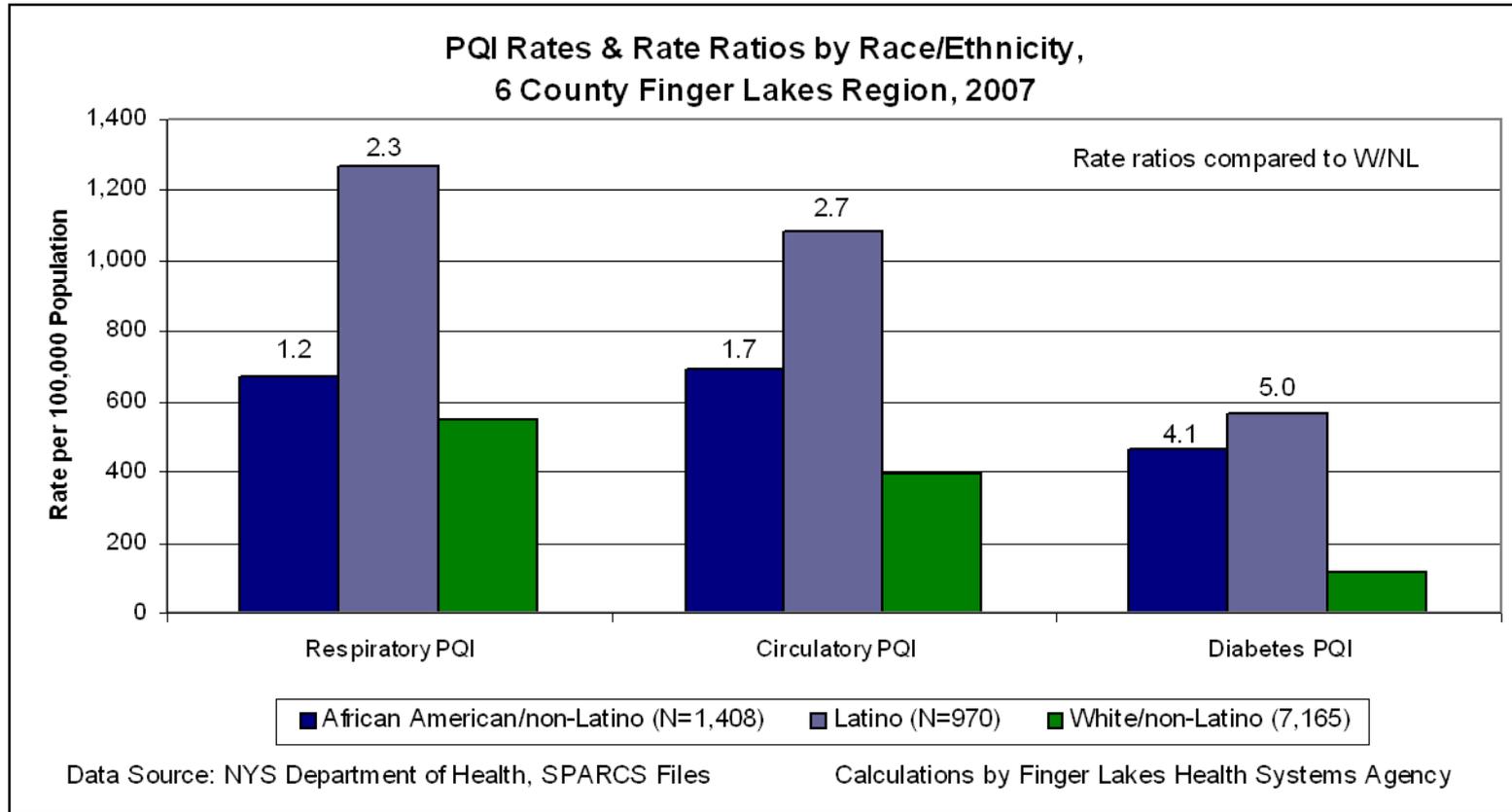
Reducing Avoidable Admissions: Disease Condition as a Variable

	Hospitalizations per 100,000 population, <u>age adjusted</u>	Percent of <u>All PQI Admissions</u>
• Respiratory Conditions	657.7 (<US)	43%
• Heart Conditions	439.3 (<US)	29%
• Diabetes	153.7 (<US)	10%
• Pediatric Asthma	81.5	31%
• Other	278.0	18%
• All Adult PQIs	1,528.7 (<US)	100%

PQI Discharges Volumes: Race/Ethnicity as a Variable

	Total	AA/NL		L		W/NL	
<u>6 Counties</u>	<u>Count</u>	<u>Count</u>	<u>%</u>	<u>Count</u>	<u>%</u>	<u>Count</u>	<u>%</u>
Respiratory PQI	4,660	518	11%	422	9%	3,720	80%
Circulatory PQI	3,570	532	15%	360	10%	2,678	75%
Diabetes PQI	1,313	358	27%	188	14%	767	58%
<u>Monroe County</u>							
Respiratory PQI	3,066	472	15%	377	12%	2,217	72%
Circulatory PQI	2,514	515	20%	298	12%	1,701	68%
Diabetes PQI	965	343	36%	147	15%	475	49%
<u>Central Subarea</u>							
Respiratory PQI	1,594	46	3%	45	3%	1,503	94%
Circulatory PQI	1,056	17	2%	62	6%	977	93%
Diabetes PQI	348	15	4%	41	12%	292	84%

PQI Discharges Rates & Ratios: Race/Ethnicity as a Variable

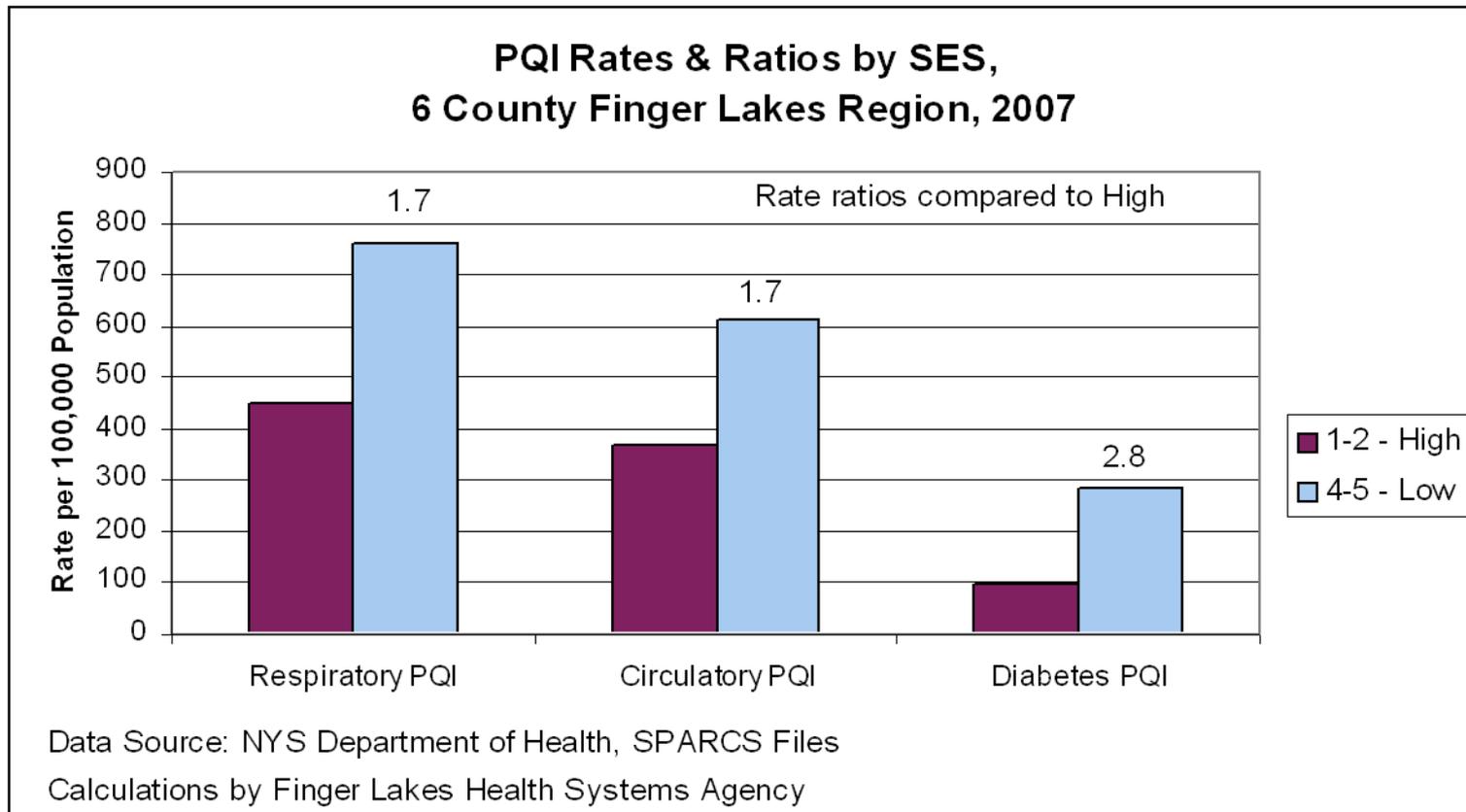


Caution must be used in interpreting rates for Latinos due to small numbers.

PQI Discharges Volumes: SES as a Variable

	Total	1-2 High		4-5 Low	
<u>6 Counties</u>	<u>Count</u>	<u>Count</u>	<u>%</u>	<u>Count</u>	<u>%</u>
Respiratory PQI	4,432	1,500	34%	1,889	43%
Circulatory PQI	3,434	1,218	35%	1,521	44%
Diabetes PQI	1,280	330	26%	699	55%
<u>Monroe County</u>					
Respiratory PQI	3,050	1,414	46%	1,213	40%
Circulatory PQI	2,528	1,176	47%	1,034	41%
Diabetes PQI	975	308	32%	559	57%
<u>Central Subarea</u>					
Respiratory PQI	1,382	86	6%	676	49%
Circulatory PQI	906	42	5%	487	54%
Diabetes PQI	305	22	7%	140	46%

PQI Discharges Rates & Ratios: SES as a Variable



PQI-Related Patient Days and Beds

	6 Counties	Monroe County		Central Subarea		
	<u>Days</u>	<u>Beds Occupied</u>	<u>Days</u>	<u>Beds Occupied</u>	<u>Days</u>	<u>Beds Occupied</u>
Respiratory PQI	25,473	70	17,091	47	8,382	23
Circulatory PQI	19,784	54	14,355	39	5,429	15
Diabetes PQI	9,950	27	7,862	22	2,088	6
Total	55,207	151	39,308	108	15,899	44

Seeing a PCP After Chronic Disease Discharge

Target - 90% at 3-5 days

days to any PCP office visit involving evaluation and management billing codes for members 18 or older, and the cumulative % of patients discharged with index diagnoses being seen in office

# of Days Post Discharge	Cumulative % of Patients	
	COPD	Heart Failure
4	14%	12%
7	27%	27%
10	37%	37%
14	44%	45%
21	53%	55%
30	59%	62%

Source: Focused Medical Analytics based on Blue Choice and Blue Choice Senior 2008 data

Conclusions from FLHSA Data

- Patients with PQI admits are generally older and insured
 - Rochester's inner city has significantly higher rates of PQI admits
 - African-Americans (1.8) and to a lesser degree Latinos (1.3) experience increased PQI admits
 - Lower socioeconomic status is an important contributor (2) to PQI admit
 - Reaching the target reduction in PQI admits requires decreasing PQI admits in the white population as well as in underserved minority populations
-

Conclusions from FLHSA Data

- Diabetes is most influenced by ethnicity and SES
 - Respiratory diseases and cardiac diseases are those most responsible for PQI admits
 - Interventions effective for all populations but especially effective in older, urban, lower SES, minority populations should be a major focus of our attention
-

Lessons from National Studies

- Of Medicare patients discharged from a hospital, 19.6% are readmitted by 30 days and 34% at 90 days. 90% viewed as preventable (1)
 - 50.2% of those readmitted did not see a physician between discharge and rehospitalization (1)
 - Most frequent causes of readmission – heart failure and pneumonia (1)
-

Lessons from National Studies

- Medicare hospitalization rates, cost of care, and hospital days were inversely correlated to frequency of primary care visits during the last 6 months of life (2)
 - More primary care visits were associated with fewer preventable hospitalizations for heart failure and COPD specifically (2)
 - Comprehensive discharge planning for elderly with Heart Failure reduced readmission rates by 25% (3)
-

Lessons from National Studies

- In 2006, only 31.9% of hospitalized patients were seen by a PCP, and only 39.8% seen by any physician that had attended to the patient in the preceding year (4)
 - With hospitalist movement growing, the numbers in 2009 are likely much higher
 - By incorporating case managers into their practices, Geisinger Health System has reduced readmissions by 20% (Personal Communication – Robert Spahr, MD. Sr. VP-Service Quality)
-

Conclusions from National Data

- Rehospitalization is the low hanging fruit of PQI hospitalization reduction
 - Most admissions are related to cardiovascular and respiratory diseases
 - Major factors in reducing Medicare re-hospitalizations are:
 - Having a primary care practitioner
 - Seeing that practitioner often post discharge
 - Having a team to **coordinate/case manage** care
-

Reducing PQI Admissions: Potential Interventions

Patient Admitted with PQI Diagnosis

Improved Hospital Discharge Planning

- Hospital-administered
- Includes med reconciliation, condition-specific education, enhanced d/c planning, phone follow-up

Coaching Patients to be More Engaged

- “Improving Transitions in Care” Program, Eric Coleman, MD (3)
- Can be funded by community effort
- Involves pt/family activation using coaching rather than case management
- Can be delivered across hospital settings

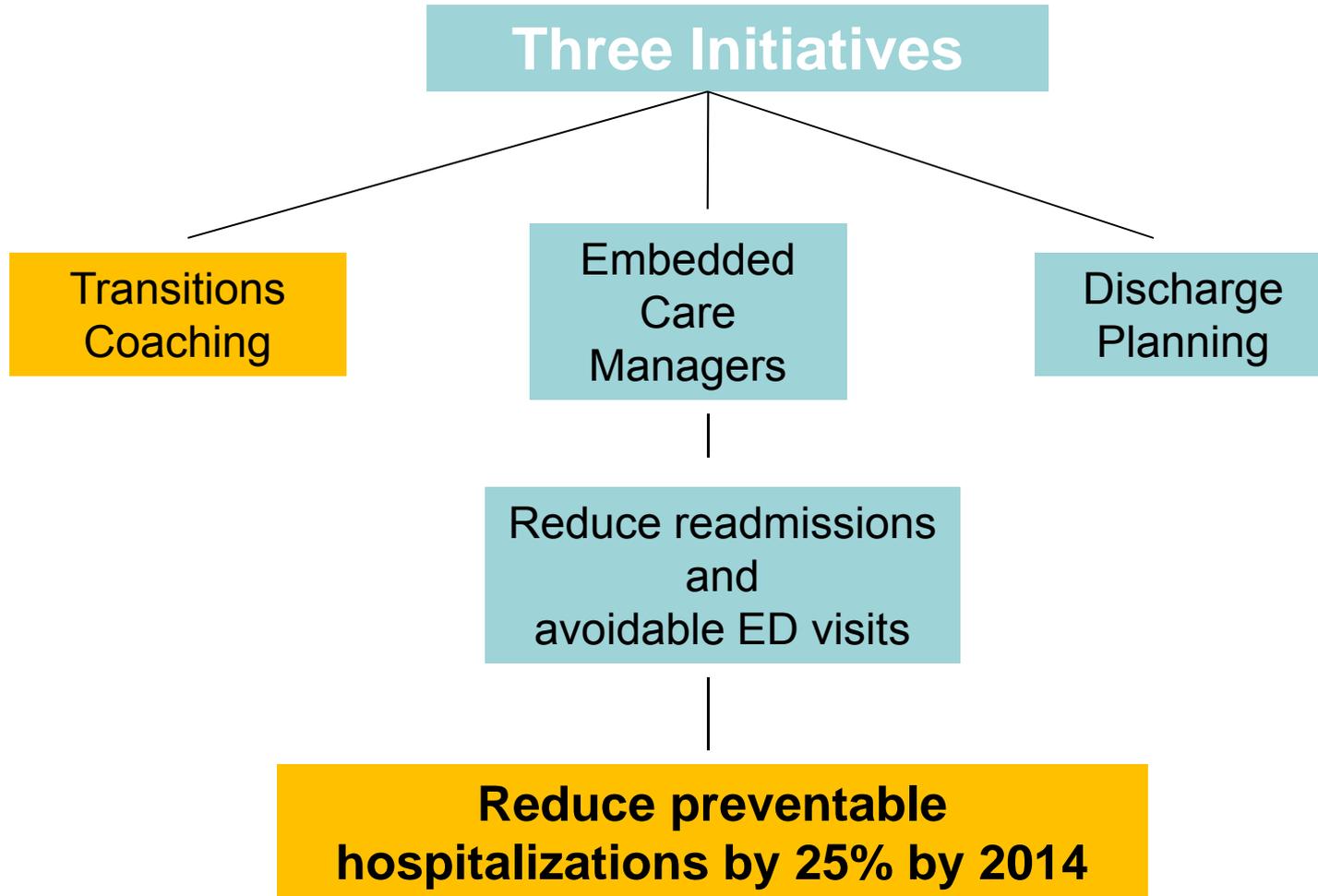
Providing Practice-Based Case Management

- Health plan funded
- Embedded case managers (CM) in primary care practices
- 1 CM/700-800 Medicare pts; 15-20% high risk pt load
- Personalized link to support svcs
- Transitions follow up
- Direct phone line access to CM

Earlier return to treating physician, more engaged patient/family, improved access to practitioners, adherence to evidence-based guideline-directed care

Reduced Readmissions

Reduce Potentially Preventable Hospitalizations



Care Transitions ProgramSM Description

- A four week program in which patients with complex care needs and family caregivers receive specific tools and work with a “Transitions CoachTM” to learn self-management skills.
- This program has four conceptual domains, or “Pillars.”
- Contact between the coach and the patient occurs in three ways:
 1. The first patient visit in the hospital before discharge
 2. One follow-up home (or SNF) visits (ideally 24-48 hours post-discharge)
 3. Three follow-up phone calls (ideally at 2, 7, and 14 days post-discharge)
 - Each visit and phone call has a specific goal that includes addressing the unique needs / goals of the patient

Progress to Date

- Training Learning Collaborative – Training for 14 coaches
September 2010 - Excellus sponsored
 - Funding – Excellus, MVP and Monroe Plan begin reimbursing for coaching services October 2010
 - Coaches Deployment – November 2010
 - Learning Collaborative to continue training – FLHSA December 2010
 - Funding – HEAL grant to begin reimbursing for coaching services to non-covered patients Dependent on state release of funding
-

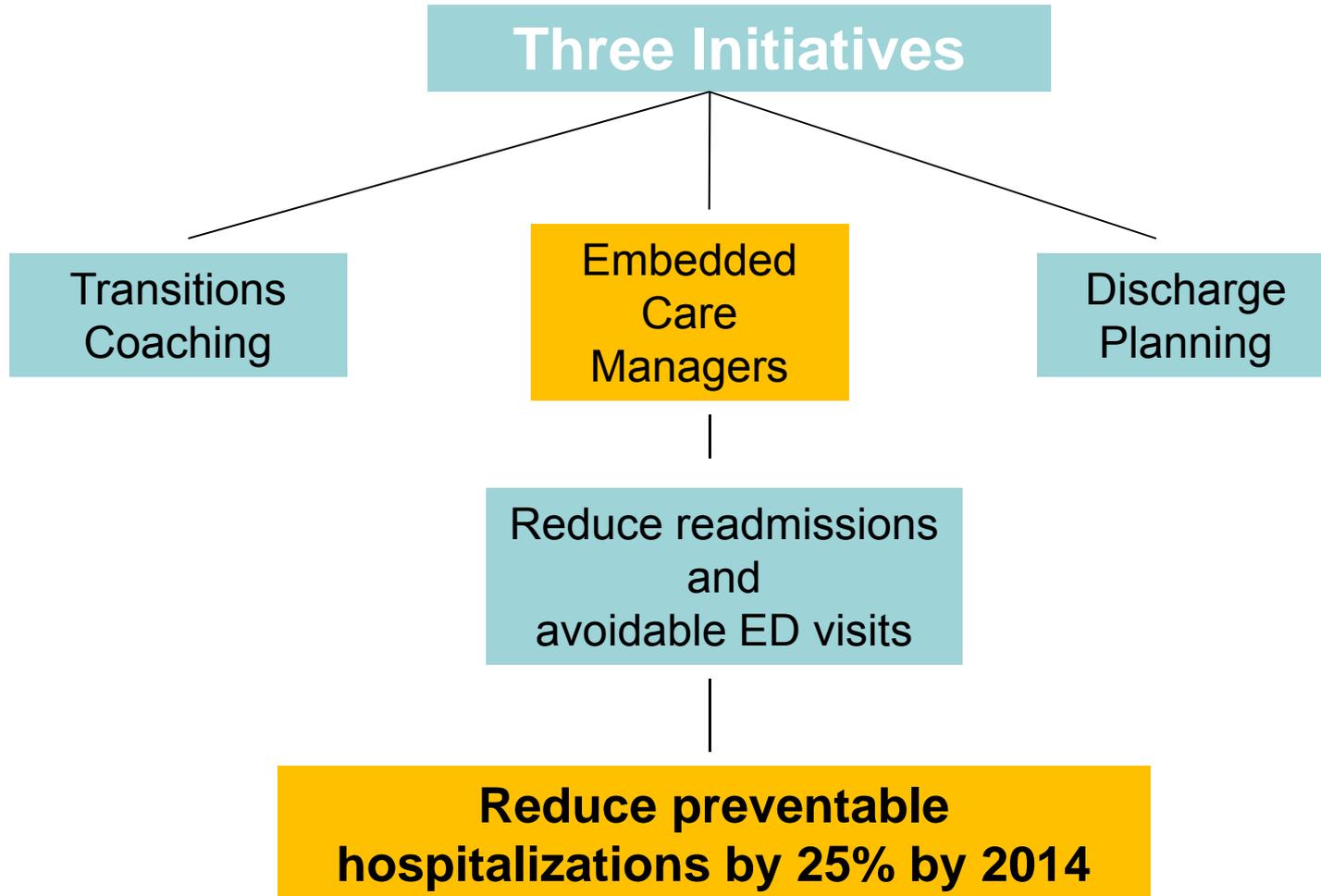
PQI Aggregate Coaching Data

Measure	Oct – Dec 2010	Jan – Feb 2011**	Totals to Date
Patients agreeing to coaching in hosp	219	234	453
Patients who Accepted Coaching (Patients seen at home)	130	128	258
Acceptance rate	59%	55%	57%
# completing program	104	77	181
% completing	80%	60%	70%
# readmitted to hospital in 30d*	15	8	23
% readmitted in 30 d	14.4	10.5%	12.7%
#/% T&R from ED in 30 d*	6/6	1/1.3	7/3.9

*-based on coaches knowledge of visits, not health plan data

**- includes Monroe Plan Data; # completing program, hospitalization and ED data based only on January enrollees

Reduce Potentially Preventable Hospitalizations



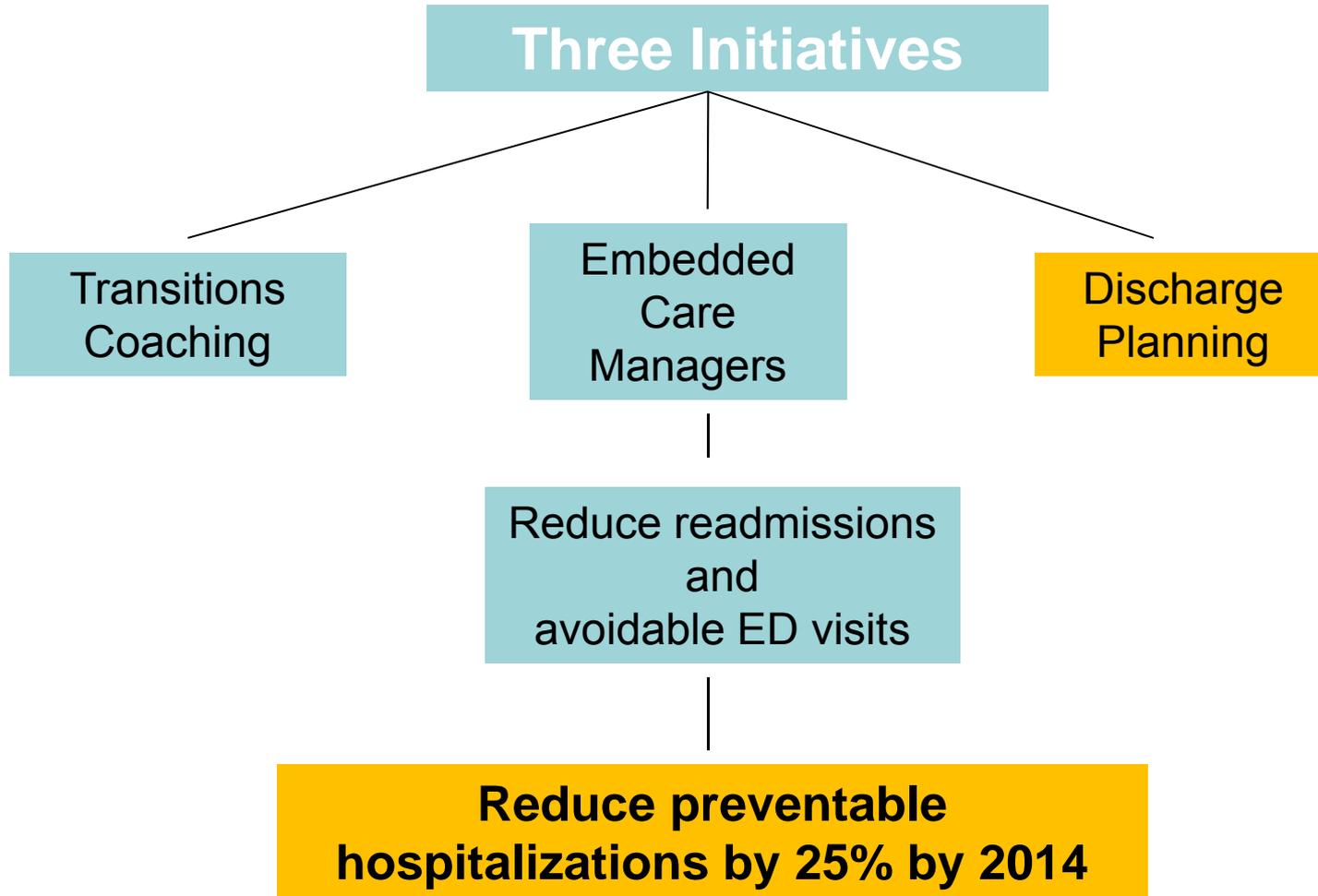
The Care Manager

- Works in collaboration with all members of an interdisciplinary team of physicians, hospital discharge planners, RN's, CSW and coaches to facilitate the effective transition after hospitalization discharge
 - Serves as the single point of contact for identified patients with chronic conditions that put them at risk for readmission
 - Coordinates services and act as the liaison between the practice and community agencies
-

Progress To Date:

- Secured funding to pilot 9 Care Managers in PCP Setting
 - Projected Hire Date: February 2011
 - Confirmed Pilot sites
 - Training and Orientation February 2011
 - Functions Defined:
 1. Identifying at-risk patients
 2. Interface with medical and social support - community services
 3. Medication reconciliation / management
 4. Self-management skills
 5. Caregiver support and education
 6. Coordination with other providers
-

Reduce Potentially Preventable Hospitalizations



Four Community Standards for Discharge Planning

Creation of a region-wide set of discharge/transition standards that, when fully implemented, will enhance patient safety and safe transition from hospital to community-based setting and lead to a reduction in the number of avoidable hospital readmissions.

Four Community Standards for Discharge Planning

1. Patient/Family centrality to the discharge planning process
 2. Medication reconciliation
 3. Information transfer
 4. Post-discharge follow up
-

Progress To Date

- URMC pilot on complex surgical floor
 - Unity piloting “teach backs”
 - RGH examining readmission circumstances; social, medical, home care plan
 - Risk Assessments
 - Looking ahead: Transportation, Indigent Medications, Patient liason and Transition Coaches Implementation and Risk Assessment
-

Treated & Release (T&R) ED Visits by 6 County Finger Lakes Region* Residents, 2006-07 Avg.

Average T&R ED Visits, 6 County Finger Lakes Region, 2006-07			
	Monroe County	Central Subarea	6 Counties
Adults (15+)			
Avg Annual	150,691	72,327	223,017
Avg Daily	413	198	611
Avg per hour	17	8	25
Peak interval	10am-12pm		
Peds (0-14)			
Avg Annual	31,483	15,454	46,936
Avg Daily	86	42	129
Avg per hour	4	2	5
Peak interval	6pm-8pm		
Data Source: NYS Dept of Health, SPARCS Files			

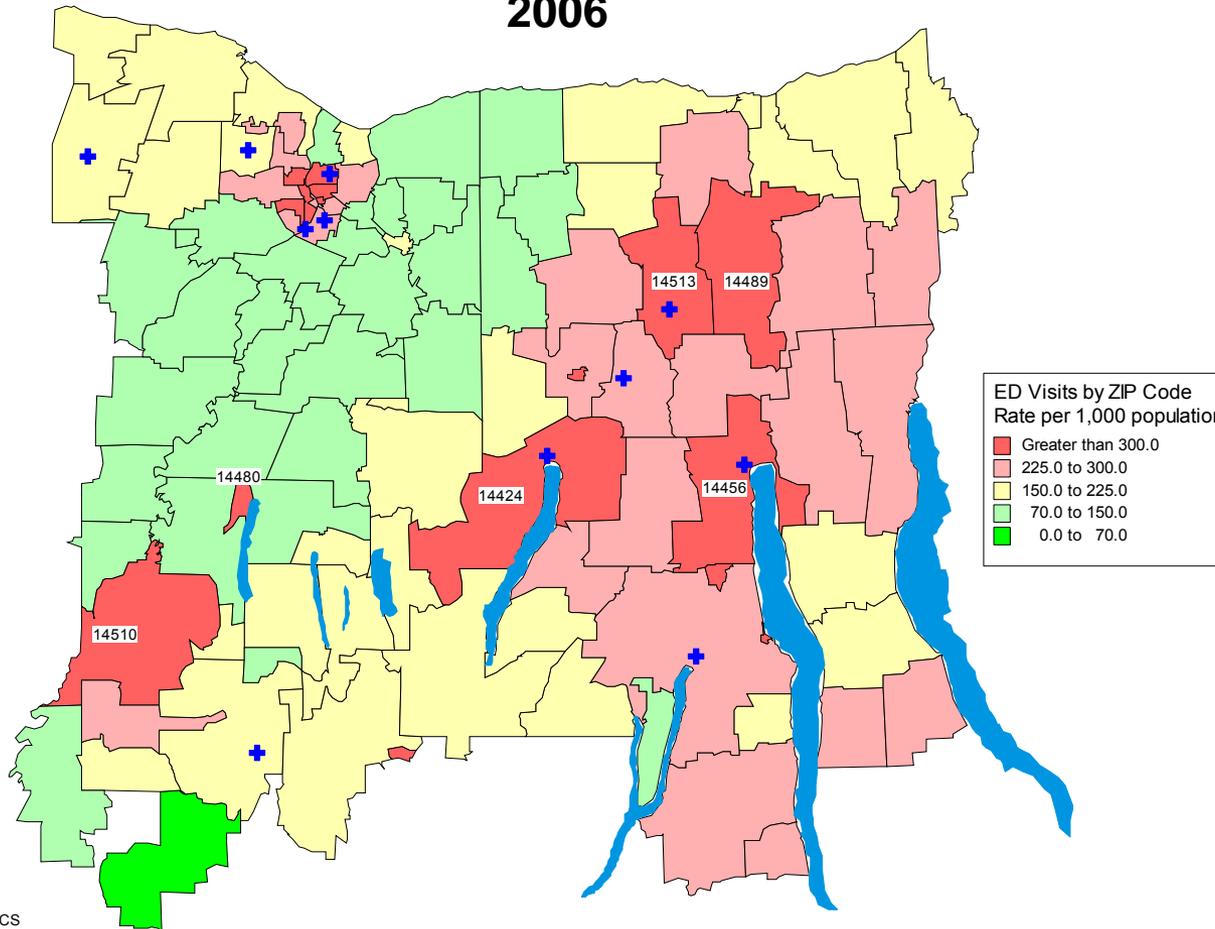
- There are two types of ED visits:
 - Treated & Admitted: results in a hospital admission, ~20%
 - Treated & Released: patient is not admitted, ~80%

*The six-county Finger Lakes region comprises Livingston, Monroe, Ontario, Seneca, Wayne, and Yates counties.

Adult T&R ED Visit Rates by ZIP Code

ED Visits by ZIP Code Age 15 and older 2006

- Hospitals +
- Unity - Park Ridge
 - Lakeside Memorial
 - Rochester General
 - Highland
 - Strong Memorial
 - Newark Wayne
 - Clifton Springs
 - F.F. Thompson
 - Geneva General
 - Soldiers & Sailors
 - Nicholas Noyes



ED Discharges from Facilities by County

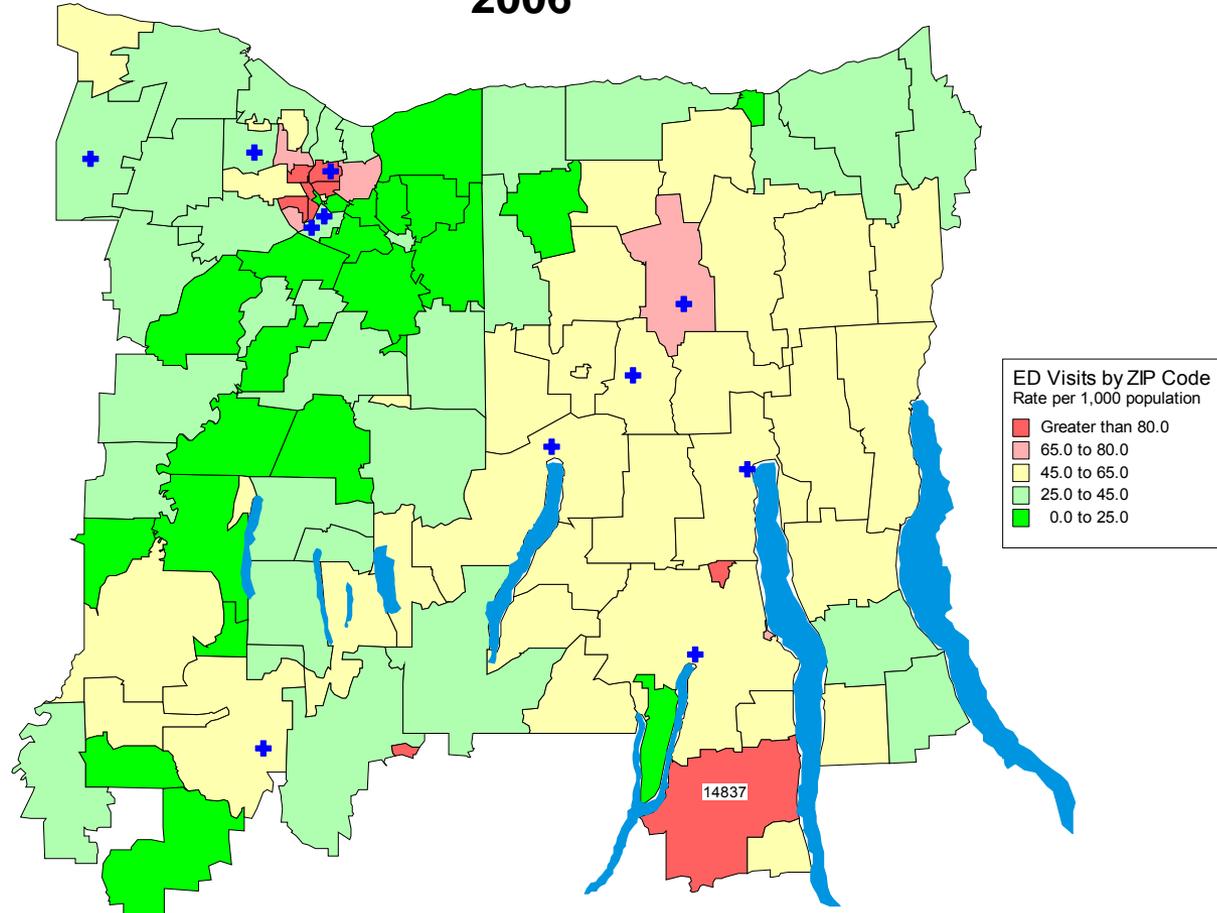
- Monroe = 163,583
- Central Subarea = 120,461
 - Livingston = 11,312
 - Ontario = 75,426
 - Wayne = 24,299
- Yates = 9,424

Ped T&R ED Visit Rates by ZIP Code

ED Visits by ZIP Code Age 0-14 2006

Hospitals +

- Unity - Park Ridge
- Lakeside Memorial
- Rochester General
- Highland
- Strong Memorial
- Newark Wayne
- Clifton Springs
- F.F. Thompson
- Geneva General
- Soldiers & Sailors
- Nicholas Noyes

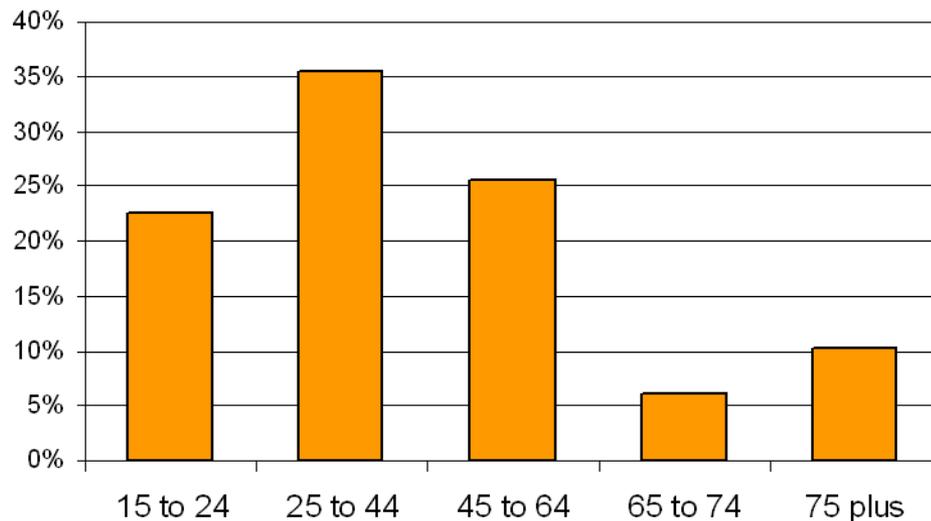


Source: NYSDOH - SPARCS

T&R ED Visits – Age as a Variable

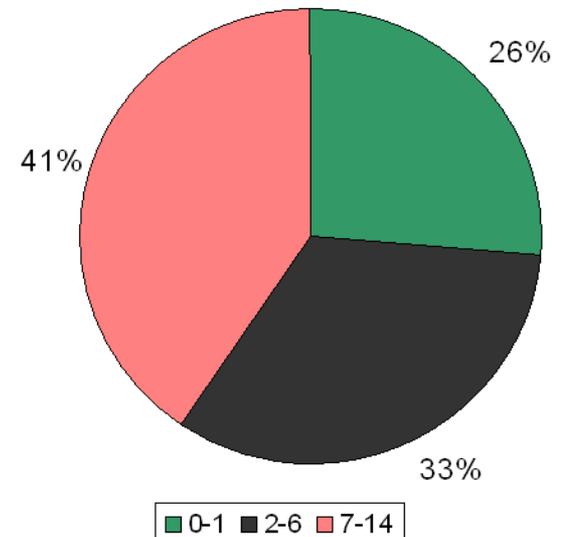
Percent Annual Average Treated & Release ED Visits,
6 County Finger Lakes Region, 2006-07

Adults
(N=233,017)



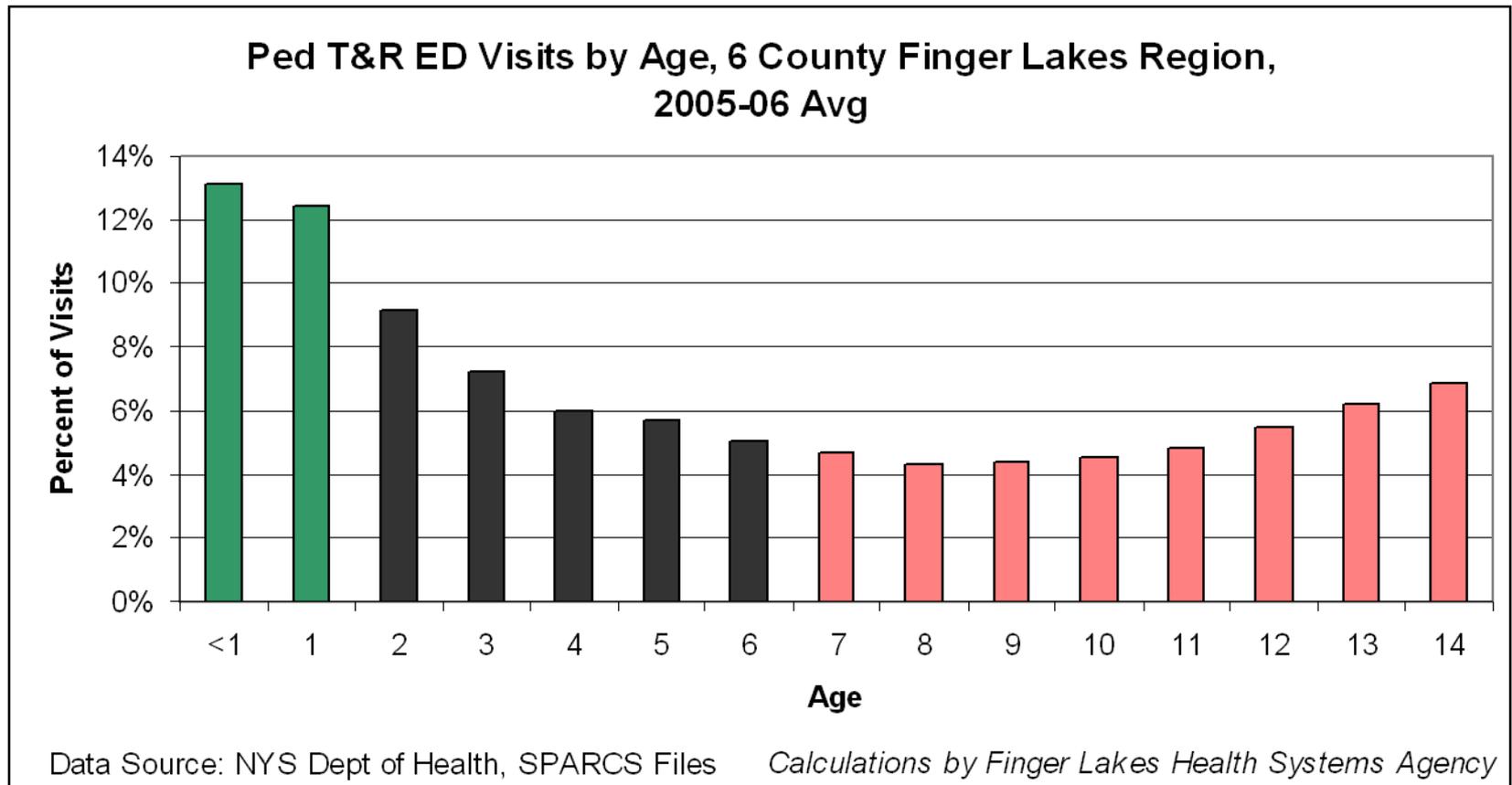
Data Source: NYS Dept of Health, SPARCS Files

Peds
(N=46,936)

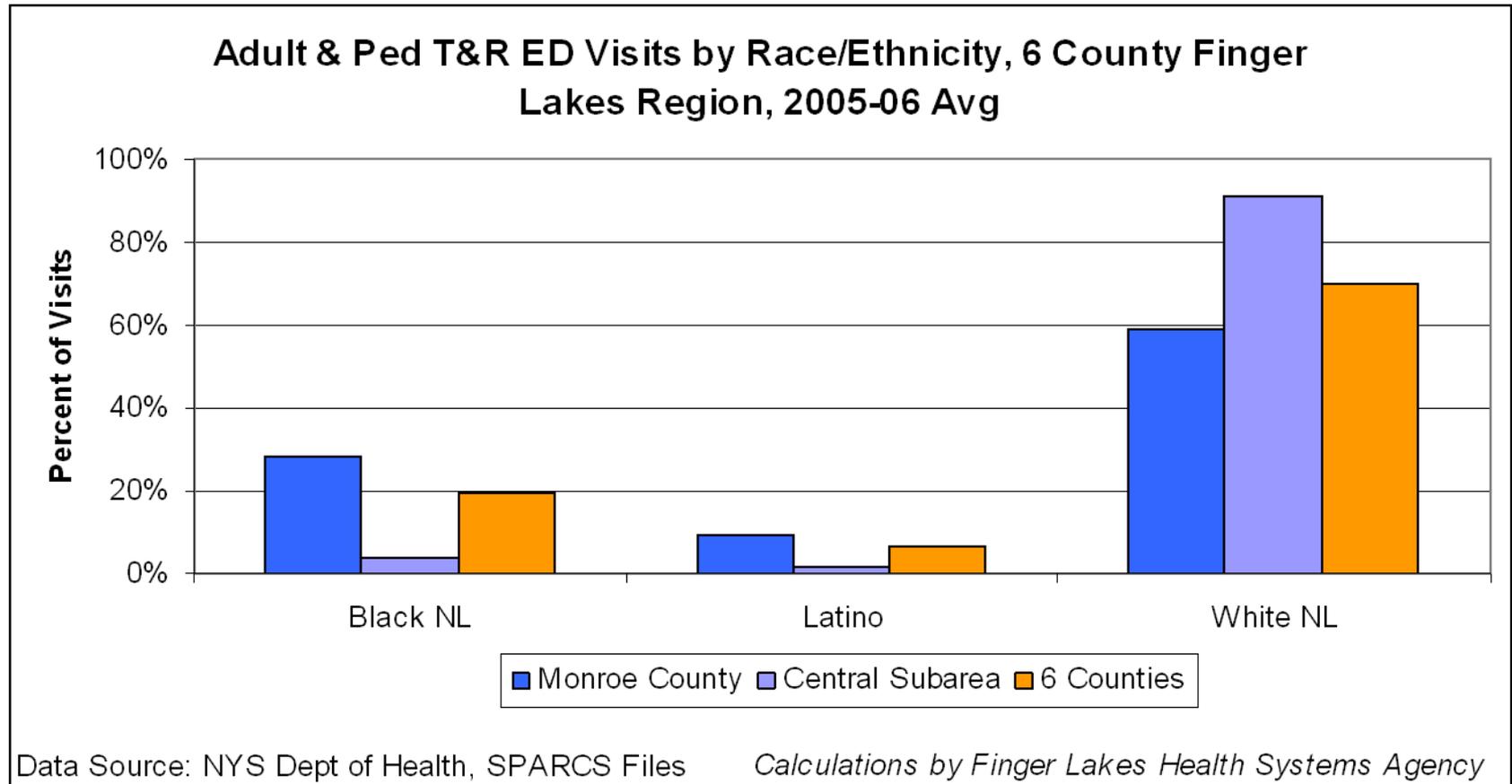


Calculations by Finger Lakes Health Systems Agency

T&R ED Visits – Peds by Age

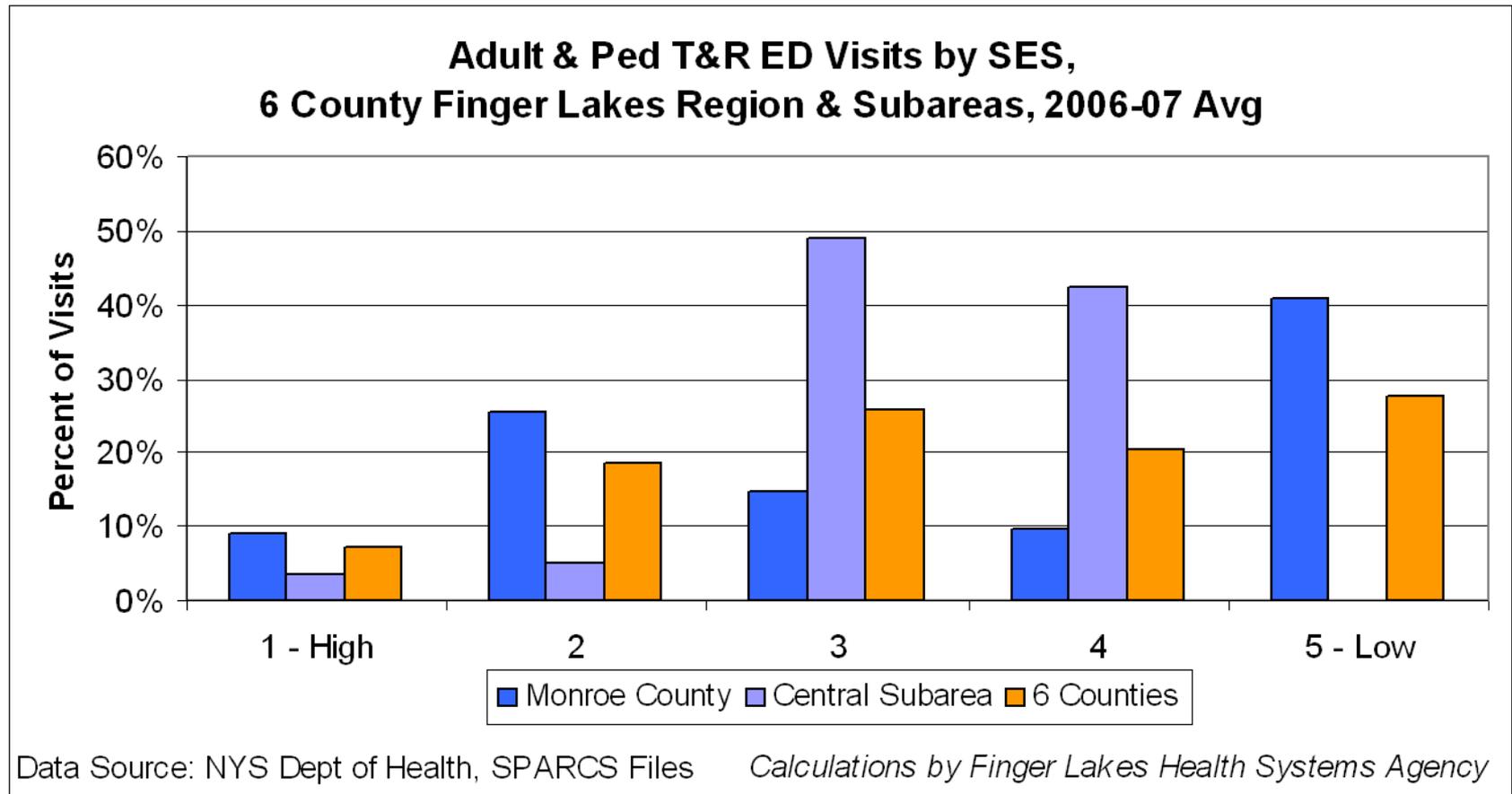


T&R ED Visits – Race/Ethnicity as a Variable



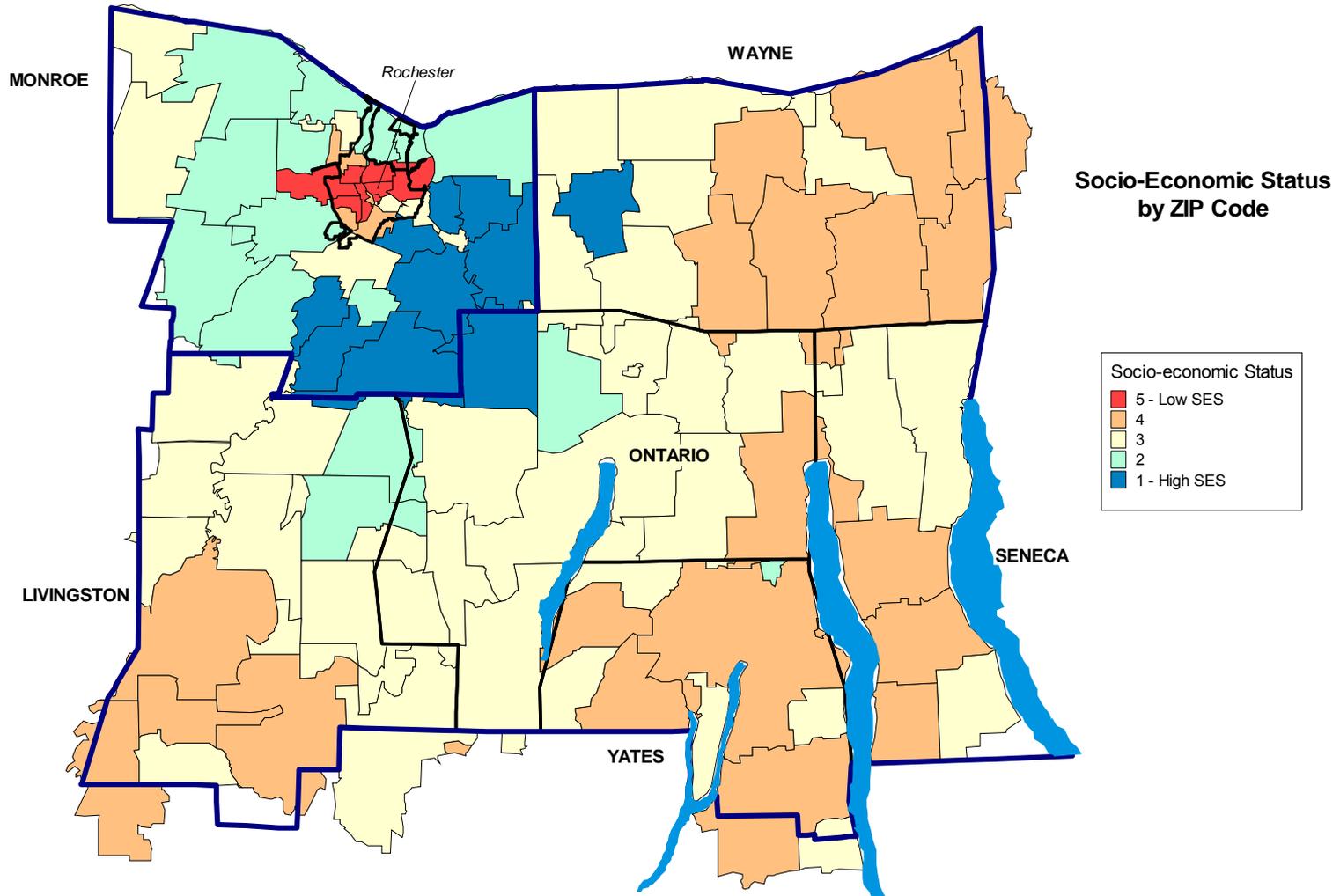
N=263,118

T&R ED Visits – SES as a Variable

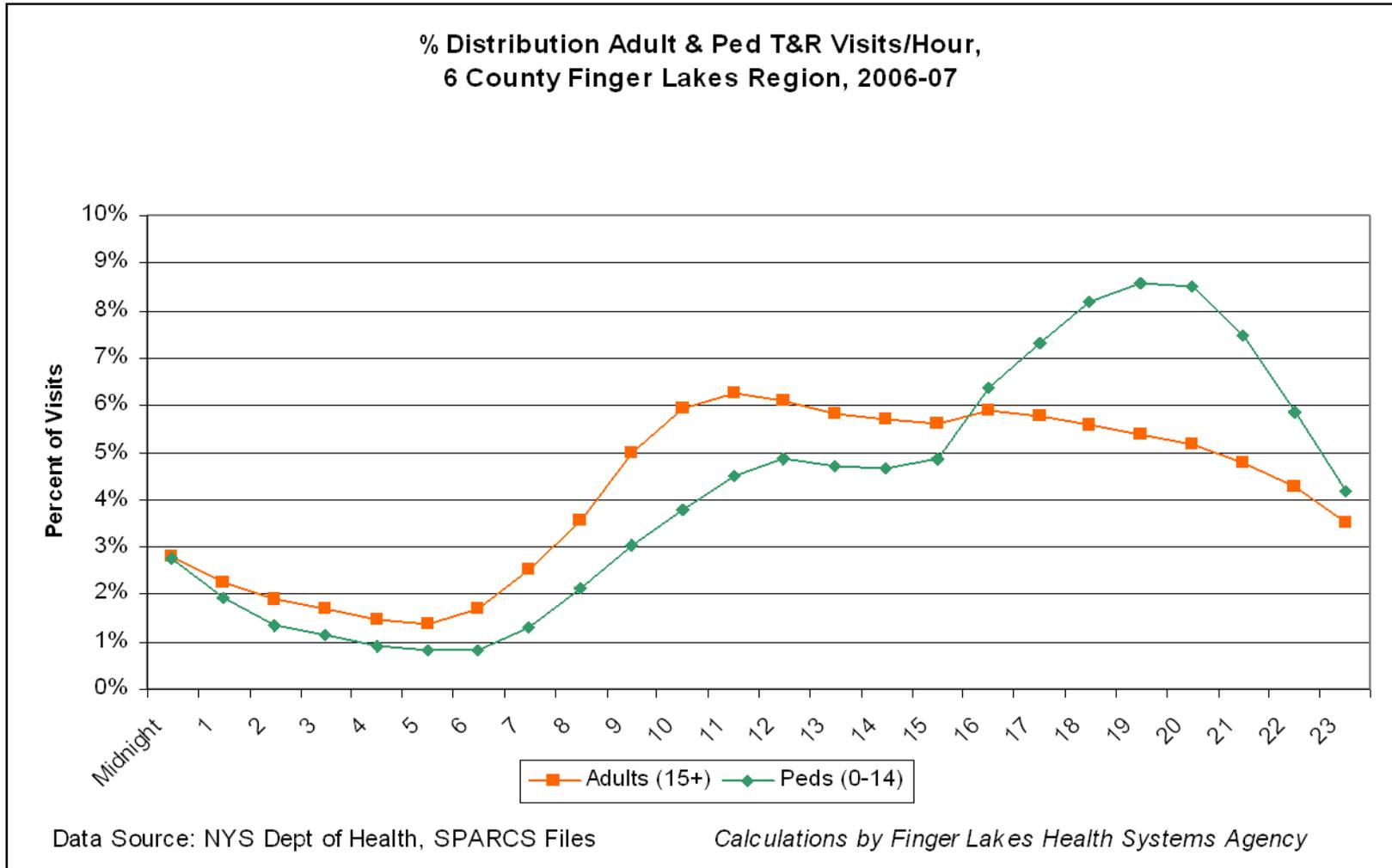


N=269,953

SES Across the 6 County Finger Lakes Region



Timing of T&R ED Visits: Not Just an After-Hours Problem



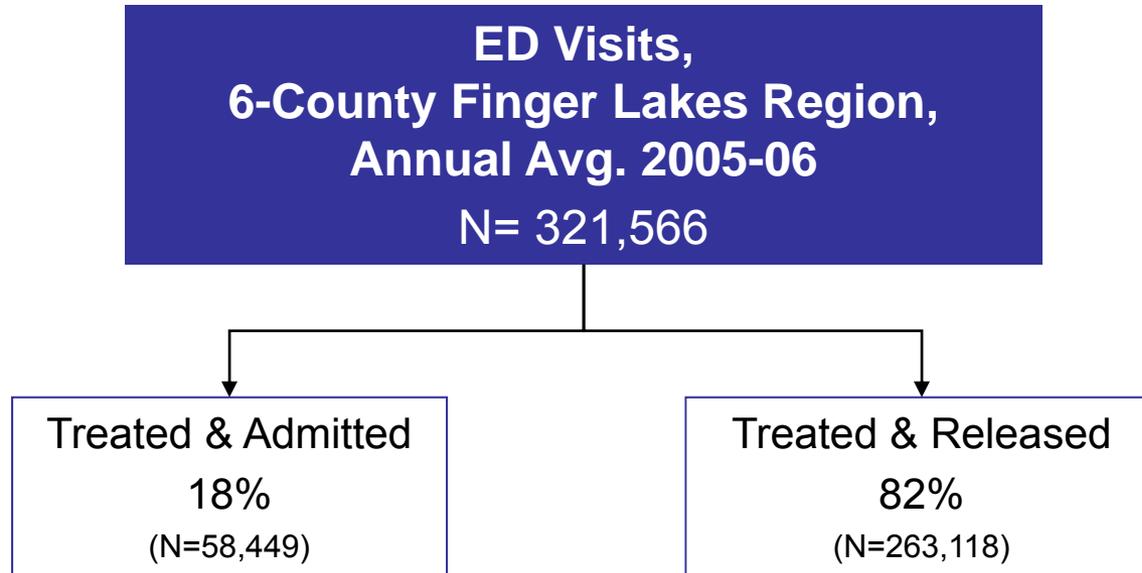
T&R ED Visits – Top 20 Reasons for Adults Visiting the ED

- **Respiratory Symptoms** – Respiratory and other chest symptoms (1), Asthma (18)
 - **Gastrointestinal Symptoms** – Abdominal and pelvic symptoms (2), Digestive symptoms (17), Gastroenteritis (20)
 - **Poorly defined Symptoms** – General symptoms (3)
 - **Trauma** – Back pain (4), Head and neck pain (5), hand trauma (6), Open head wounds (7), non-specific injury (8), Sprains and strains (9), ankle and foot (11), leg (13), joint problems (14), General pain syndromes (15), Upper limb (19)
 - **Infections** – Urinary (10), Cellulitis (16)
 - **Medication and drug related problems** – Medication adverse events (12)
-

T&R ED Visits – Top 20 Reasons for Peds Visiting the ED

- **Acute infections** – Otitis media (1), upper respiratory infections (2), fever (3), pharyngitis (7), strep throat (14), pneumonia (19)
 - **Nausea, diarrhea and abdominal pain** – Gastroenteritis and colitis (4), vomiting (10), other GI/Pelvic symptoms (18)
 - **Trauma** - Forehead and eyebrow (5), head (9), face/scalp/neck (11), open wound of head (15), finger (16), ankle/foot (17), lip (20)
 - **Asthma/Pulmonary** – Acute asthma (6), croup (12), unspecified asthma (13)
 - Other unknown disease – (8)
-

Scope: ED Visits from 6-County Finger Lakes Residents



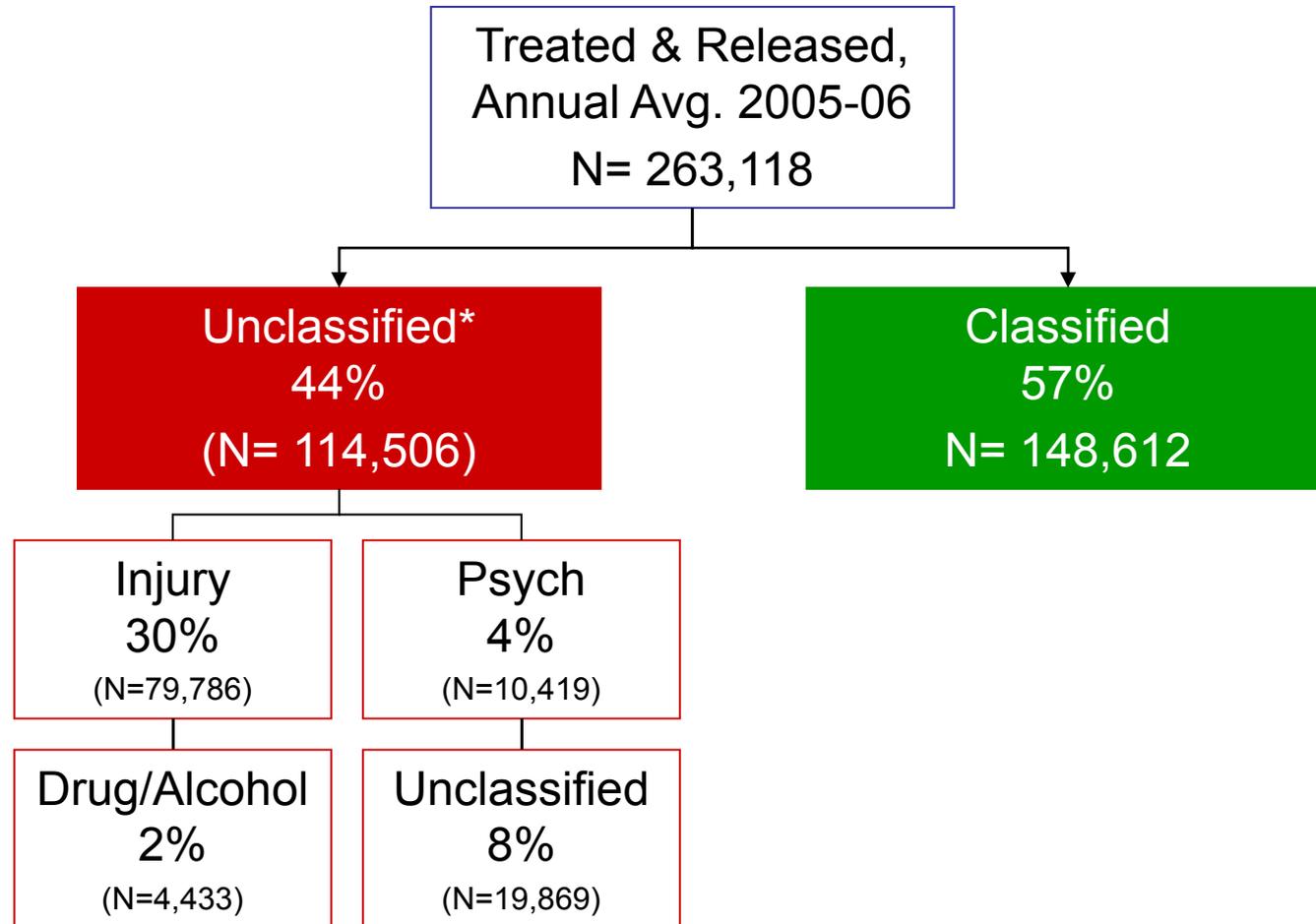
- What proportion of T&R visits were for conditions that might have been prevented or avoided with better access to primary care?

Analytic Tool: NYU ED Algorithm (1)

- **Non-emergent** – Medical care is not required within 12 hours
- **Emergent-primary care treatable** – Treatment is required in 12 hours, but care could have been provided effectively and safely in an ambulatory care setting
- **Emergent-ED care needed: preventable/avoidable** – Immediate care in an ED setting is needed, but the condition could potentially have been prevented or avoided with timely and effective ambulatory care
- **Emergent-ED care needed: not preventable/avoidable** – Immediate care in an ED setting is needed and the condition could not have been prevented or avoided with ambulatory care

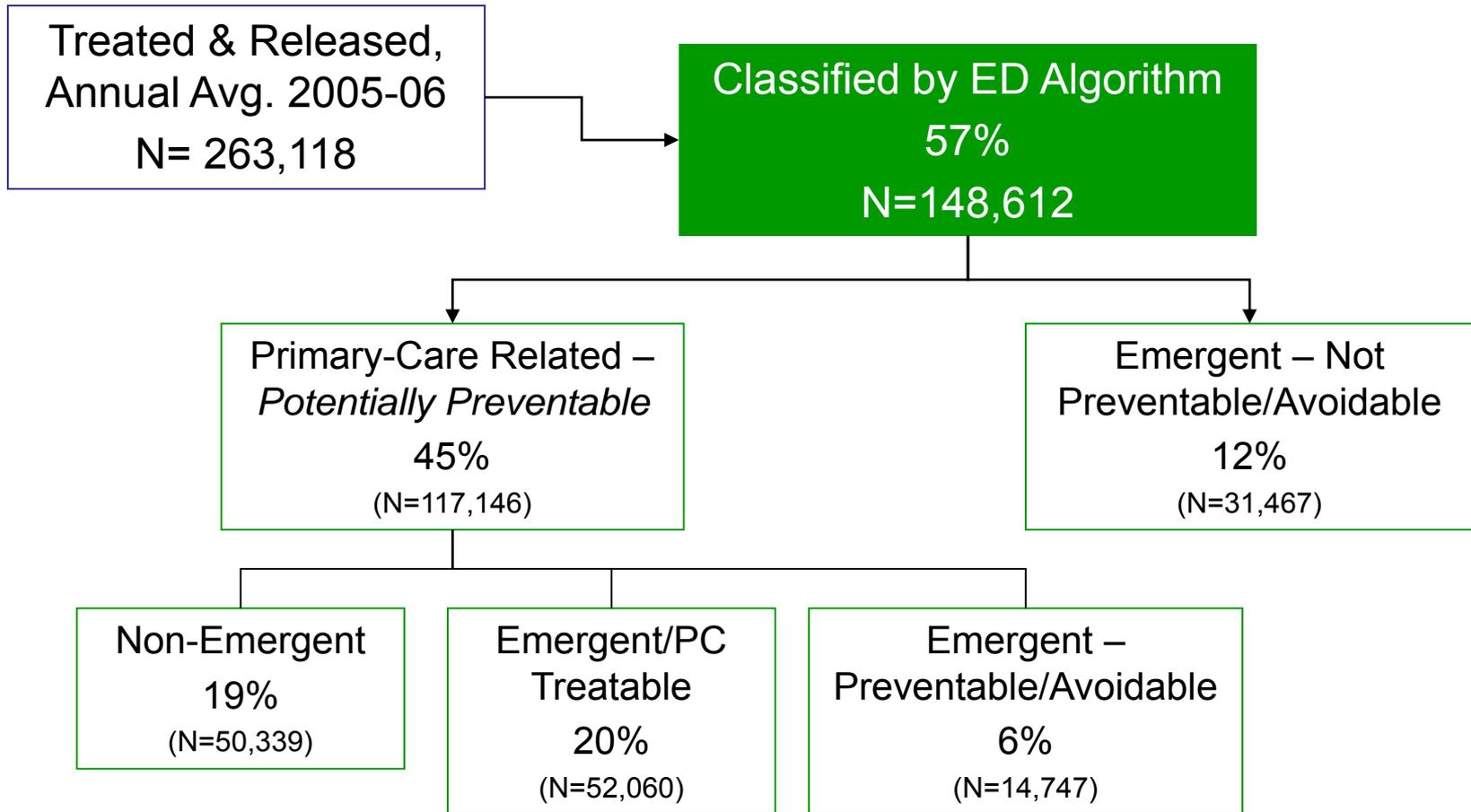
(1) Billings, J, Parikh, N, & Mijanovich, T. (2000 November). Emergency department use: The New York story. *Issue Brief (Commonwealth Fund)*, 434, 1-12.

Classification of T&R ED Visits w/ the ED Algorithm



**The algorithm separates out visits with a primary diagnosis involving mental health, substance abuse, or injury since these conditions are difficult to classify.*

Percent of T&R Visits that are Primary Care-Related

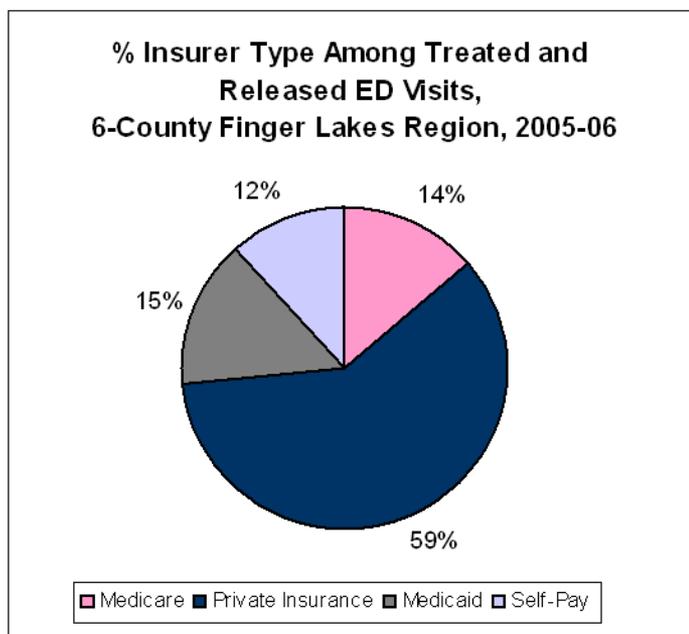


Total Classified Potentially Preventable T&R in 2005-6: 117,146
2014 Target Reduction: 15% = 17,572 visits

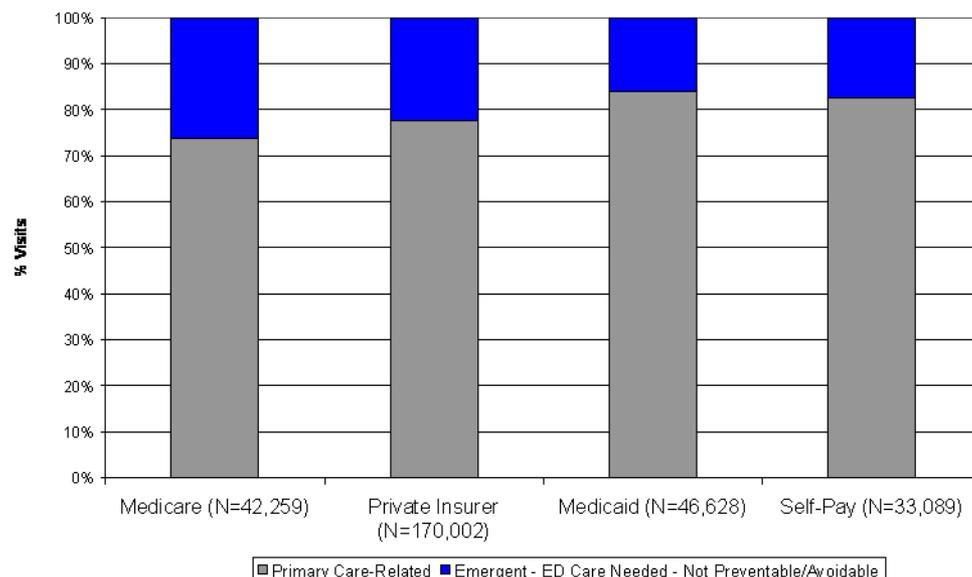
Classified T&R Visits by Demographic Characteristics

Percent Distribution of Classified Treat and Release ED Visits, 6 County Finger Lakes Region, Annual Avg 2005-06				
	Primary Care-Related (N=117,145)		Emergent - ED Care Needed - Not Preventable/ Avoidable (N=31,467)	
Sex				
Female	69,127	59%	18,161	58%
Male	48,019	41%	13,306	42%
Age Groups				
0-14	23,007	20%	3,072	10%
15-24	20,254	17%	4,418	14%
25-44	35,711	30%	9,709	31%
45-64	23,291	20%	8,175	26%
65+	14,883	13%	6,092	19%
Patient Residence				
Monroe County	75,579	65%	21,340	68%
Central Subarea	41,566	35%	10,127	32%
Race/Ethnicity				
African American/Non-Latino	26,846	23%	6,055	19%
Latino	9,453	8%	1,954	6%
White/Non-Latino	76,513	65%	22,442	71%
Other	2,696	2%	619	2%
Unknown	1,638	1%	397	1%
Socioeconomic Index				
1 - High	6,945	6%	2,668	9%
2	18,951	16%	6,262	20%
3	30,833	26%	8,118	26%
4	25,174	22%	6,035	19%
5 - Low	34,919	30%	8,299	26%
Source: NYS Department of Health, SPARCS Files				

Reducing Primary Care-Related ED Visits – Insurance Status as a Variable



Classified Treat & Release ED Visit Type by Insurer, 6-County Finger Lakes Region, 2005-06

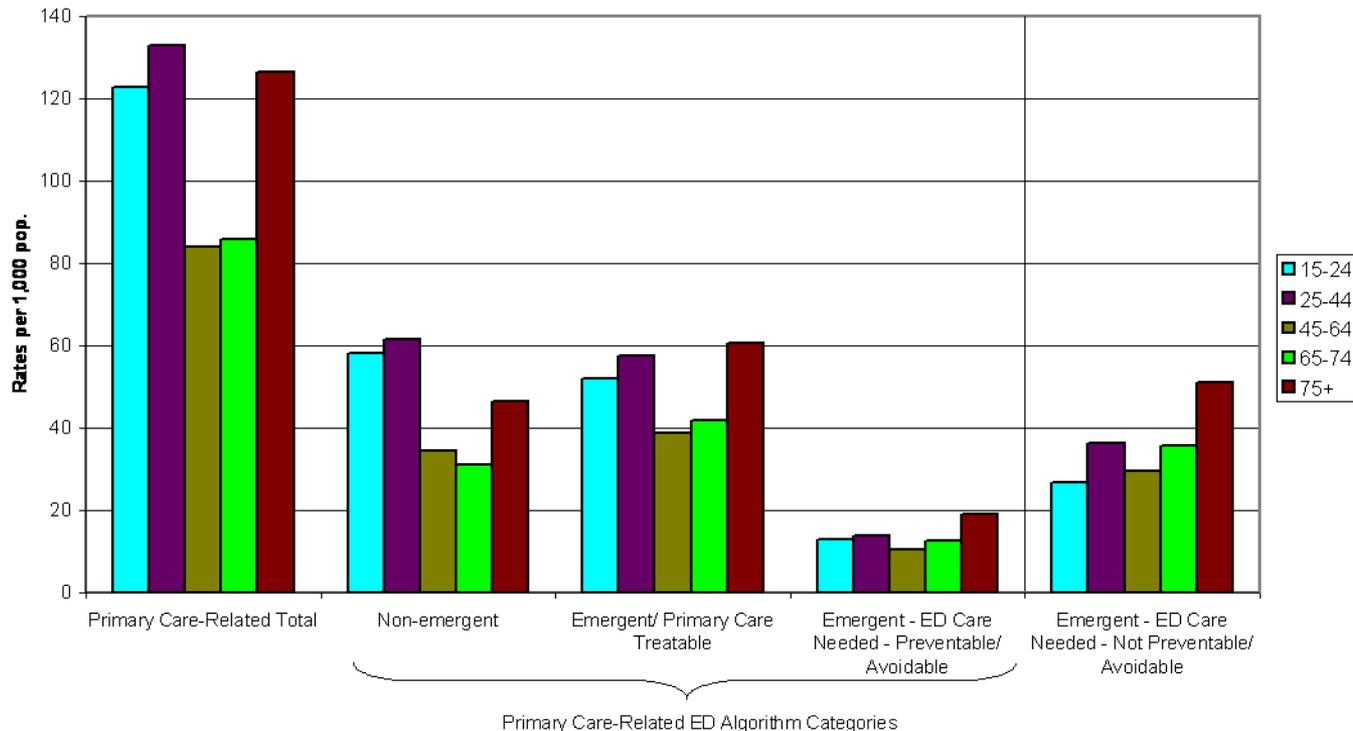


Data Source: NYS Dept of Health, SPARCS

- ~60% of Treated & Released ED visits were made by 6-County Finger Lakes residents who had private insurance (N=299,648).
- ED use for ambulatory care sensitive conditions did not significantly vary by insurance status.
- Insurance is not the driver in use of the ED for primary care.

Reducing Primary Care-Related ED Visits – Age as a Variable

Classified ED Use Rates by Type of ED Visit by Adult Age Groups, 6-County Finger Lakes Region, 2005-06



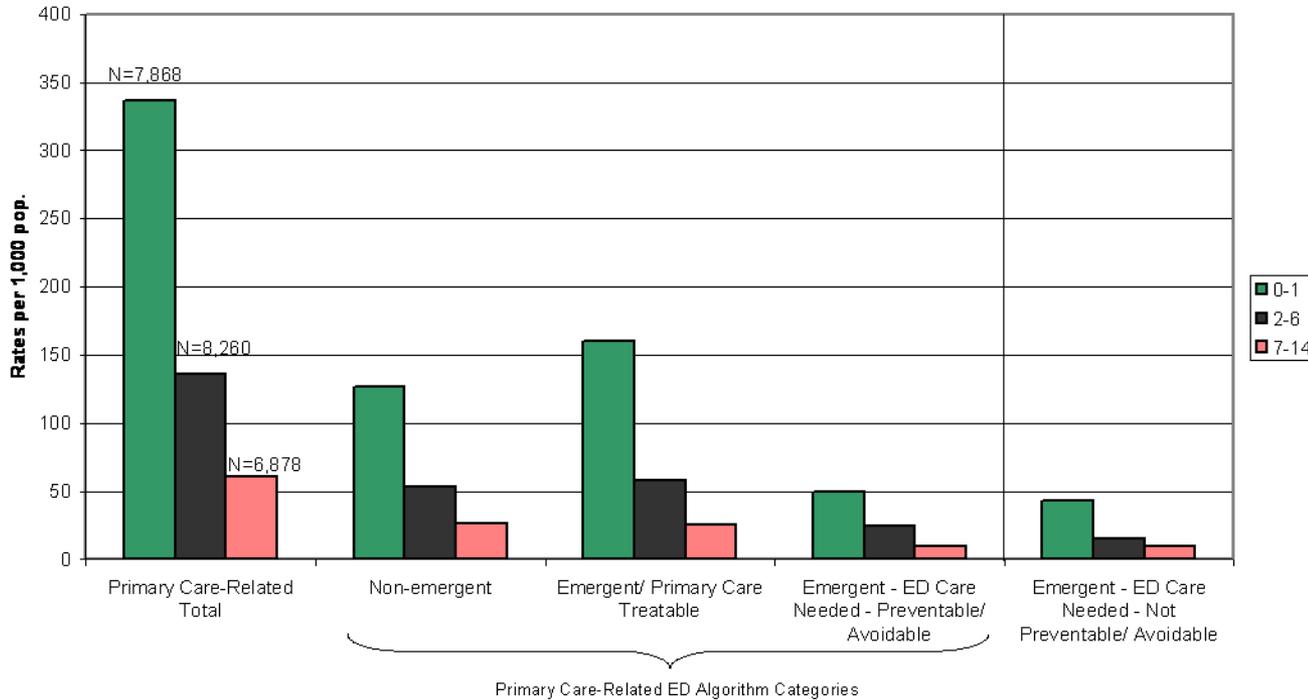
- Visits from adults 15-44 represent 48% of all primary care-related visits (N=111,929).

Data Source: NYS Dept of Health, SPARCS files

The 6-County Finger Lakes Region comprises Livingston, Monroe, Ontario, Seneca, Wayne, and Yates counties.

Reducing Primary Care-Related ED Visits – Age as a Variable

Classified ED Use Rates by Type of ED Visit by Pediatric Age Groups, 6-County Finger Lakes Region, 2005-06



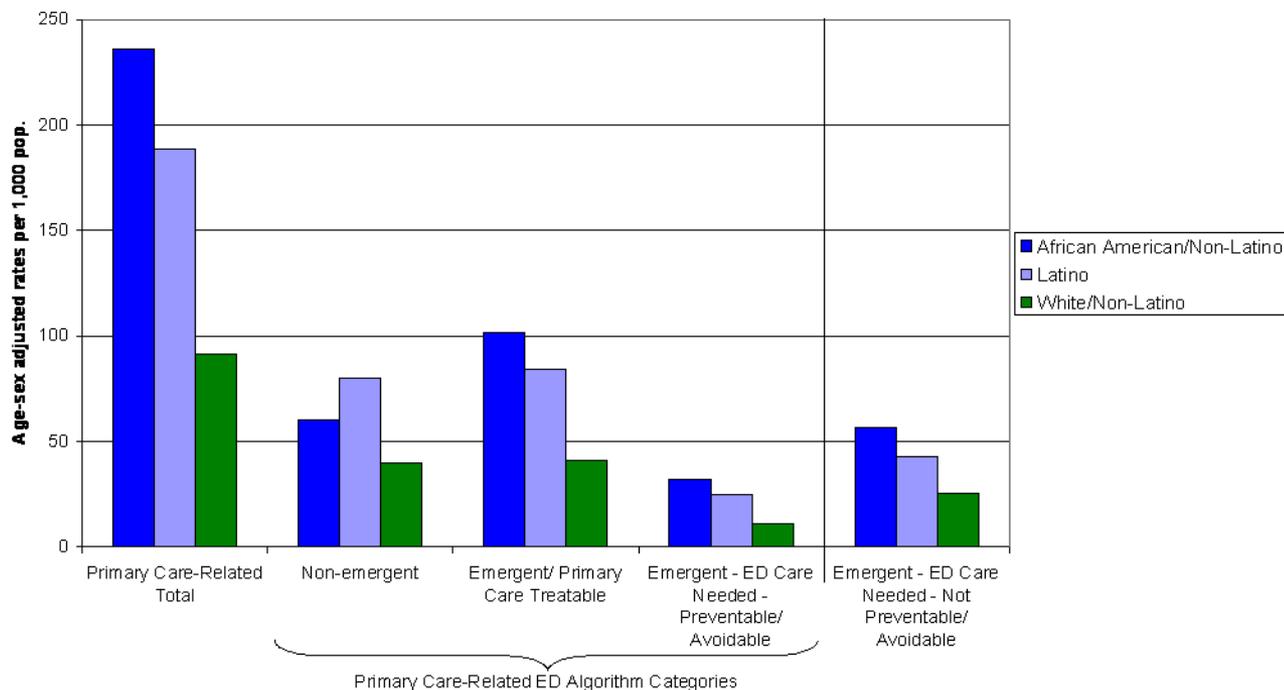
- On average from 2005-06, visits from children 0-14 represented 20% of all primary care-related visits (N=23,006).

Data Source: NYS Dept of Health, SPARCS files

The 6-County Finger Lakes Region comprises Livingston, Monroe, Ontario, Seneca, Wayne, and Yates counties.

Reducing Primary Care-Related ED Visits – Race/Ethnicity as a Variable

**Classified ED Use Rates by Type of ED Visit
by Race/Ethnicity, 6-County Finger Lakes Region, 2005-06**



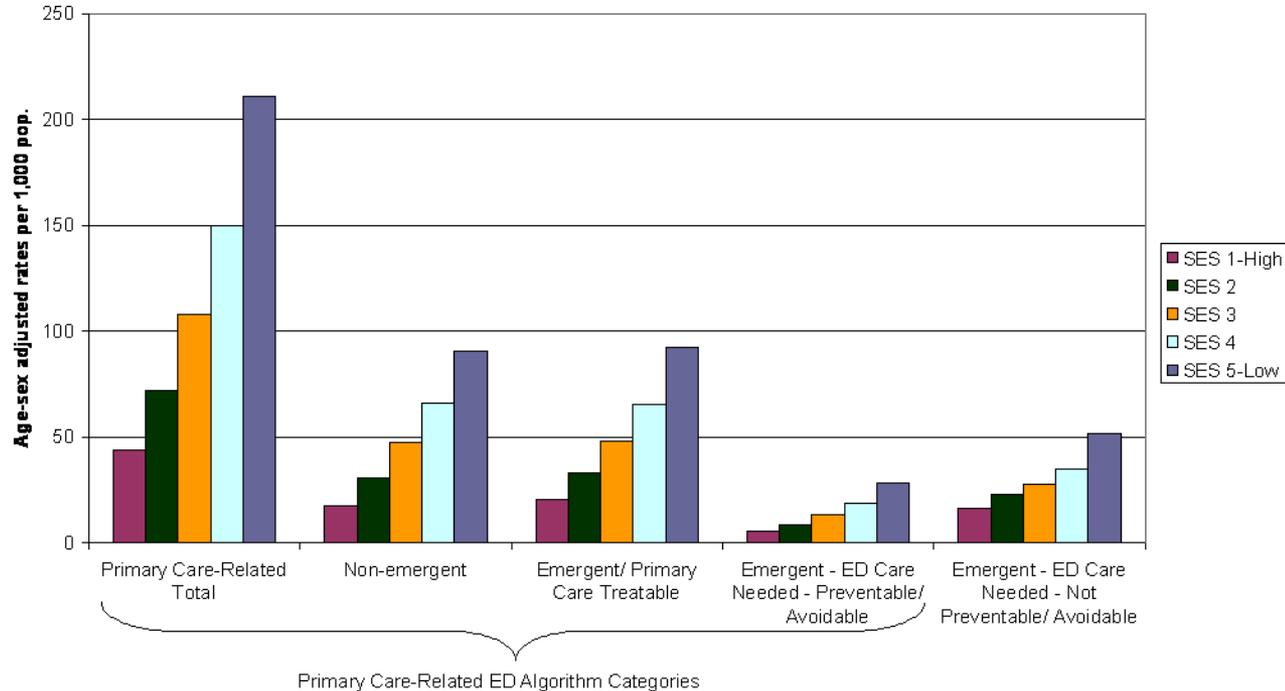
Data Source: NYS Dept of Health, SPARCS files
Data are age-sex adjusted to 2000 U.S. population

The 6-County Finger Lakes Region comprises Livingston, Monroe, Ontario, Seneca, Wayne, and Yates counties.

- African American/non-Latinos (2.6x) and Latinos (2.0x) are more likely to make primary care-related ED visits than White/non-Latinos.

Reducing Primary Care-Related ED Visits – Socioeconomic Status (SES) as a Variable

Classified ED Use Rates by Type of ED Visit by SES, 6-County Finger Lakes Region, 2005-06



- On average from 2005-06, individuals with the lowest SES (5) were almost 5 times as likely to make a primary care-related ED visit than those with the highest SES (1).

Data Source: NYS Dept of Health, SPARCS files
Data are age-sex adjusted to 2000 U.S. population

The 6-County Finger Lakes Region comprises Livingston, Monroe, Ontario, Seneca, Wayne, and Yates counties.

Conclusions from FLHSA Compiled Data

- The primary focus to reduce primary care-related ED visits is on patients of lower SES, especially African Americans and Latinos ages 15 to 44, and newborns (ages 0-1).
 - The majority of ED visits are made by white, mid- and lower SES individuals. Interventions must target this group as well
 - Insurance status is not the major driver of ED use.
 - Peak time for ED visits is afternoon and early evening; times that office practices are or can be “open.”
 - Visits are for symptoms and trauma in adults; infections, trauma and symptoms in children
 - We need more local data on reasons why people seek primary care in the ED and potential barriers to receiving care in the schools, physician offices and urgent care centers.
-

Lessons from National Studies

- Population drivers of ED use include race/ethnicity, low income, fair/poor health, being enrolled in an HMO, and proximity to an ED (2).
 - African-Americans, and Medicaid or uninsured patients constitute a disproportionate share of ED visits for ambulatory care sensitive conditions – a trend that does not appear to be explained by either differences in disease prevalence or severity (3).
 - Patients were more likely to list medical necessity, convenience, a preference for the ED, and affordability than limitations of insurance as reasons for going to the ED (4).
 - Interventions should be multifaceted.
-

Lessons from National Studies

- Influence of insurance coverage on ED use under debate
 - The rise in ED use appears to be driven by non-poor individuals who have insurance and a usual source of care (5).
 - Uninsured patients are slightly more likely to make non-urgent ED visits than those with private insurance (6).
 - Low-income, uninsured, and Medicaid patients depend more on EDs than people with Medicare or private coverage (7).
 - Available data do not support assumptions that uninsured patients are a primary cause of ED overcrowding, present with less acute conditions than insured patients, or seek ED care primarily for convenience (8).
-

Issues to Keep in Mind

- The Institute for Healthcare Improvement ED reduction collaborative and the California Quality Collective found patient and physician focus groups to be important ways of understanding reasons for patients preferentially using the ED as a source of urgent care.
 - Programs to provide primary care to uninsured using the ED have been successful in reducing ED and hospital use.
 - Reducing ED use will influence hospital margins; especially focusing on reducing ED use in those with insurance. We understand this is a complex issue for hospitals.
-

Reducing Avoidable ED Use Interventions

- Telemed acute visits for children 1-18
 - Educational intervention for children 0-1
 - Providing Resources for Primary Care moving toward Patient Centered Medical Home model of care
-

Progress to Date

- Educational tool chosen and practice indentified for educational intervention (OB office)
 - Telemed expansion already expanded in Rochester school district
 - Standardization of telemed coding being implemented
 - PCP Resources identified in HEAL funding:
 - Practice consultants
 - IT resources
 - Learning collaborative on care management
-

SAGE

- A comprehensive long range plan to address the health service needs of the 65 and older population
 - Create a vision for a local system that makes health care more accessible for older adults, minimizes disparities, and that is financially viable
 - Address:
 - The aging population
 - Caregiver decline
 - Financial instability
 - Workforce shortage
-

Recommendations

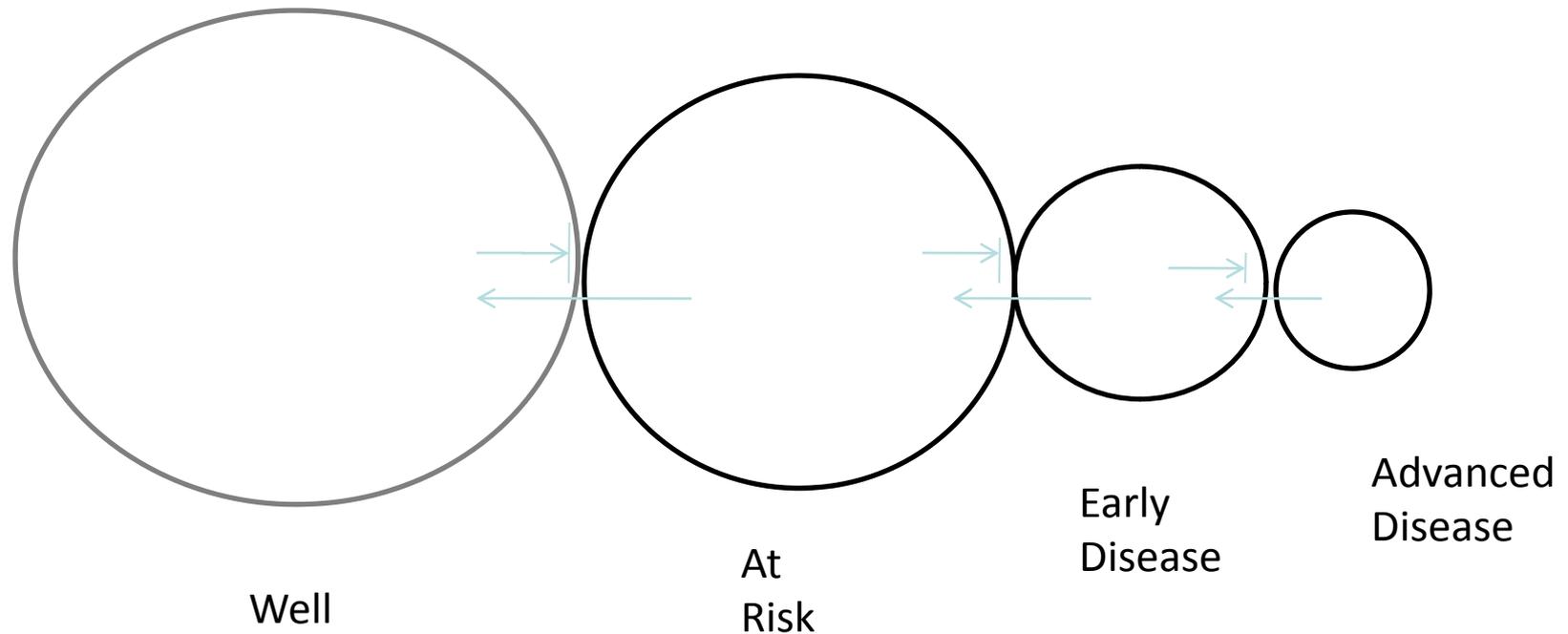
- Increase the array of home and community based services
 - Rebalance Long Term Care
 - Improve access to care
 - Change the current reimbursement system
 - Enhance support for “informal” caregivers
 - Enhance transportation services to maintain independence
 - Expand housing options
 - Increase the number of trained workers dedicated to geriatric health and community based services
-

High Blood Pressure Collaborative

- RBA Healthcare Planning Team desired a project to implement and test “transformed” health care – movement to the Wagner Model
 - Partnered with the FLHSA to staff the project
 - Convened a multistakeholder coalition of 63 community organizations to direct and champion the efforts in the community
 - Has 6 workgroups:
 - Best Practice
 - Behavior Change
 - Measurement
 - Plan Design
 - Communication
 - Community Engagement
-

Population Segmentation into Stages of Disease*

*arrows indicate desired direction of population shift



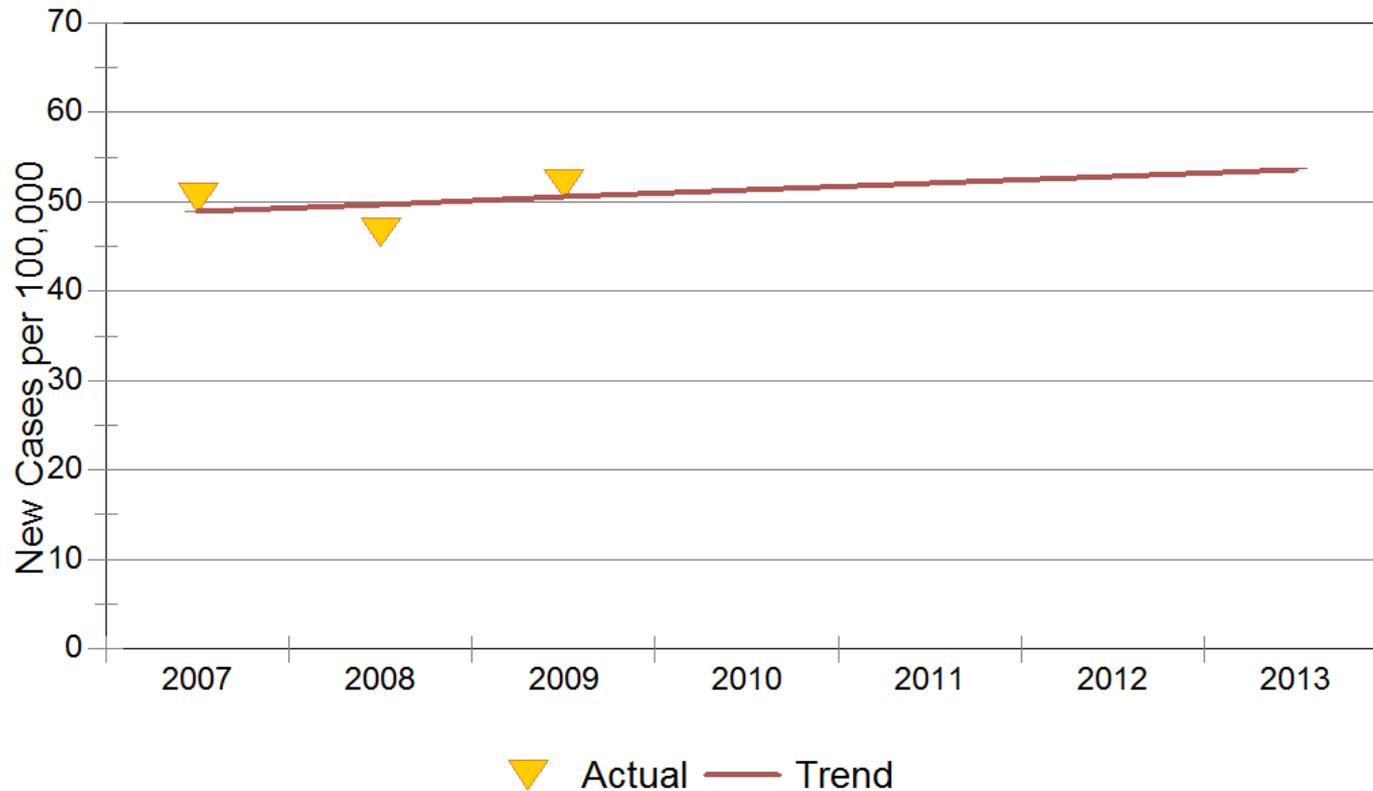
Health Care Transformation

FROM	TO
SILOED EFFORTS BY STAKEHOLDERS	INTEGRATION OF CARE
CARE IS DETERMINED BY TODAY'S PROBLEM AND TIME AVAILABLE TODAY	CARE IS DETERMINED BY A PROACTIVE PLAN TO MEET HEALTH NEEDS, WITH OR WITHOUT VISITS
QUALITY DEFINED AS AVOIDING "BAD" EVENTS	CONTINUOUS QUALITY IMPROVEMENT INCORPORATED INTO DAILY PRACTICE
CARE TO SEPARATE INDIVIDUALS	POPULATION BASED CARE
REWARDED FOR VOLUME	REWARDED FOR QUALITY
PASSIVE PATIENT ROLE	ENGAGED PATIENTS

Consequences of High Blood Pressure:

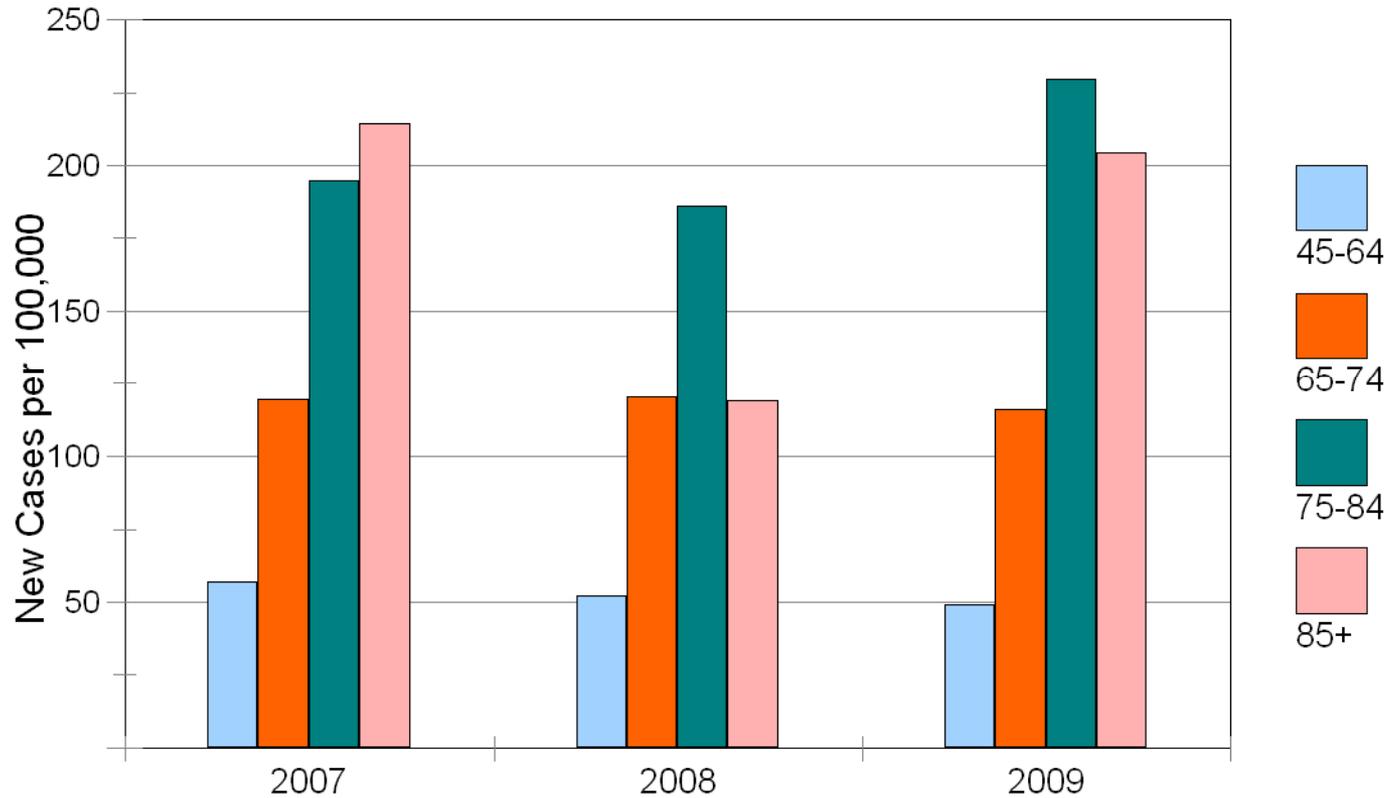
Initiation of Dialysis

New Renal Dialysis Cases Monroe Co Residents 18 & Older



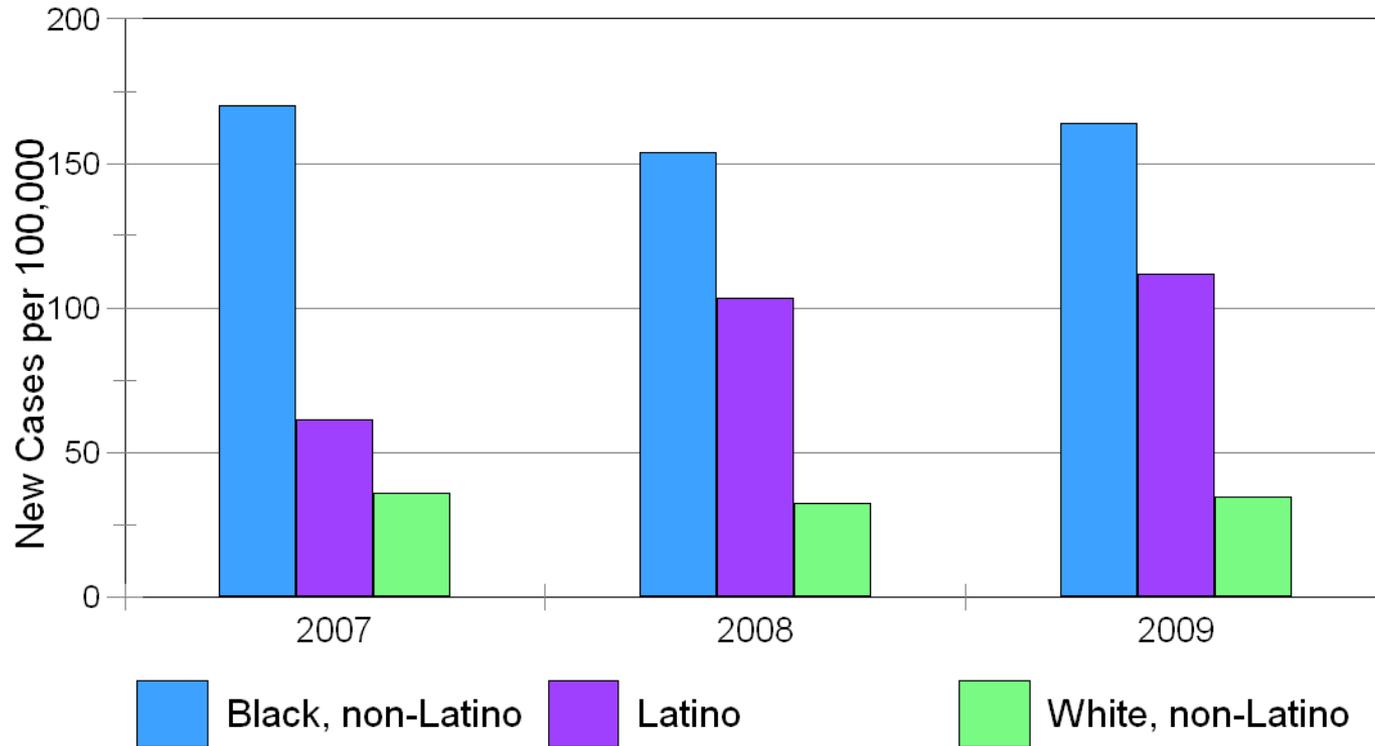
Rates are age-sex adjusted to standard 2000 U.S. population distribution: R-squared for trend is .08
Data Source: IPRO/ESRD Network of New York; calculations by FLHSA

New Renal Dialysis Case Rate Monroe Residents by Age Group



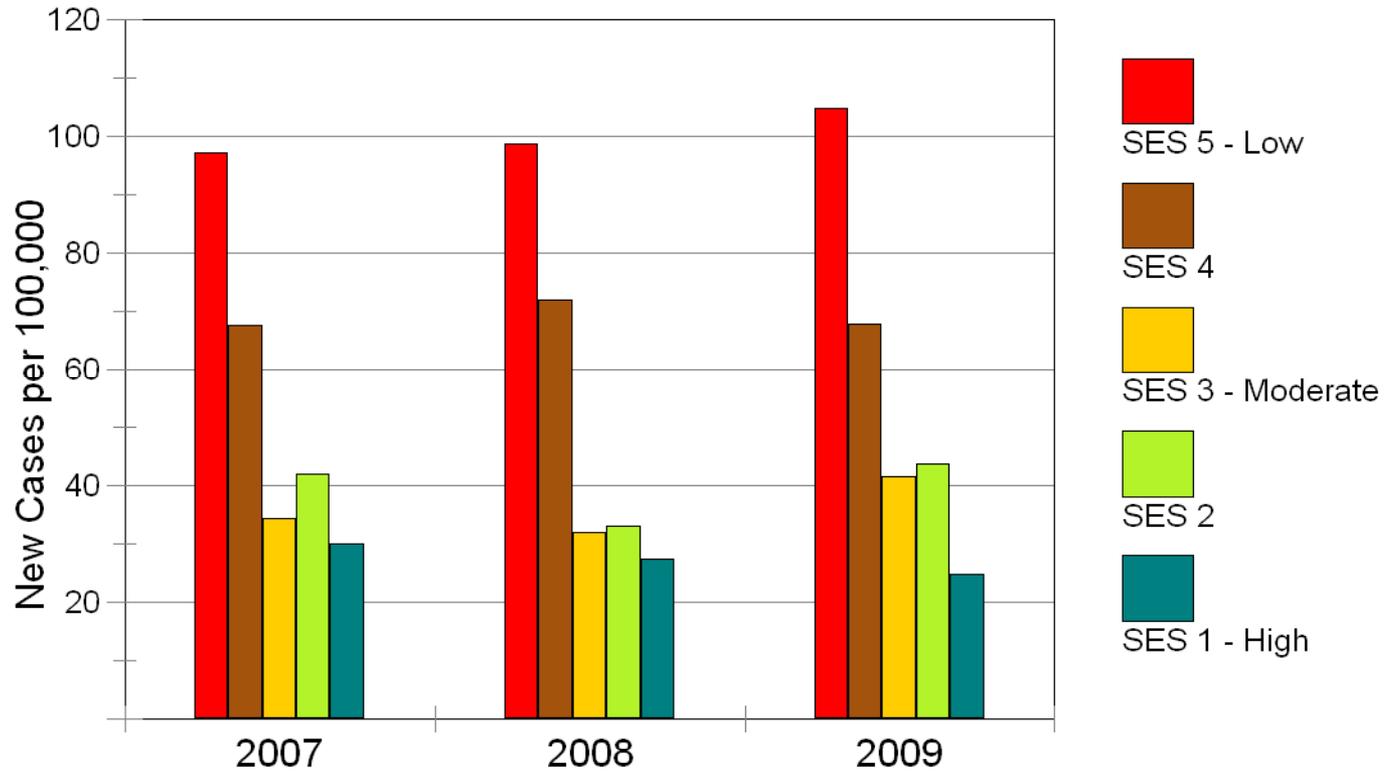
Data Source: IPRO/ESRD Network of New York; calculations by FLHSA

New Renal Dialysis Case Rate Monroe 18 & Older Residents by Race/Ethnicity



Rates are age-sex adjusted to the 2000 standard U.S. population distribution
Data Source: IPRO/ESRD Network of New York; calculations by FLHSA

New Renal Dialysis Case Rate Monroe 18 & Older by Socio-Economic Status



Rates are age-sex adjusted to the standard 2000 U.S. population distribution
Data Source: IPRO/ESRD Network of New York; calculations by FLHSA

Conclusions: Kidney Failure

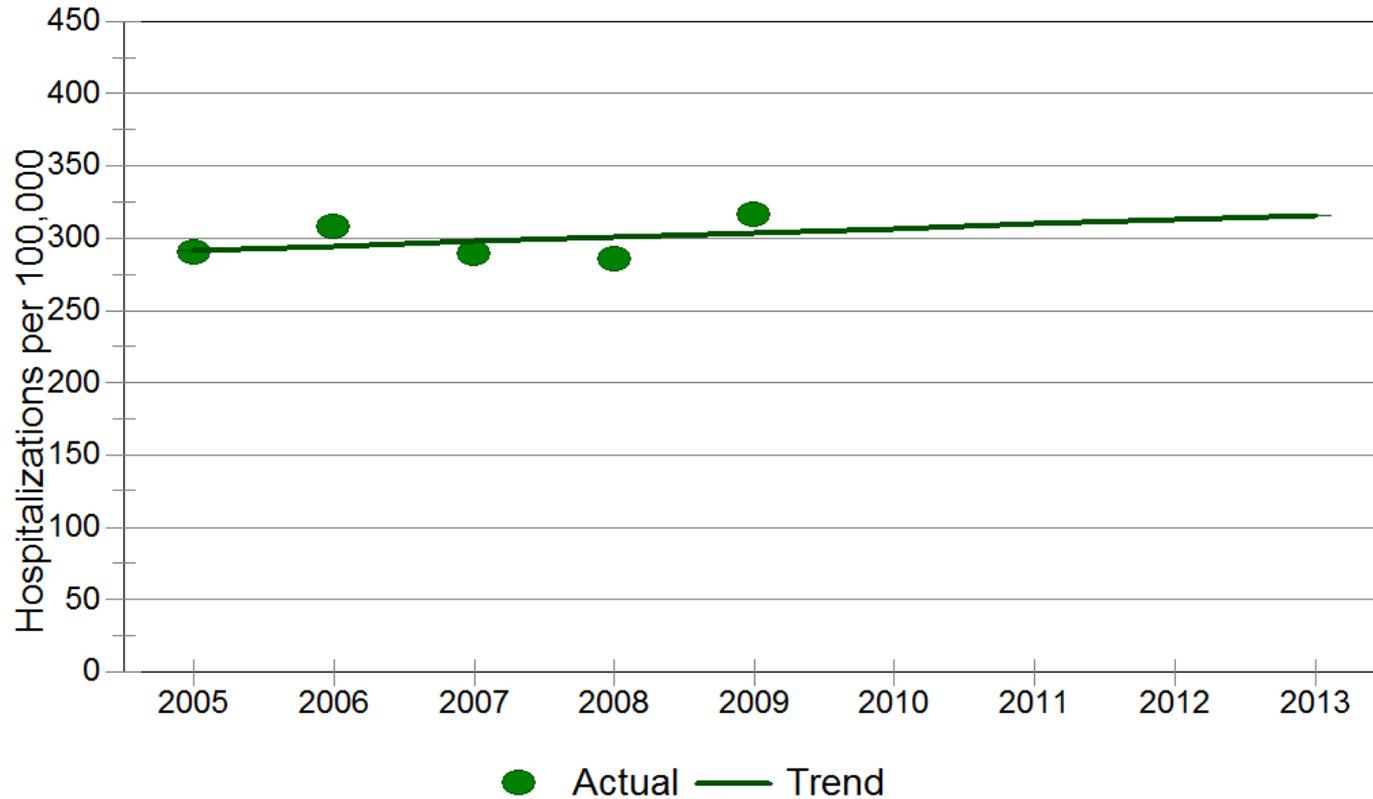
- Kidney Failure rates have been constant over the past three years
 - The cost of dialysis for a year is \$75,000
 - The cost to the community for initiation of dialysis yearly is in excess of \$21,500,000
 - Those at risk of renal failure are:
 - Elderly
 - African-Americans and Latinos
 - The most socially disadvantaged
-

Consequences of High Blood Pressure:

Stroke

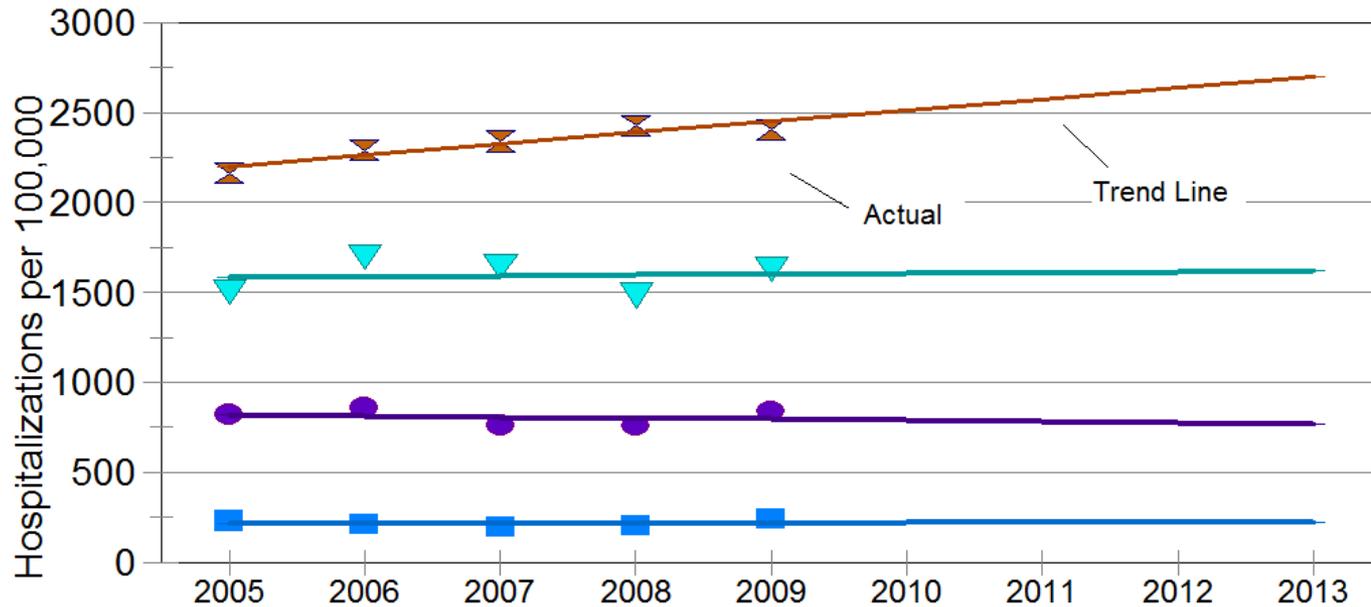
Stroke Hospitalization Rate

Monroe Residents 18 & Older



Rates are age-sex adjusted to 2000 standard U.S. population; R-squared for trend line is .13
Data Source: NYS Department of Health, Inpatient SPARCS files

Stroke Hospitalization Rates Monroe Co Residents by Age Group



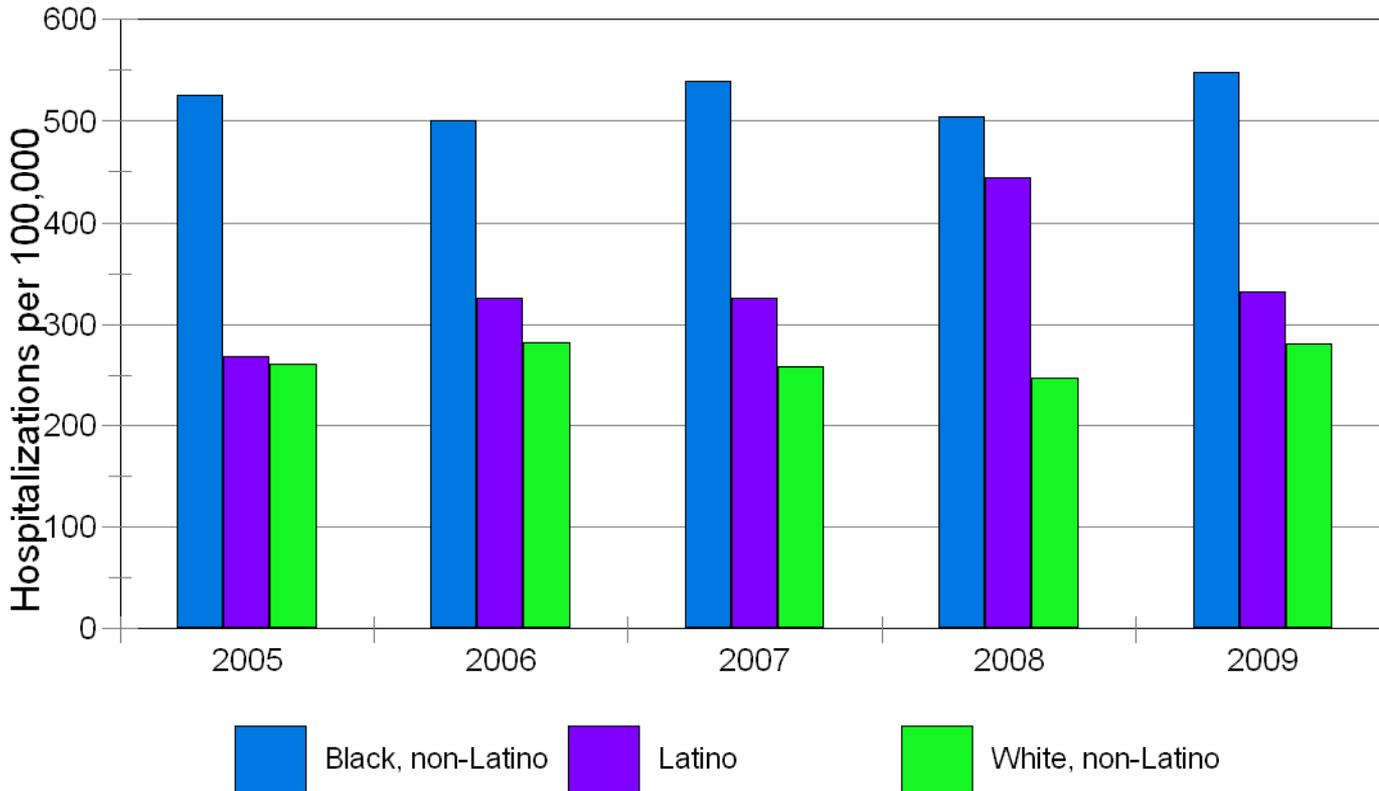
■ 45 to 64 Yrs Old
 ● 65 to 74 Yrs Old
 ▼ 75 to 84 Yrs Old
 ▲ 85 & Older

R-squared for 45-64 trend is .01, 65-74 trend .05, 75-84 trend .01, 85+ trend .86

Data Source: NYS Department of Health, Inpatient SPARCS files

Stroke Hospitalization Rate

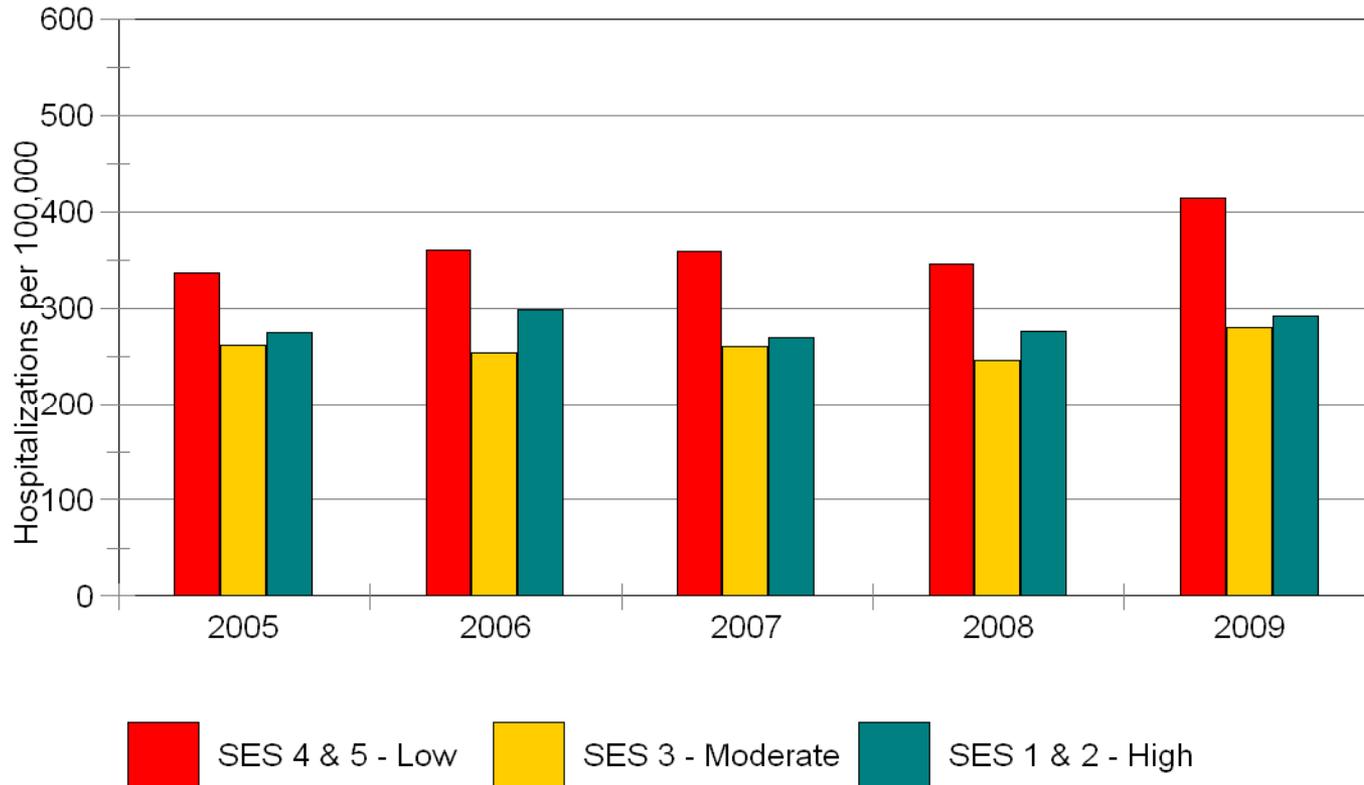
Monroe Residents by Race/Ethnicity



Rates are age-sex adjusted to the standard 2000 U.S. population distribution
Data Source: NYS Department of Health, Inpatient SPARCS files

Stroke Hospitalization Rates

Monroe Residents by Socio-Econ Status



Socio-economic status is based on ZIP code SES using 2000 Census of Population data
Rates are age-sex adjusted to standard 2000 U.S. population
Data Source: NYS Department of Health, Inpatient SPARCS files

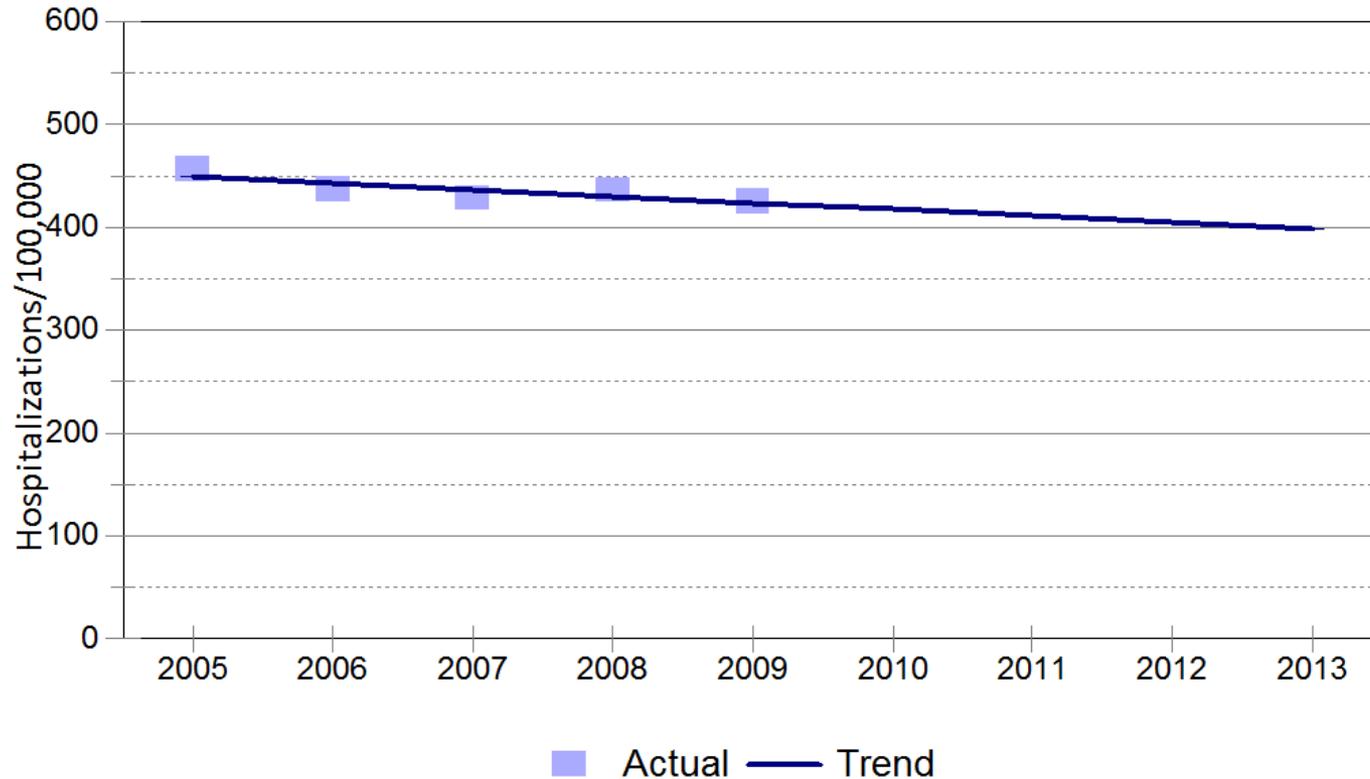
Conclusions: Stroke

- Hospitalization rate for Stroke is unchanged over the past five years
 - Those most at risk are:
 - Elderly
 - African-Americans and Latinos (the disparity is increasing)
 - The most socio-economically disadvantaged (the disparity is increasing)
-

Consequences of High Blood Pressure:

Heart Failure

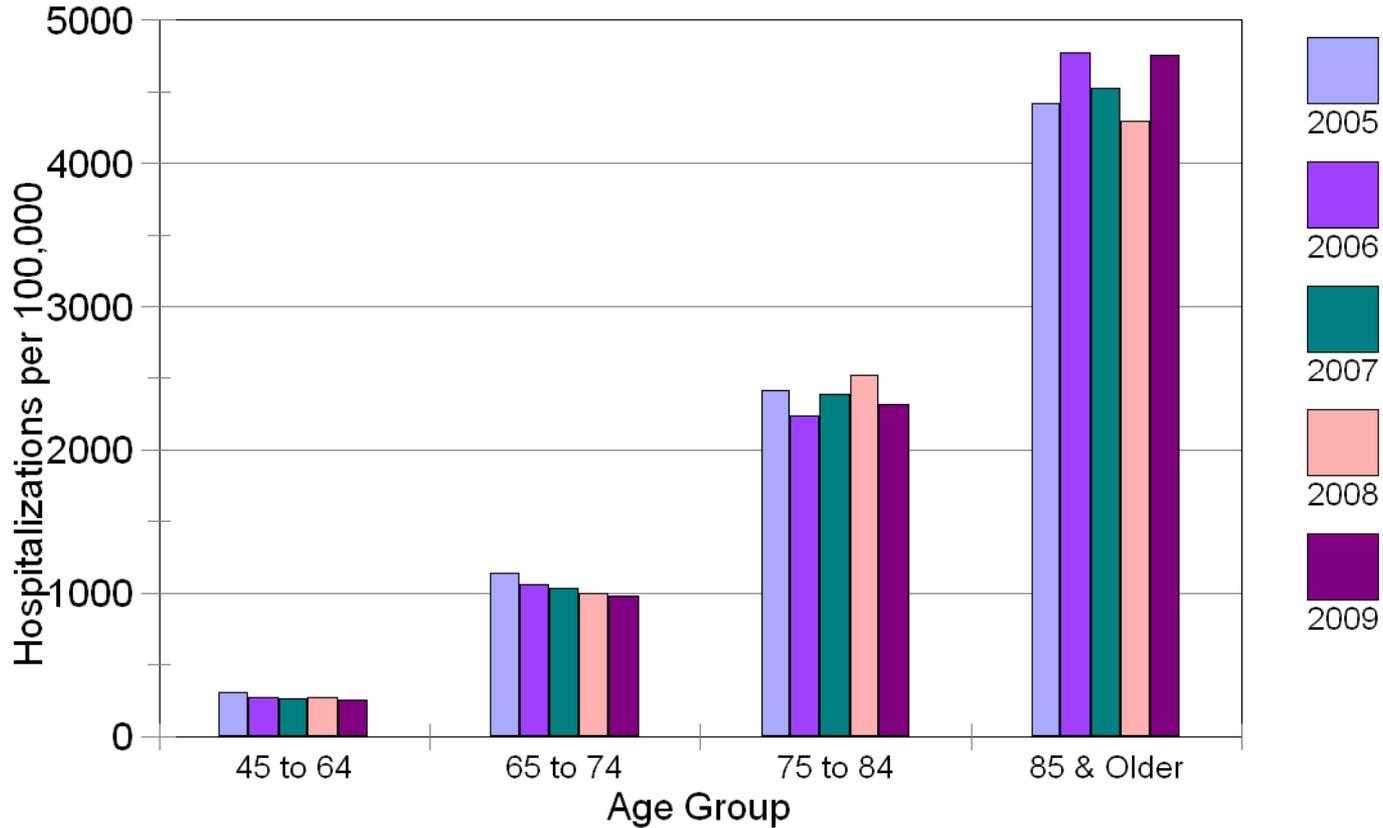
Heart Failure Hospitalization Rate Monroe County Residents 18 & Older



Rates are age-sex adjusted to the standard 2000 U.S. population distribution
R-squared trend line .69
Data Source: NYS Department of Health, Inpatient SPARCS files

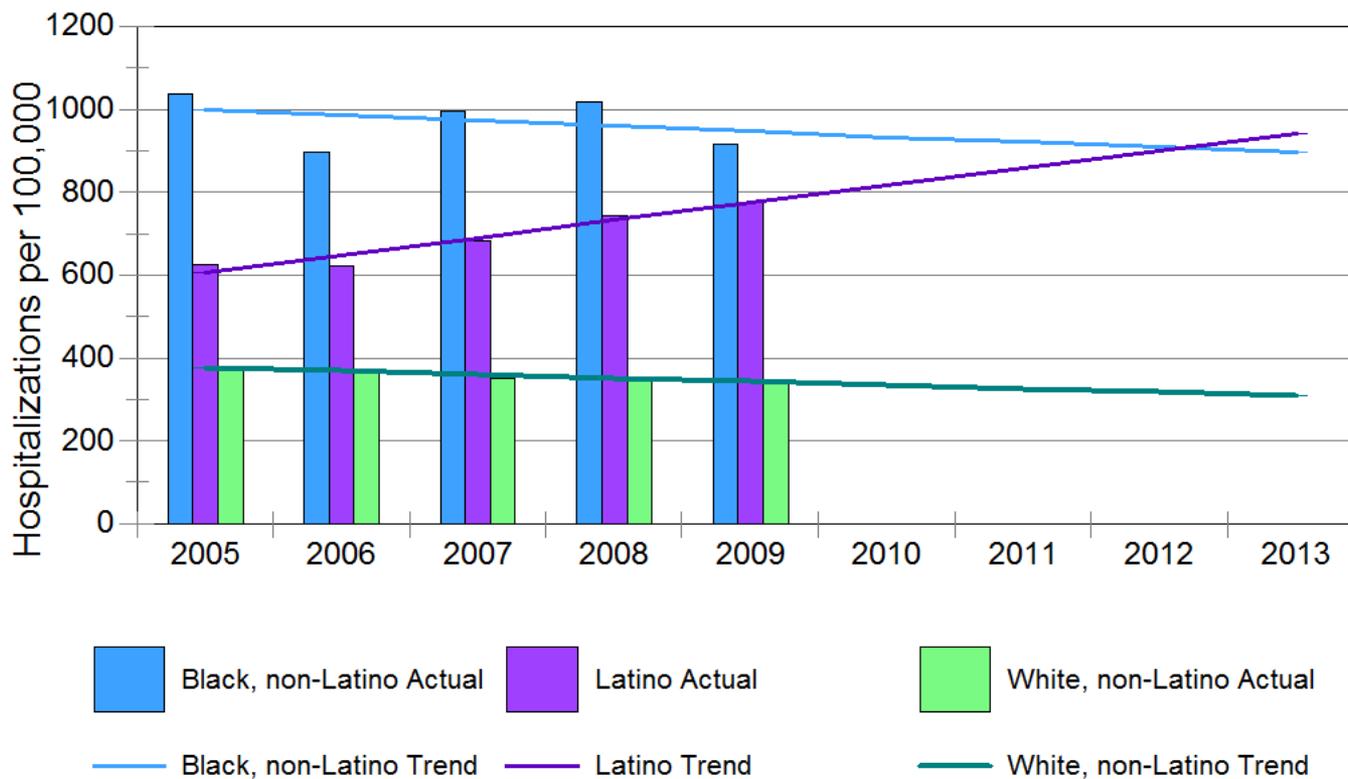
Heart Failure Hospitalization Rates

Monroe Co Residents by Age Group



Data Source: NYS Department of Health, Inpatient SPARCS files

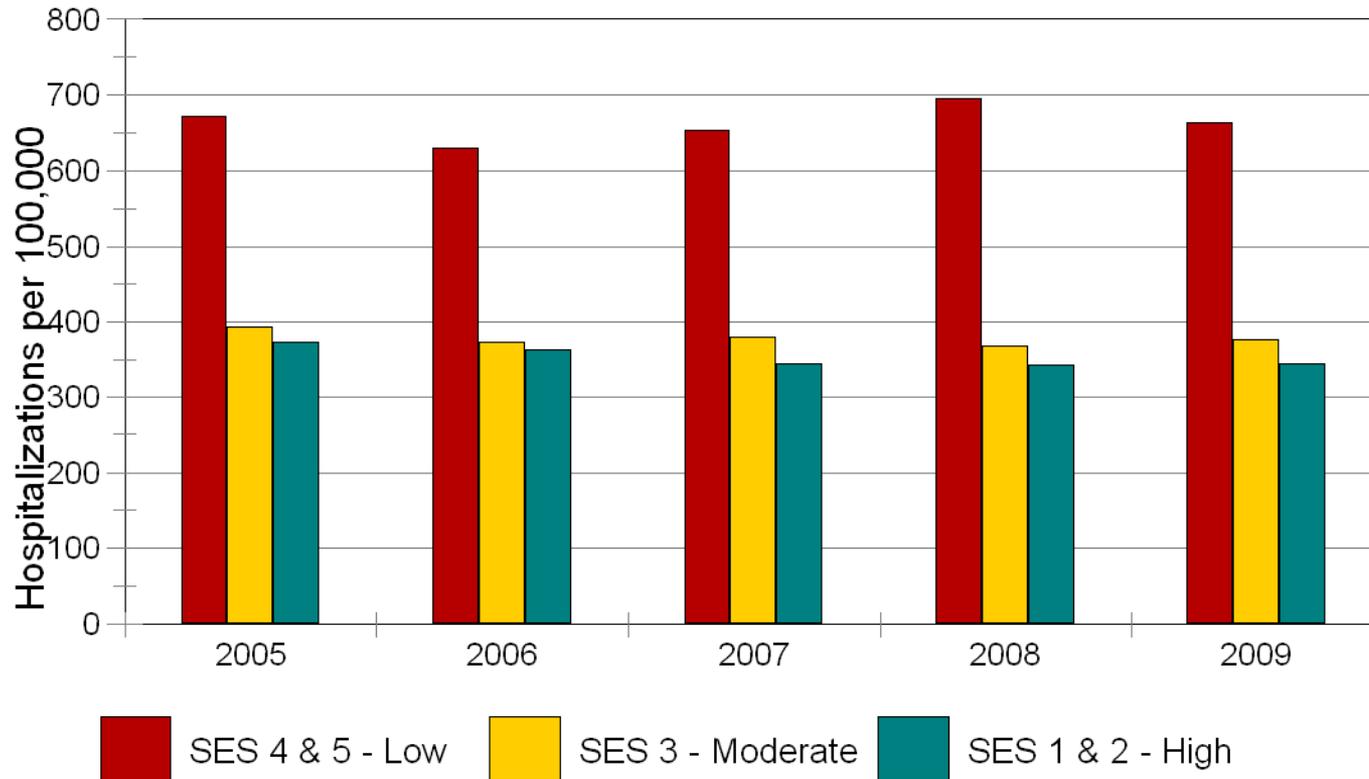
Heart Failure Hospitalization Rate Monroe Residents by Race/Ethnicity



Rates are age-sex adjusted to the standard 2000 U.S. population distribution
 R-squared Black, non-Latino .11, R-squared Latino .93, R-squared White, non-Latino .87
 Data Source: NYS Department of Health, Inpatient SPARCS files

Heart Failure Hospitalization Rates

Monroe Residents by Socio-Econ Status



Socio-economic status is based on ZIP code SES using 2000 Census of Population data
Data Source: NYS Department of Health, Inpatient SPARCS files

Conclusions: Heart Failure

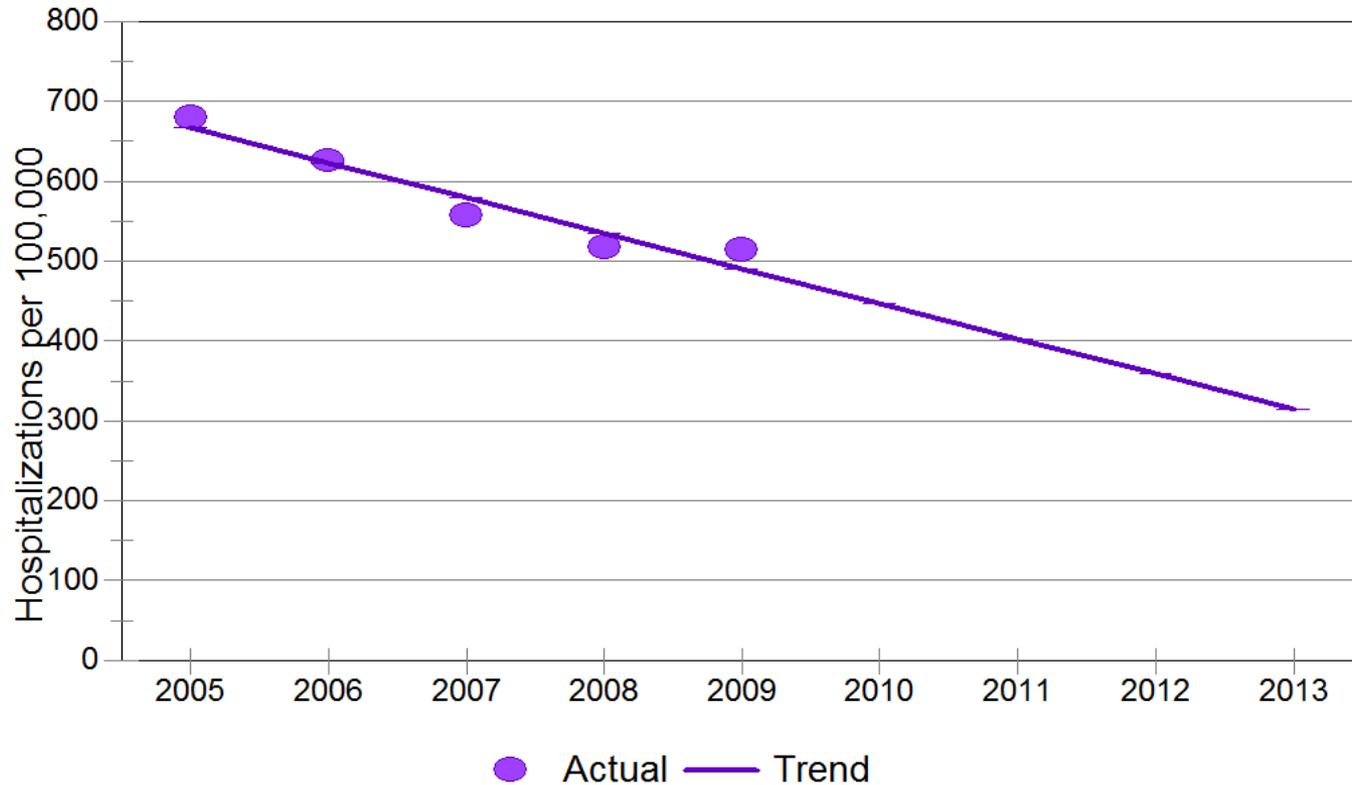
- Admissions for Heart Failure are remain relatively constant
 - Those most at risk are:
 - Elderly
 - African-Americans and Latinos
 - The most socio-economically disadvantaged and the disparity is increasing
-

Consequences of High Blood Pressure:

Coronary Artery Disease

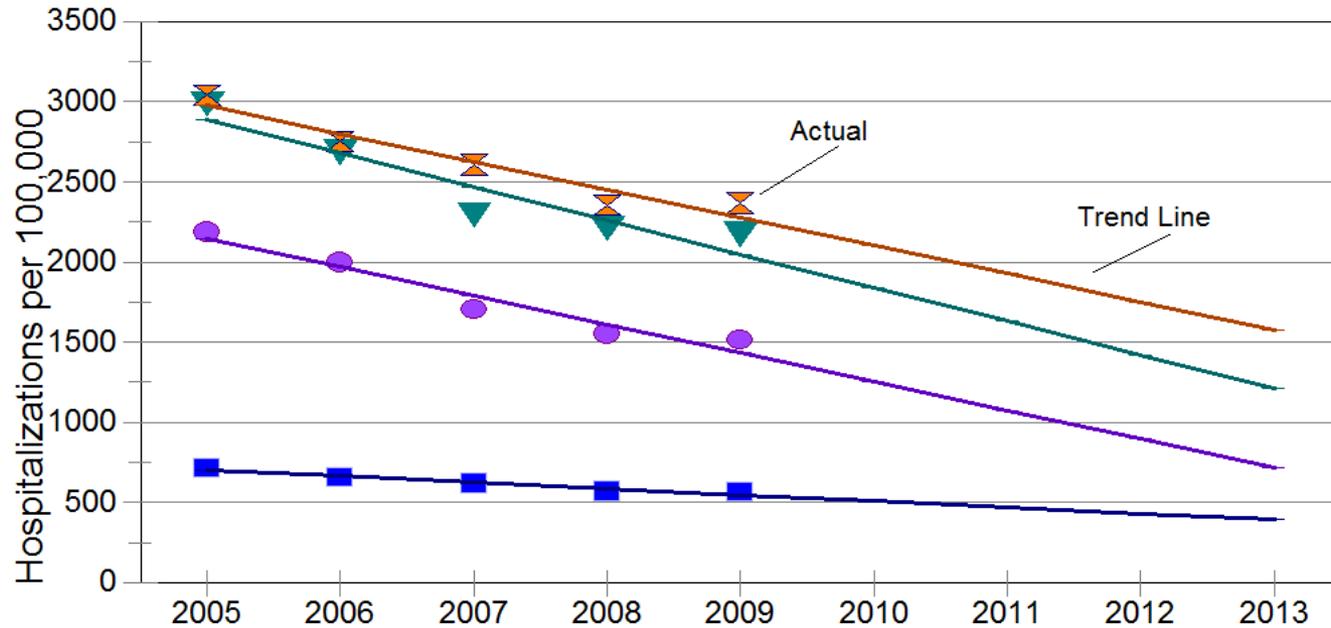
Coronary Artery Disease Hospitalization Rate

Monroe Residents 18 & Older



Rates are age-sex adjusted to 2000 standard U.S. population; R-squared for trend line is .93
Data Source: NYS Department of Health, Inpatient SPARCS files

Coronary Artery Disease Hospitalization Rates Monroe Co Residents by Age Group

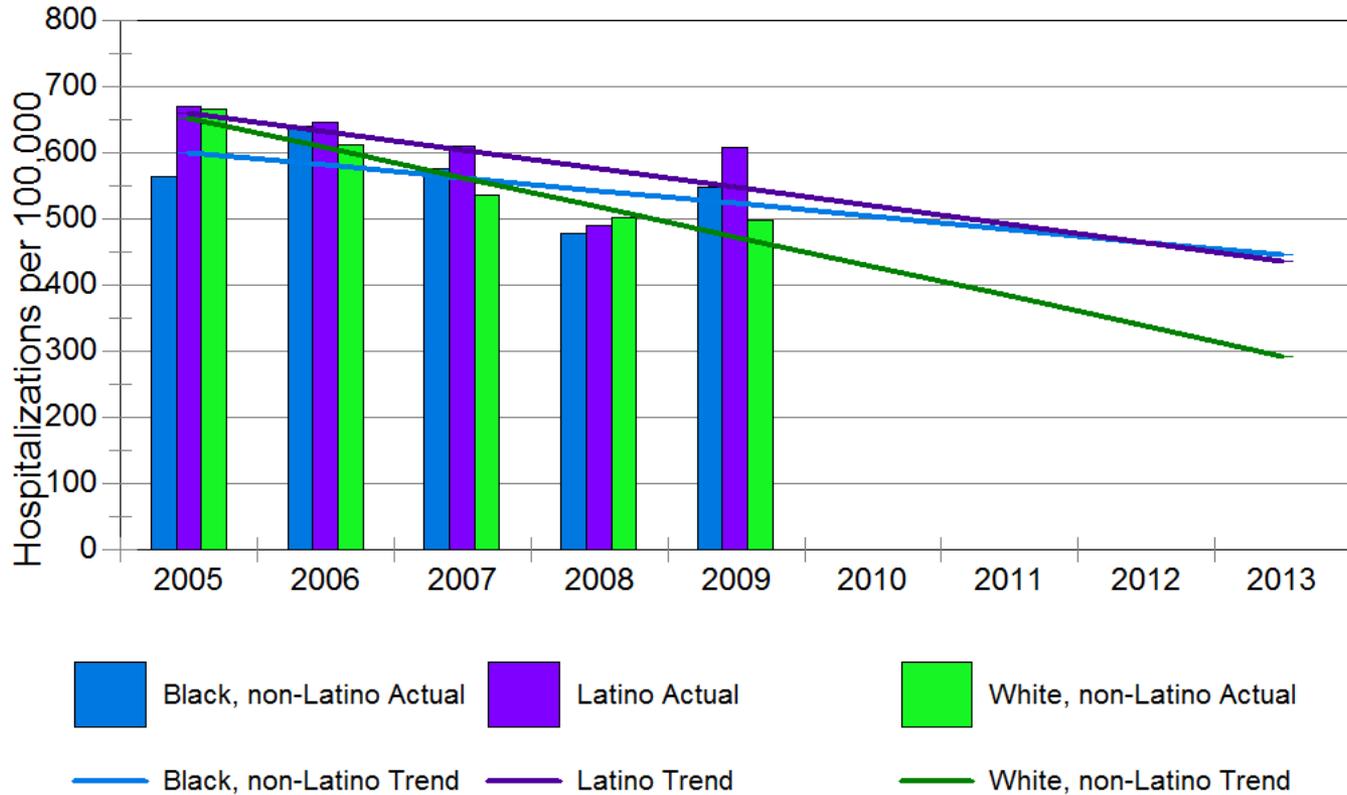


■ 45 to 64 Yrs Old ● 65 to 74 Yrs Old ▼ 75 to 84 Yrs Old ▲ 85 & Older

R-squared for 45-64 trend is .95, 65-74 trend .94, 75-84 trend .88, 85+ trend .92

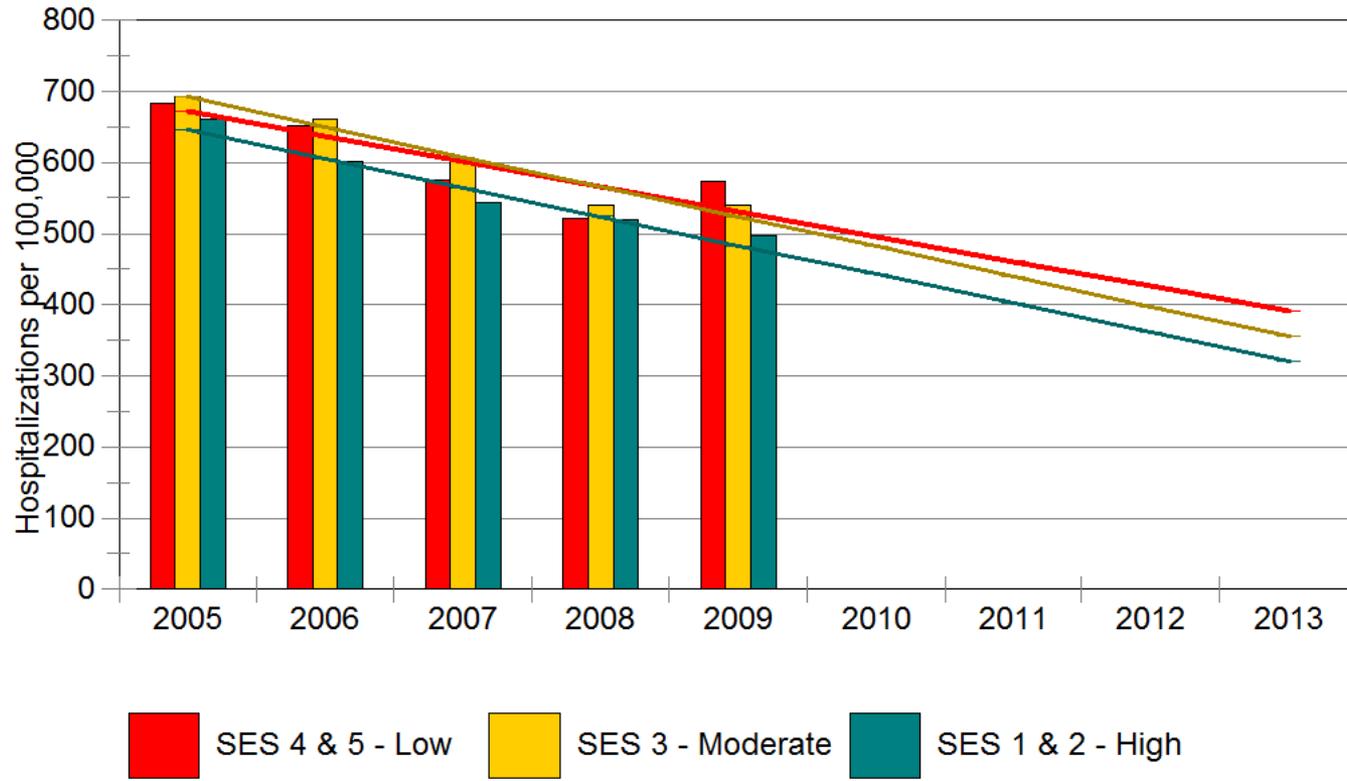
Data Source: NYS Department of Health, Inpatient SPARCS files

Coronary Artery Disease Hospitalization Rates Monroe Residents by Race/Ethnicity



Rates are age-sex adjusted to the standard 2000 U.S. population distribution
 R-squared Black, non-Latino .28, R-squared Latino .41, R-squared White, non-Latino .92
 Data Source: NYS Department of Health, Inpatient SPARCS files

Coronary Artery Disease Hospitalization Rates Monroe Residents by Socio-Econ Status



Socio-economic status is based on ZIP code SES using 2000 Census of Population data
 R-squared Low SES .72; Moderate SES .94; High SES .95; Rates are age-sex adjusted to standard 2000 U.S. population
 Data Source: NYS Department of Health, Inpatient SPARCS files

Conclusions:

Coronary Artery Disease

- The number of admissions for CAD are falling
 - Those most at risk are:
 - Elderly
 - African-Americans and Latinos
-

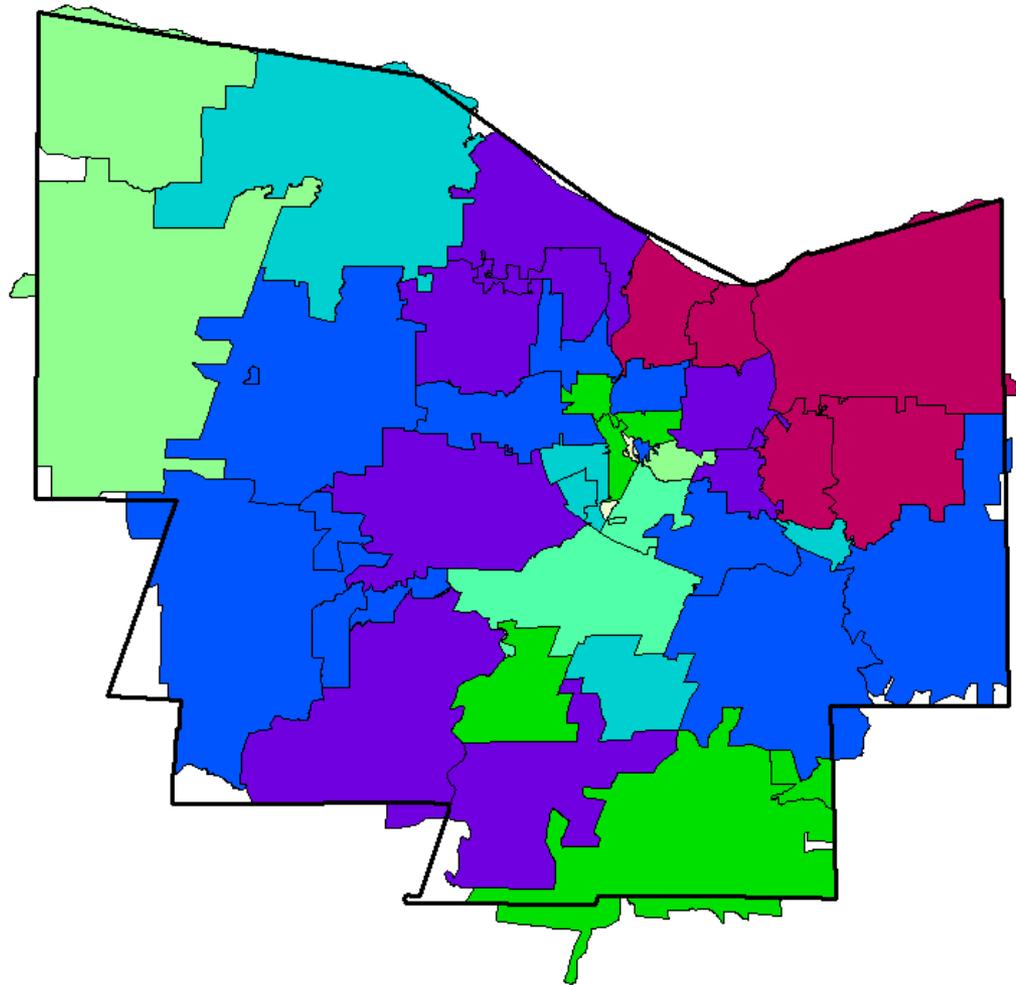
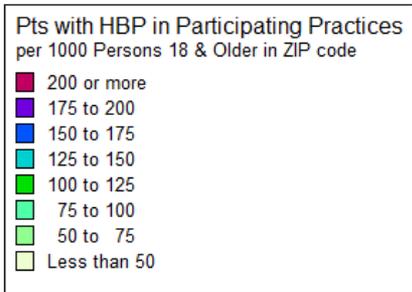
Community-wide HBP Registry Data

- Monroe County patients for whom BP data available – 56,864
 - Participating Systems:
 - Jordan Health System
 - RGH
 - Unity
 - URMC
 - Westside
-

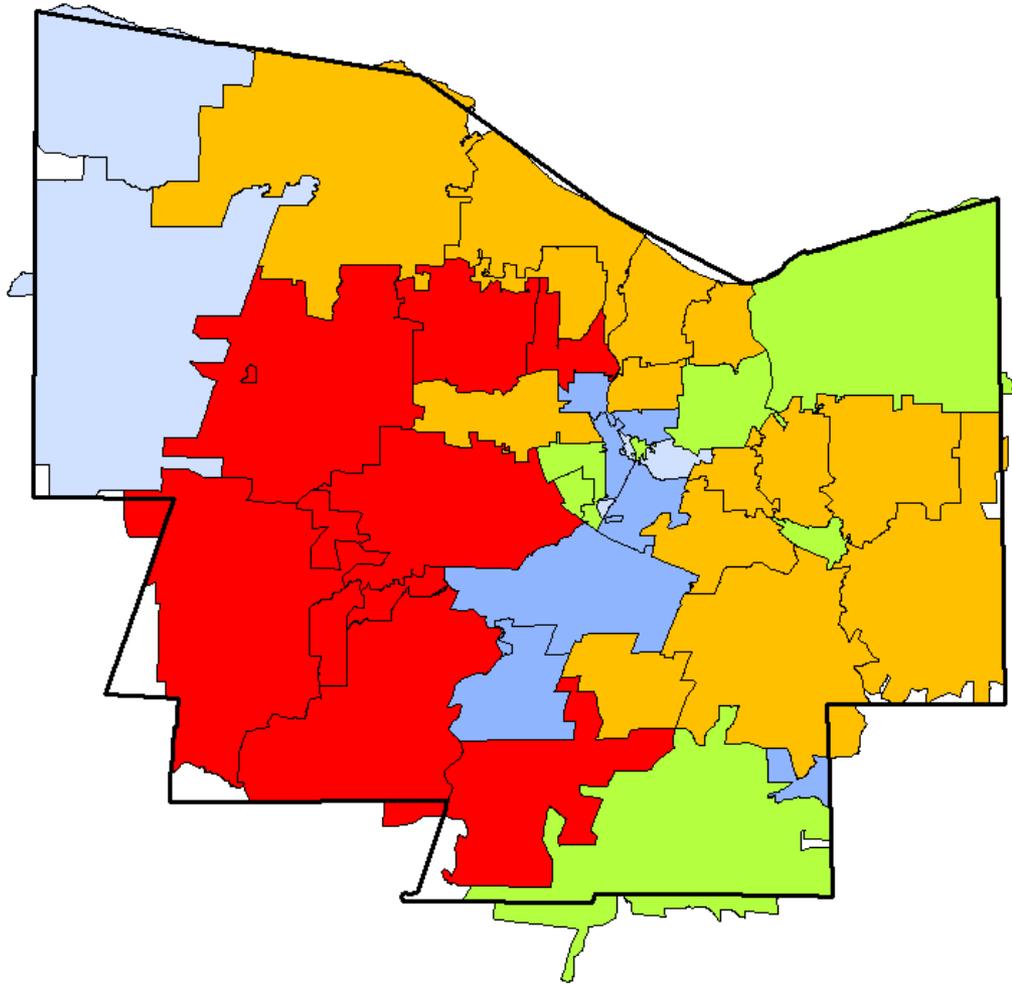
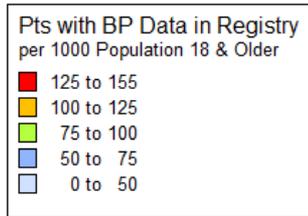
Key Facts

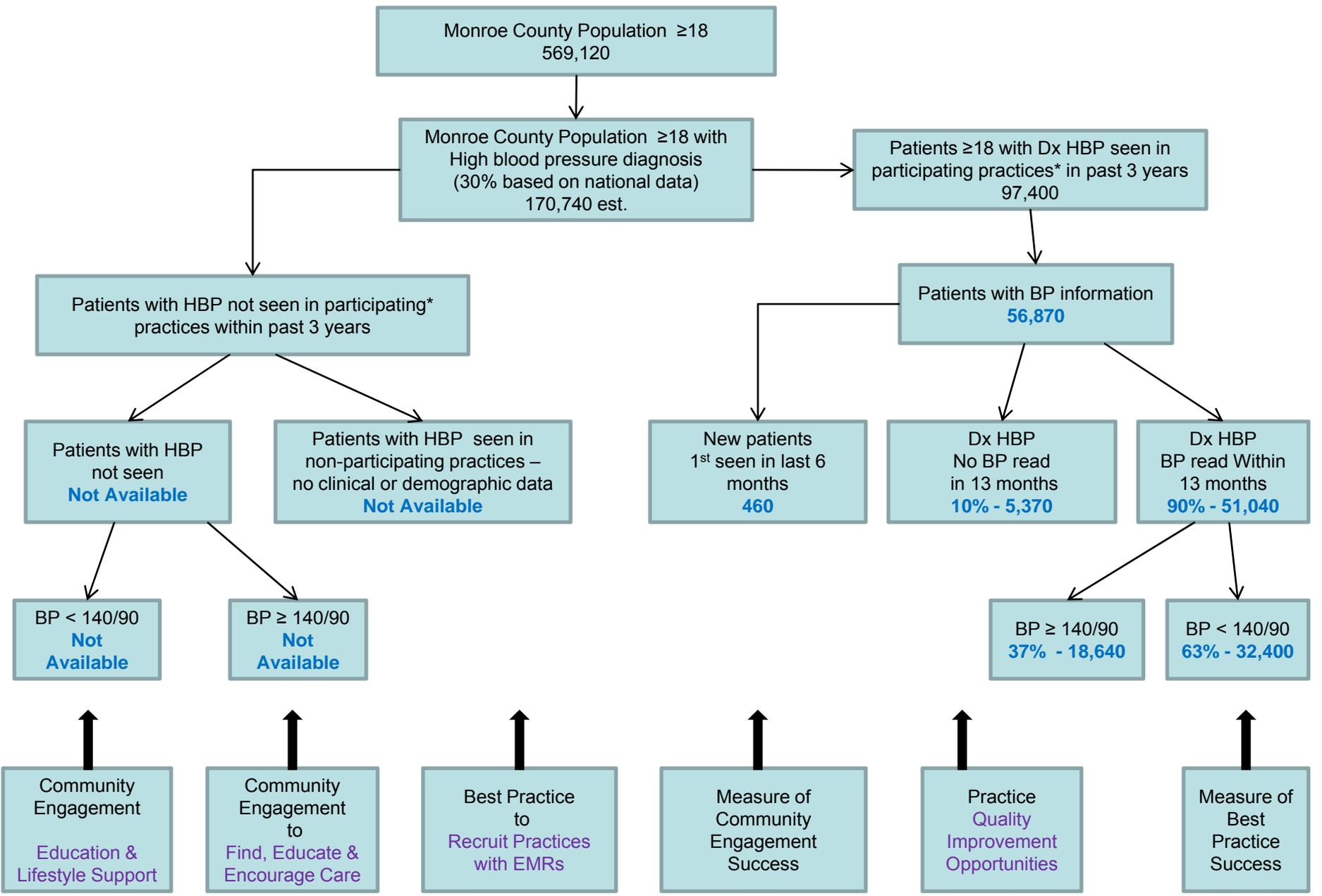
- Number of patients reported on - 56,864
 - New patients (<1%) – 458
 - Established patients – 56,406
 - % with no BP in last 13 months 10%
 - % with BP read in last 13 months 90%
 - Patients with BP <140/90 63% (Nt'l avg 56%)
 - Patients with BP \geq 140/90 37%
-

**Patients with High Blood Pressure
Seen in Participating Practices
During the Last 3 Years
per 1000 Population 18 & Older
by ZIP Code**



**Patients with High Blood Pressure
Seen in Participating Practices
During the Last 3 Years
with Blood Pressure Data in Registry
per 1000 Population 18 & Older
by ZIP Code**





Patients with HBP not seen in participating* practices within past 3 years

Patients with HBP not seen
Not Available

Patients with HBP seen in non-participating practices – no clinical or demographic data
Not Available

BP < 140/90
Not Available

BP ≥ 140/90
Not Available

Community Engagement
Education & Lifestyle Support

Community Engagement to Find, Educate & Encourage Care

Best Practice to Recruit Practices with EMRs

Measure of Community Engagement Success

Practice Quality Improvement Opportunities

Measure of Best Practice Success

Monroe County Population ≥18
569,120

Monroe County Population ≥18 with High blood pressure diagnosis (30% based on national data)
170,740 est.

Patients ≥18 with Dx HBP seen in participating practices* in past 3 years
97,400

Patients with BP information
56,870

New patients 1st seen in last 6 months
460

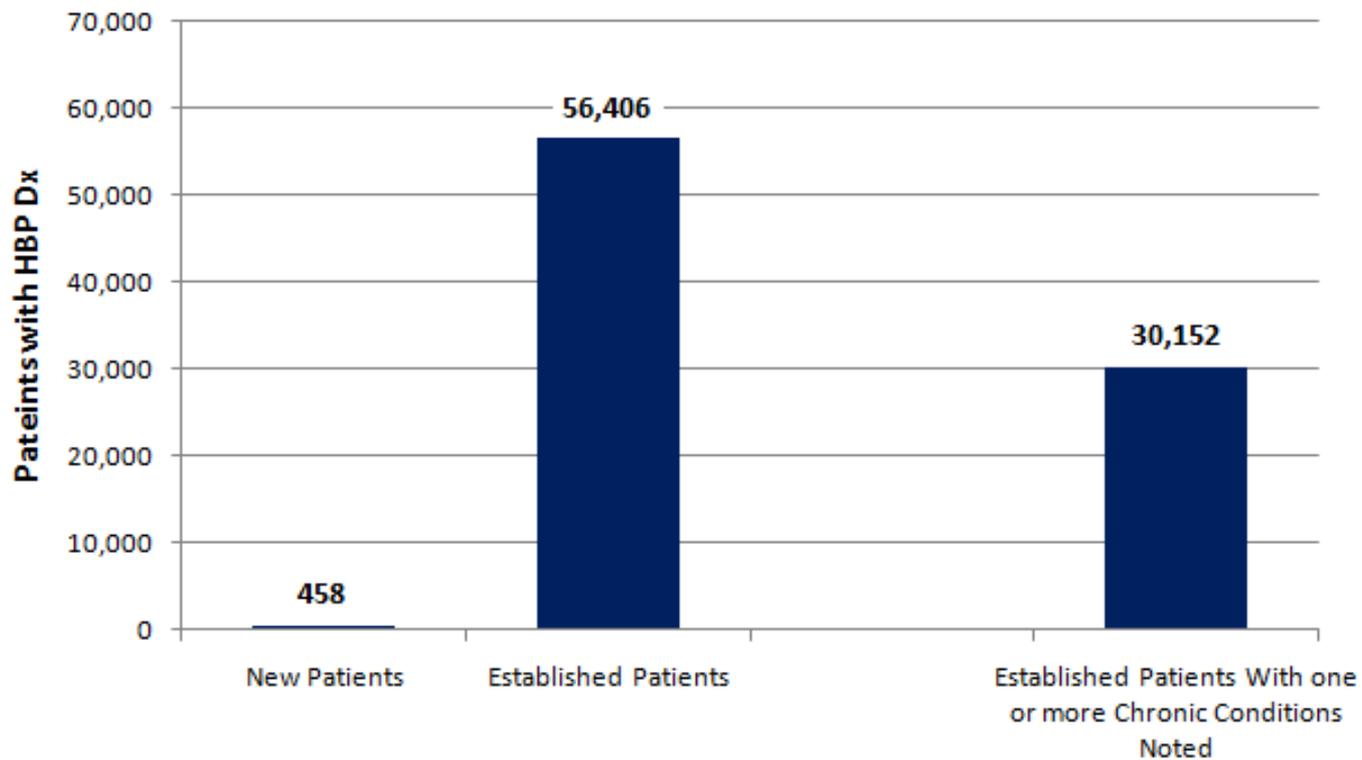
Dx HBP No BP read in 13 months
10% - 5,370

Dx HBP BP read Within 13 months
90% - 51,040

BP ≥ 140/90
37% - 18,640

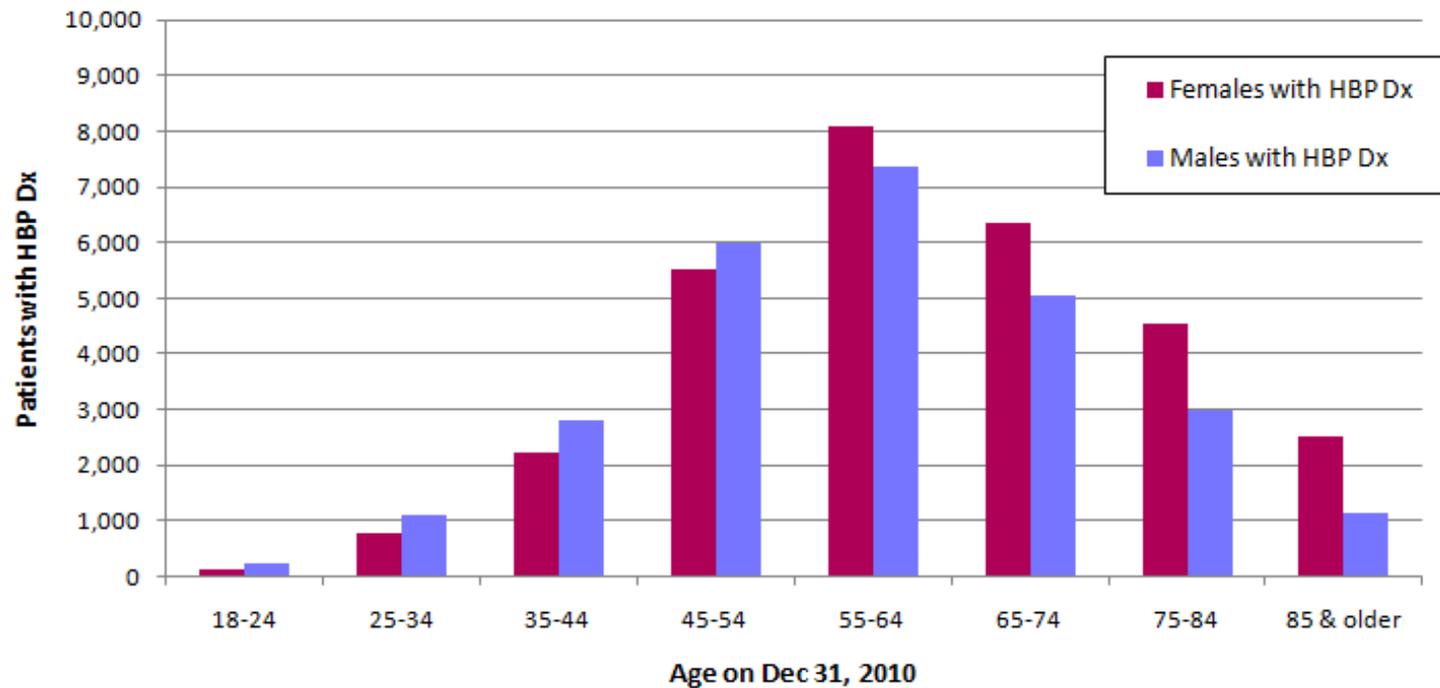
BP < 140/90
63% - 32,400

Monroe Co Residents 18 & Older with BP Data in Registry by Selected Characteristics



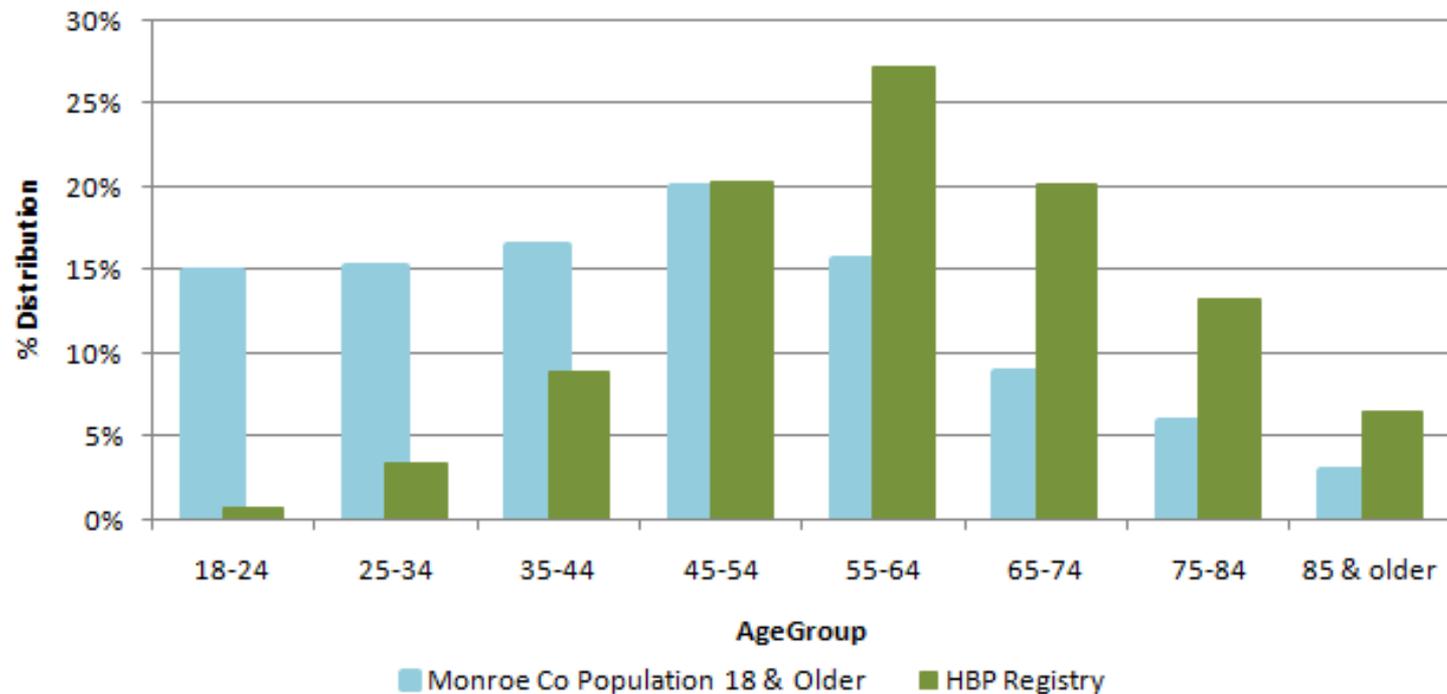
December 31, 2010 registry as of April 2011

Monroe Residents 18 & Older with Complete Data in HBP Registry by Age & Sex



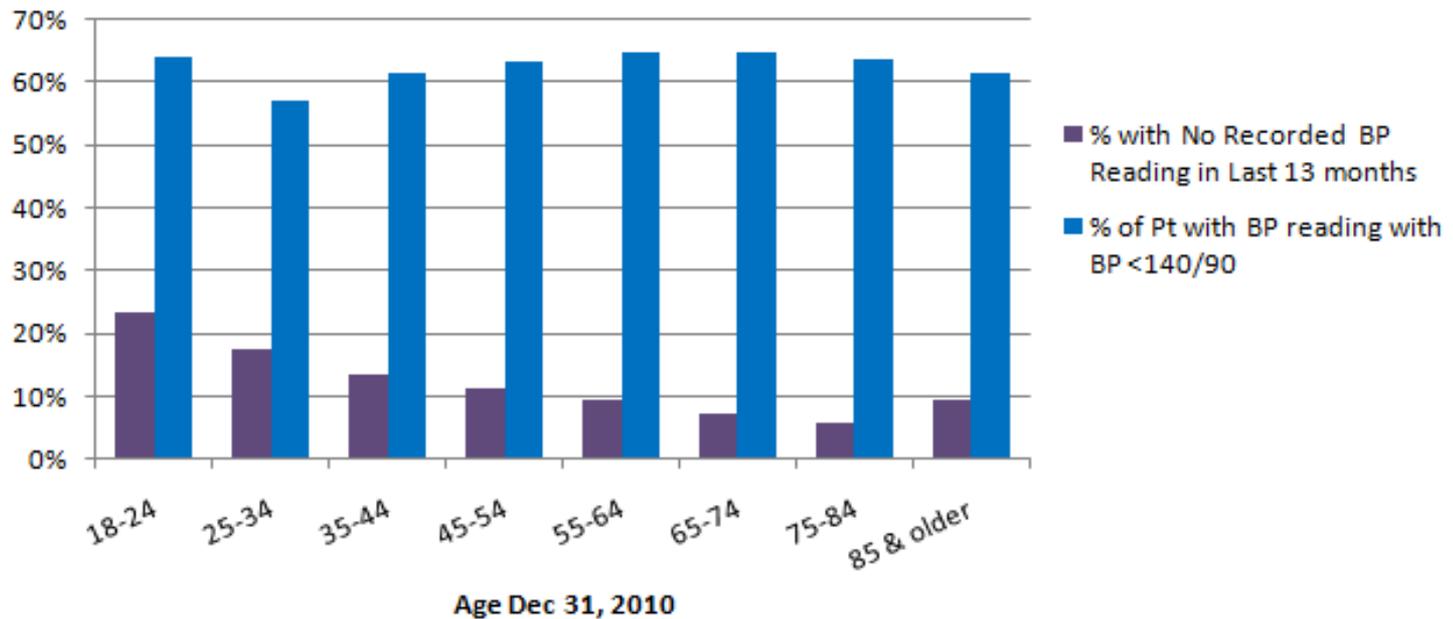
December 31, 2010 registry as of April 2011

Monroe Residents 18 & Older in HBP Registry by Age Distribution Compared to County Population



December 31, 2010 registry as of April 2011

Monroe Co Residents 18 & Older in HBP Registry Established Patients Reading & Control Rates by Age



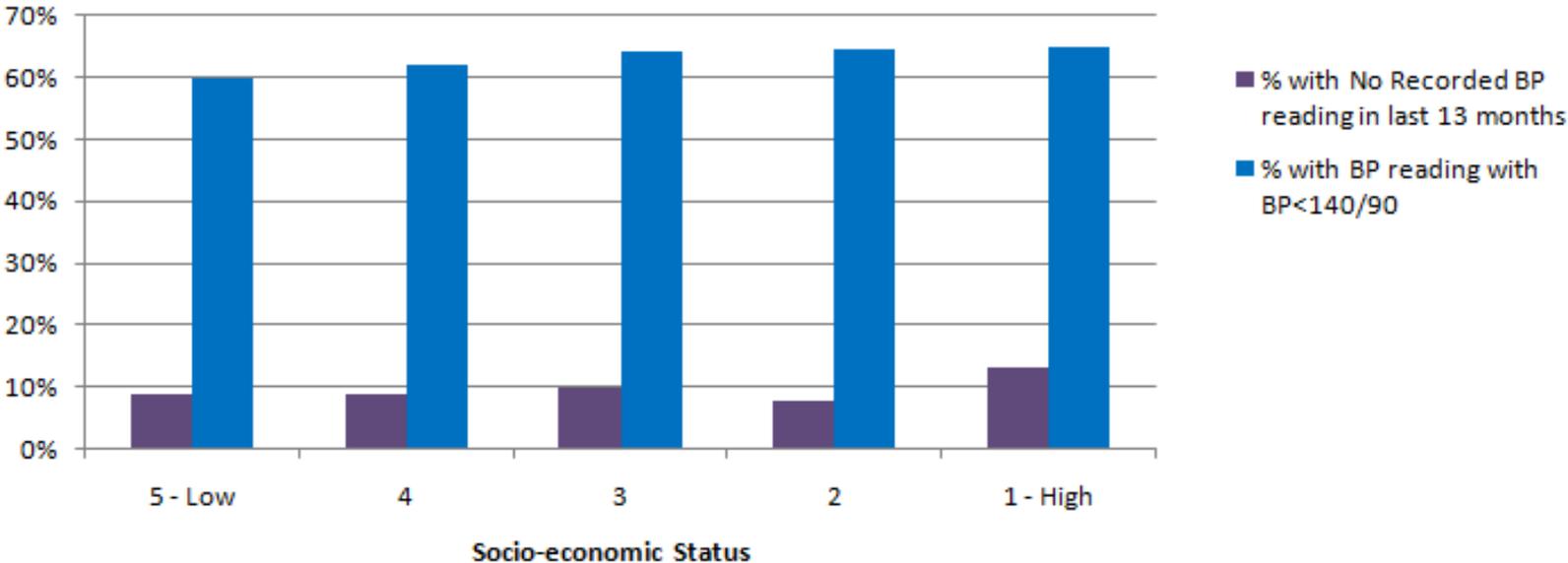
December 31, 2010 registry as of April 2011

Monroe Co Residents in HBP Registry Distribution by Socio-Economic Status Compared to County Population



SES is based on Patient ZIP Code SES based on 2000 Census of Population data
December 31, 2010 registry as of April 2011

Monroe Co Residents 18 & Older in HBP Registry Established Patients Reading & Control Rates by SES



SES is based on patient ZIP code SES from the 2000 Census of Population
Dec 31, 2010 registry as of April 2011

Conclusions:

- Aggregated community wide practice reporting represents > 30% of patients with HBP
 - New patient measure can serve as an evaluation of community engagement
 - Most patients are being seen – those that are not can be viewed as QI Opportunity
 - 36% of patients have not reached goal BP and can be viewed as QI opportunity
 - Additional practices with EMR should be recruited
-

Progress to Date

- Practices engaged to provide data and participate with changes in office management of Hypertension
 - Community awareness with targeting of minority neighborhoods
 - Church outreach
 - Barbershop screenings
 - Communication plan for broad public campaign
 - Measures agreed upon with sources identified
 - Educational institutions engaged for participation in screenings
 - Center for Community Health involved to direct behavior change efforts
-



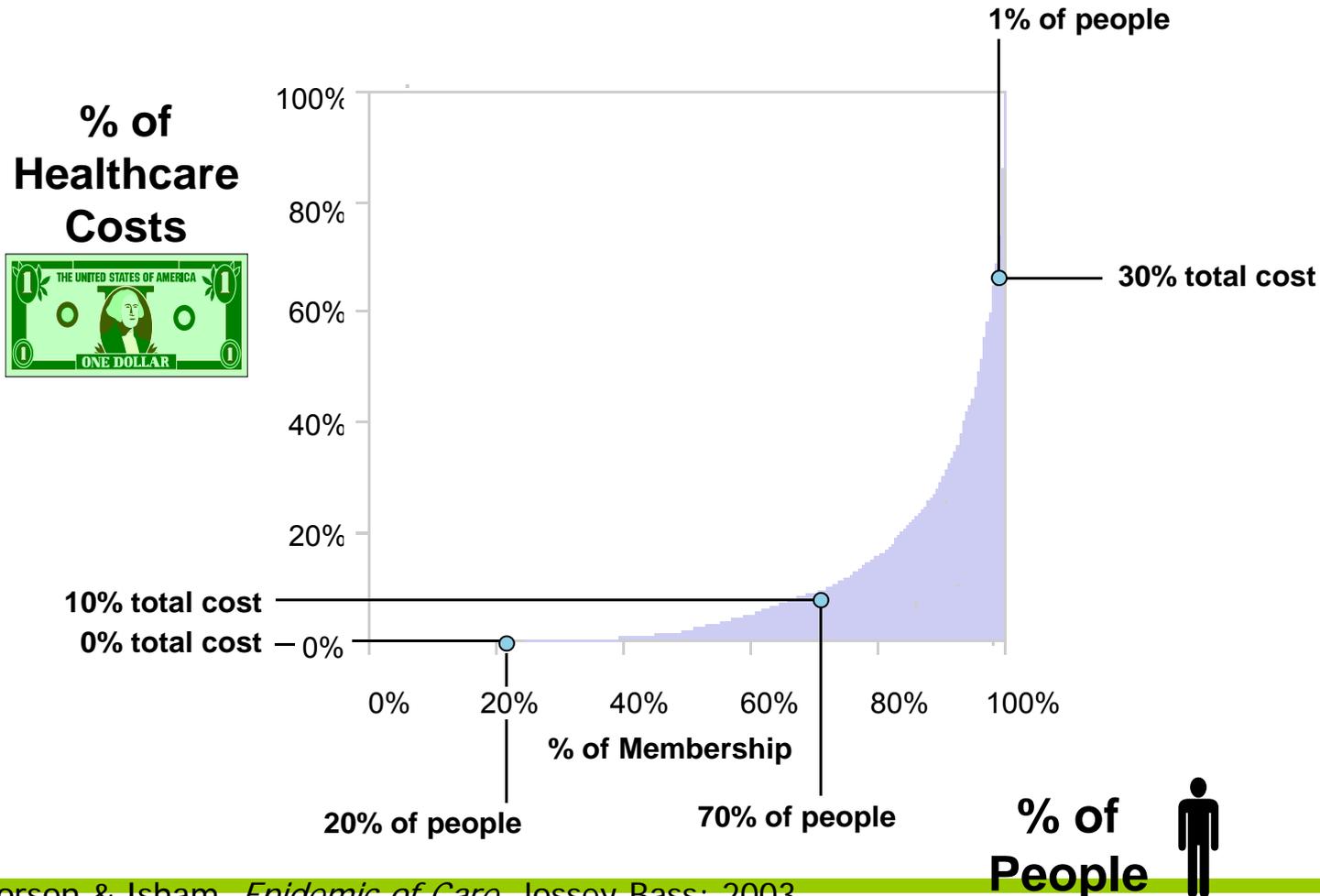
Finger Lakes Health Systems Agency

The triangle represents our agency's role as a fulcrum—the point on which a lever pivots—boosting the community's health by leveraging the strengths of all stakeholders. The fulcrum is also a point of equilibrium, reflecting our ability to balance the needs of consumers, providers and payers on complex health matters. The inner triangle also evokes the Greek letter delta—used in medical and mathematical contexts to represent change—with a forward lean as we work with our community to achieve positive changes in health care.

Give me a lever long enough and a fulcrum on which to place it,
and I shall move the world. —Archimedes

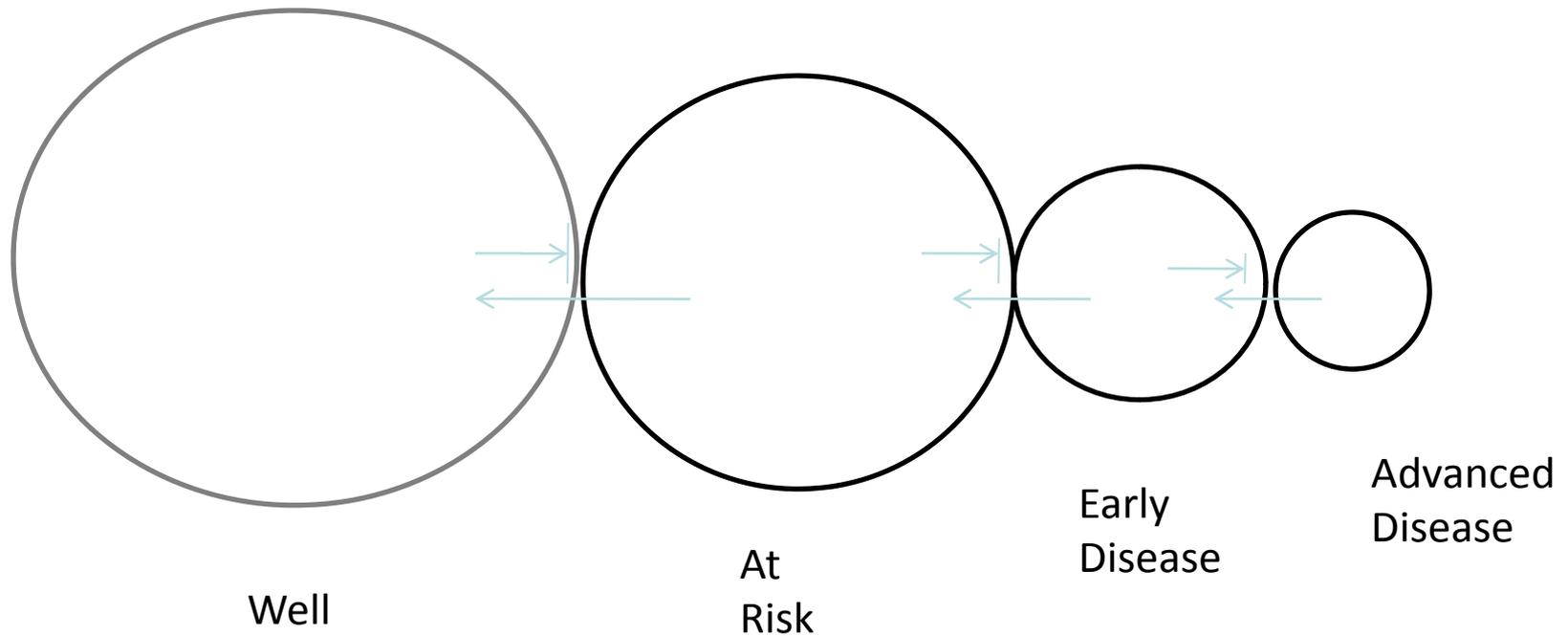
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Cost distribution of care (Working Americans)

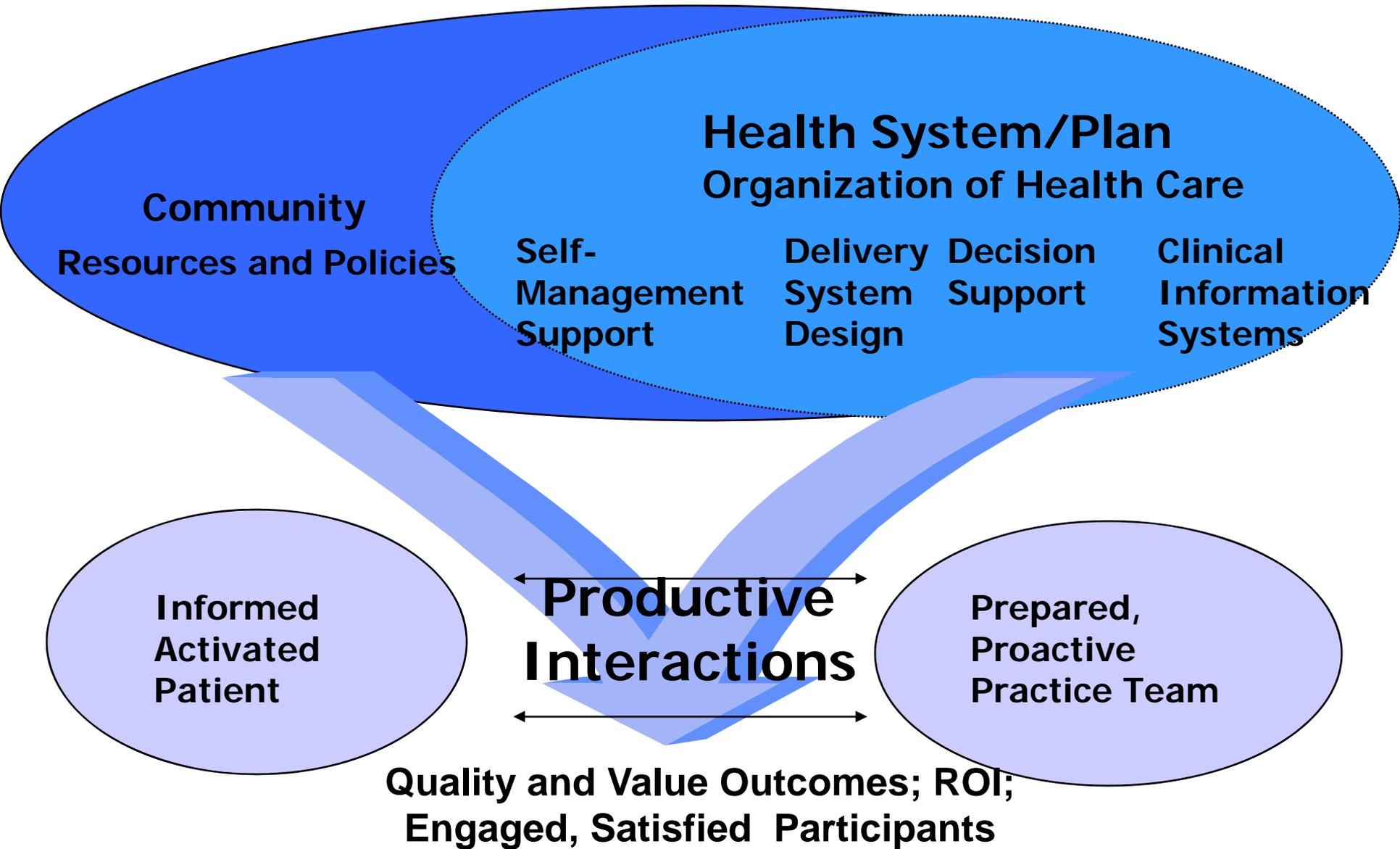


Population Segmentation into Stages of Disease*

*arrows indicate desired direction of population shift

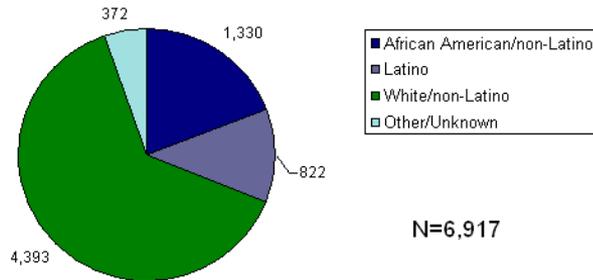


The Chronic Care Model*



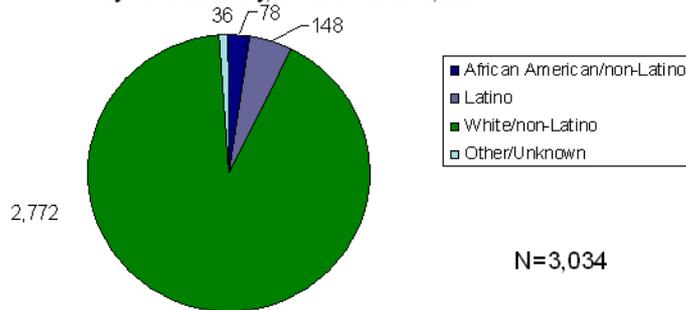
PQI Discharges Volumes: Race/Ethnicity as a Variable

**Respiratory, Circulatory, & Diabetes PQI Discharge Volume
by Race/Ethnicity, Monroe County, 2007**



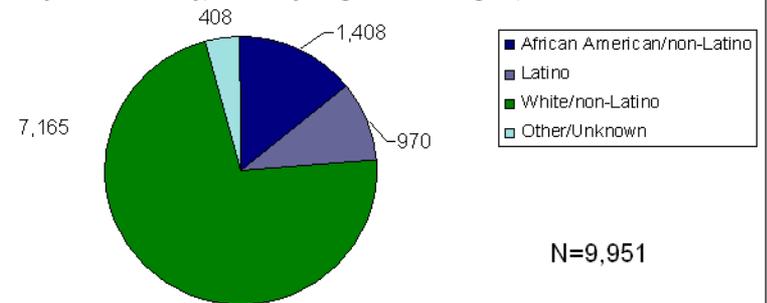
Data Source: NYS Department of Health, SPARCS Files
Calculations by Finger Lakes Health Systems Agency

**Respiratory, Circulatory, & Diabetes PQI Discharge Volume
by Race/Ethnicity, Central Subarea, 2007**



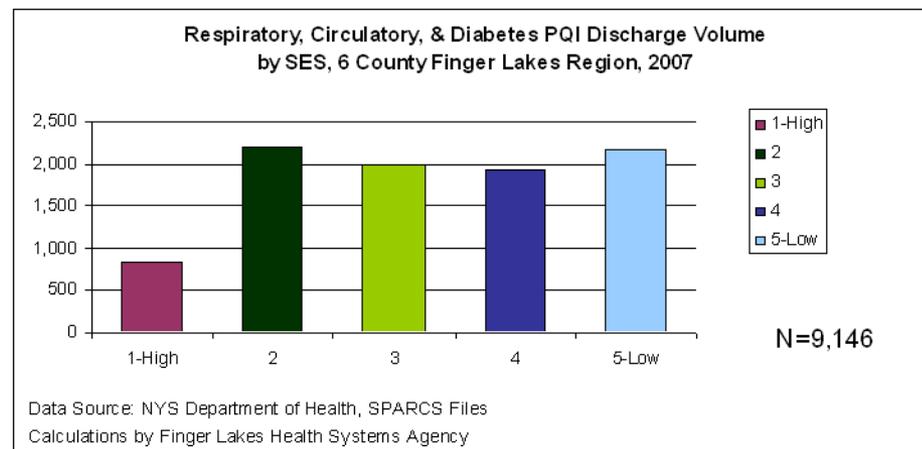
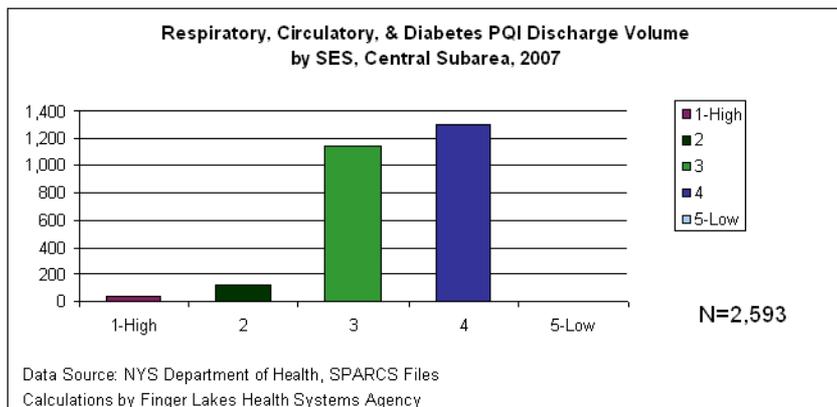
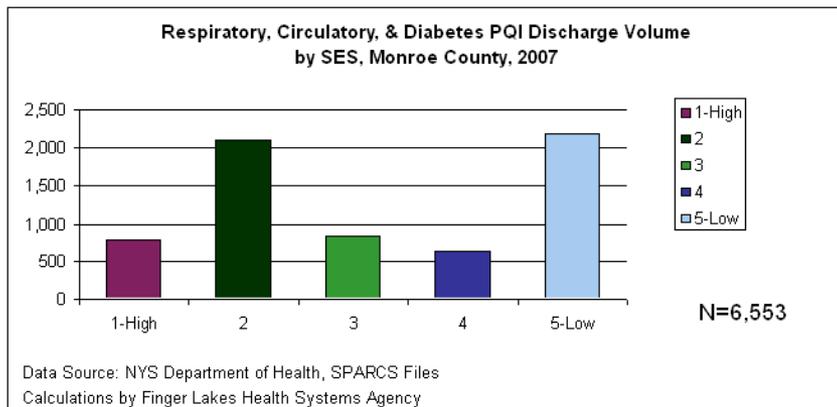
Data Source: NYS Department of Health, SPARCS Files
Calculations by Finger Lakes Health Systems Agency

**Respiratory, Circulatory, & Diabetes PQI Discharge Volume
by Race/Ethnicity, 6 County Finger Lakes Region, 2007**

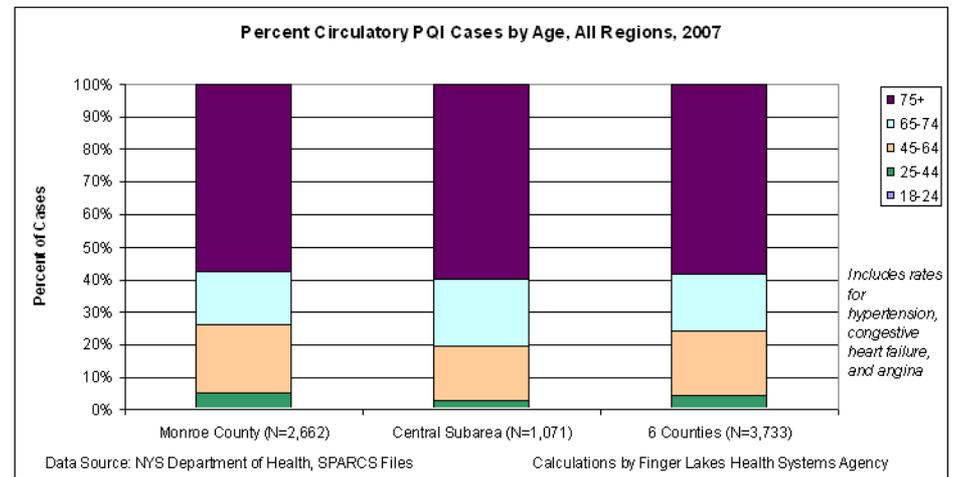
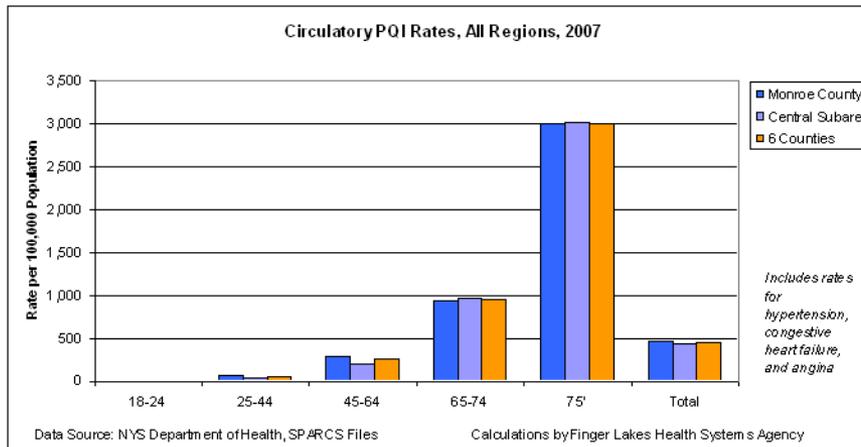


Data Source: NYS Department of Health, SPARCS Files
Calculations by Finger Lakes Health Systems Agency

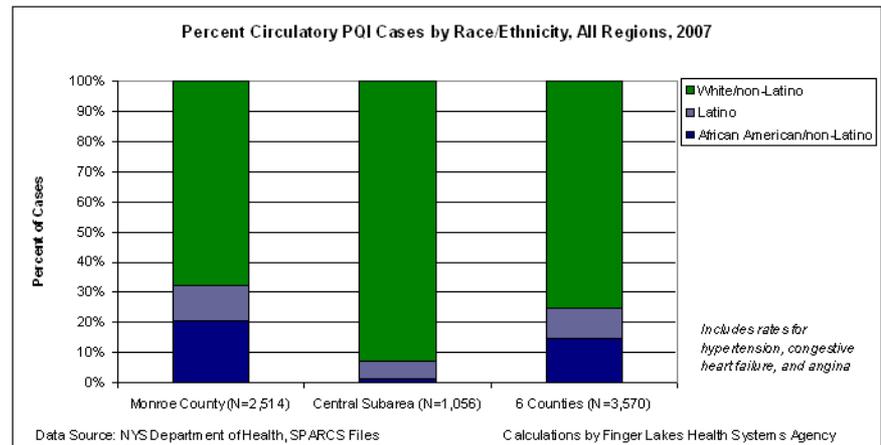
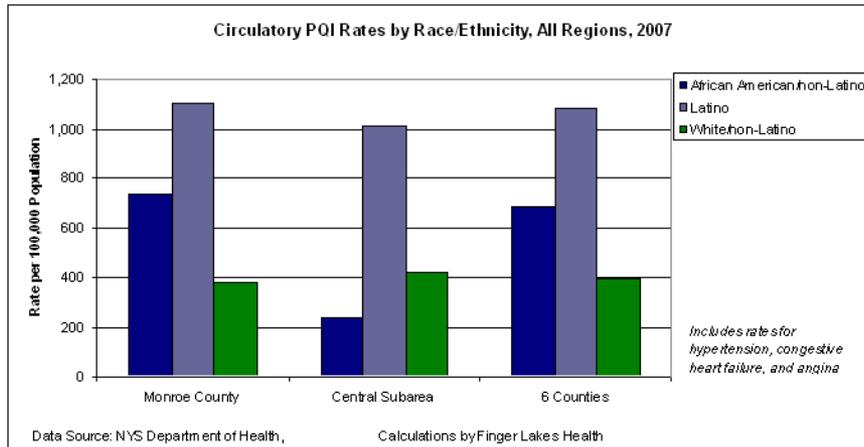
PQI Discharges Volumes: SES as a Variable



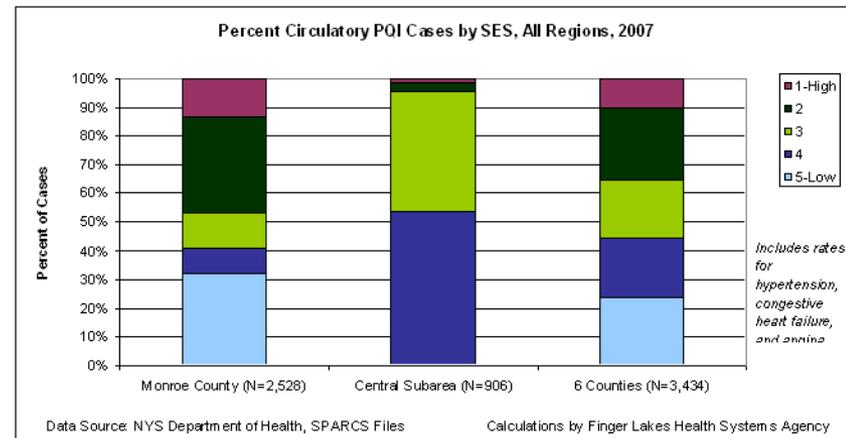
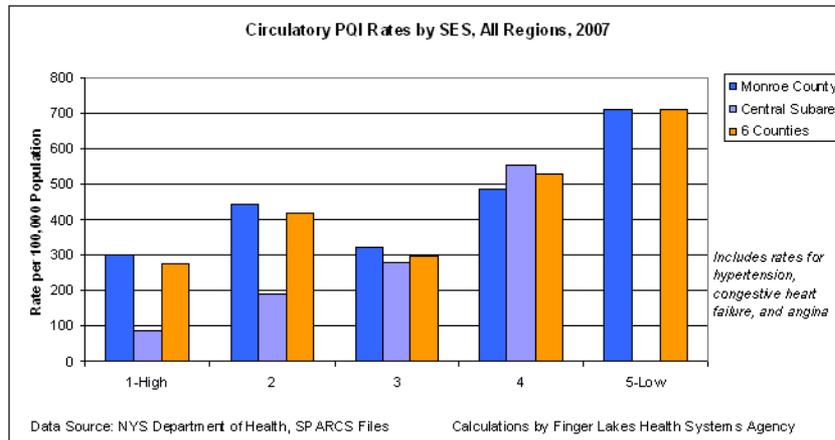
Circulatory PQI Rates & Percentages: Age as a Variable



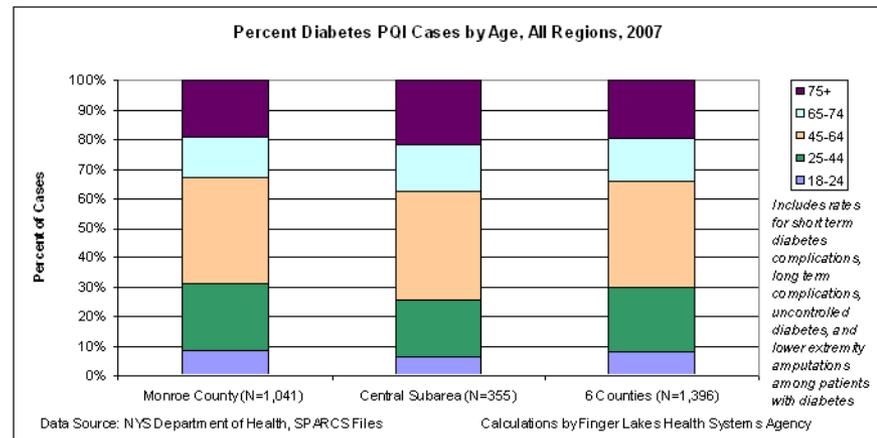
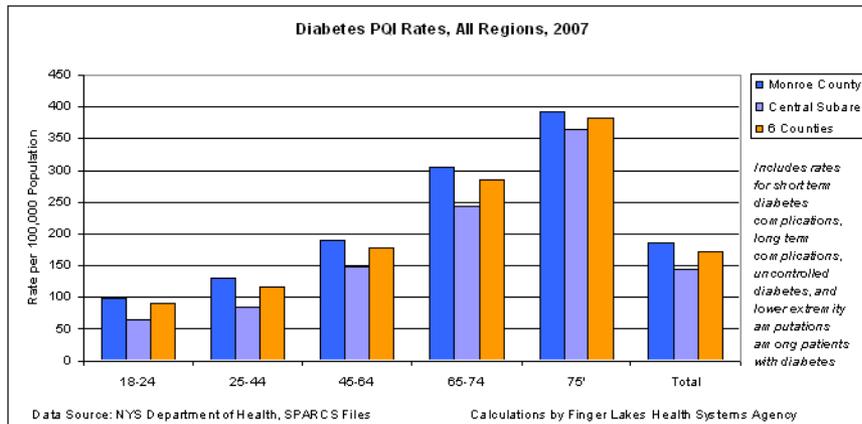
Circulatory PQI Rates & Percentages: Race/Ethnicity as a Variable



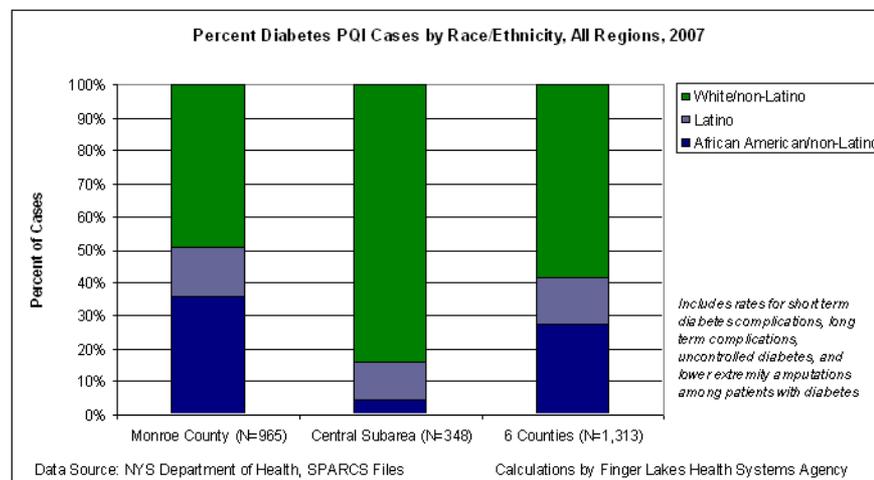
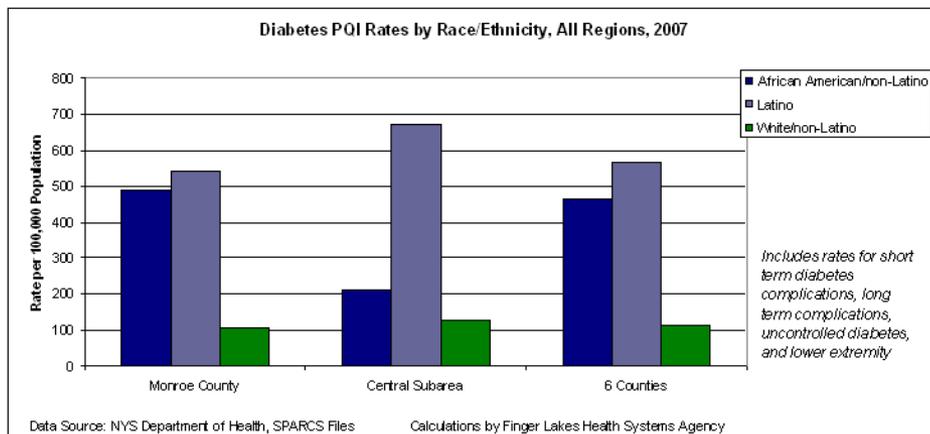
Circulatory PQI Rates & Percentages: SES as a Variable



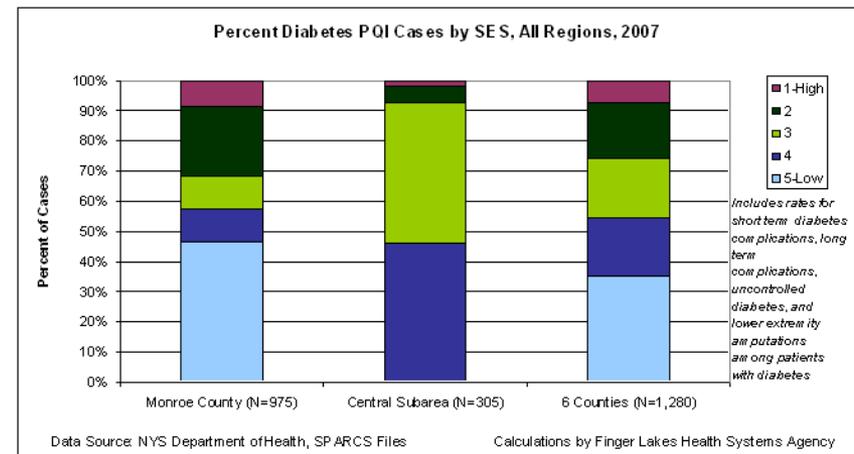
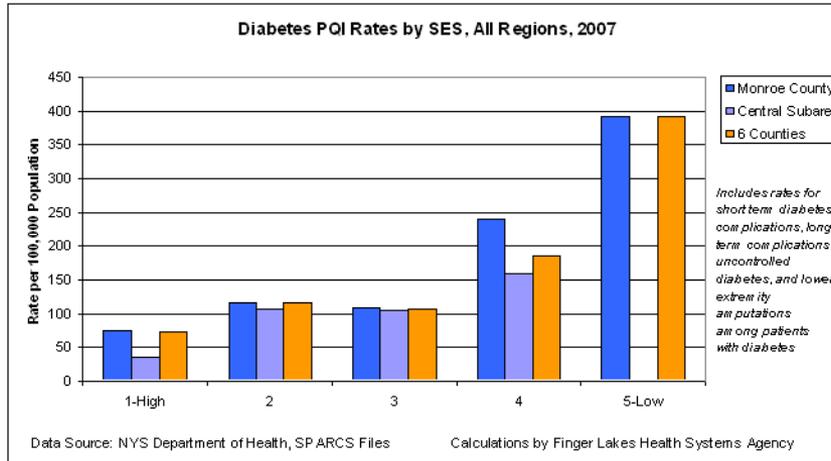
Diabetes PQI Rates & Percentages: Age as a Variable



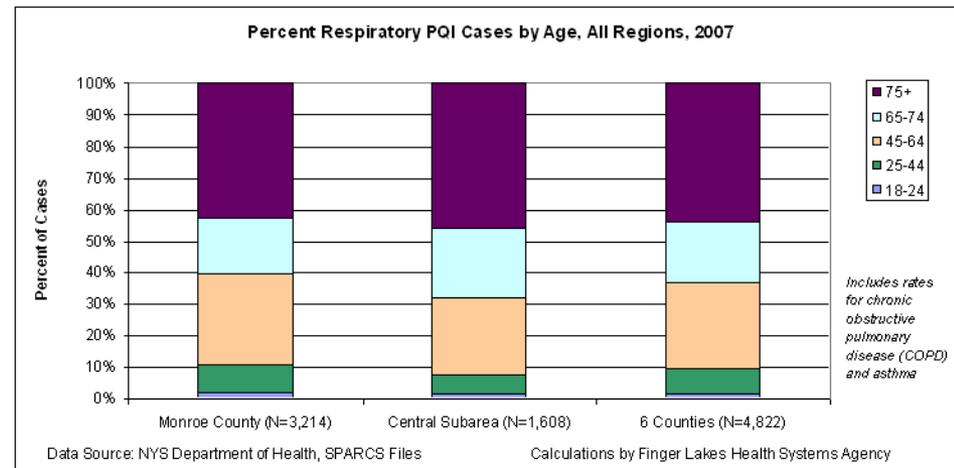
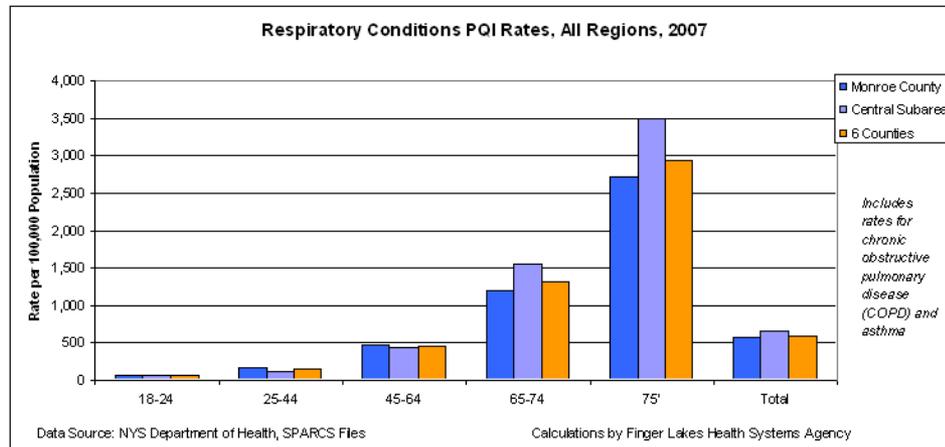
Diabetes PQI Rates & Percentages: Race/Ethnicity as a Variable



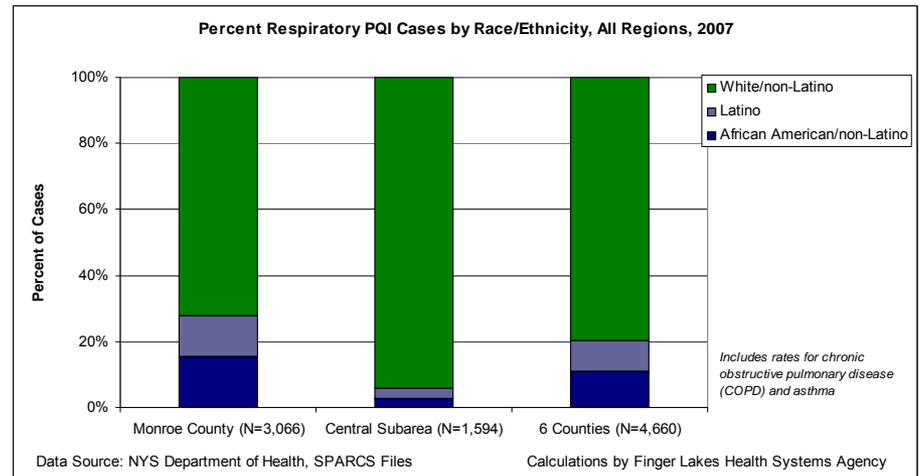
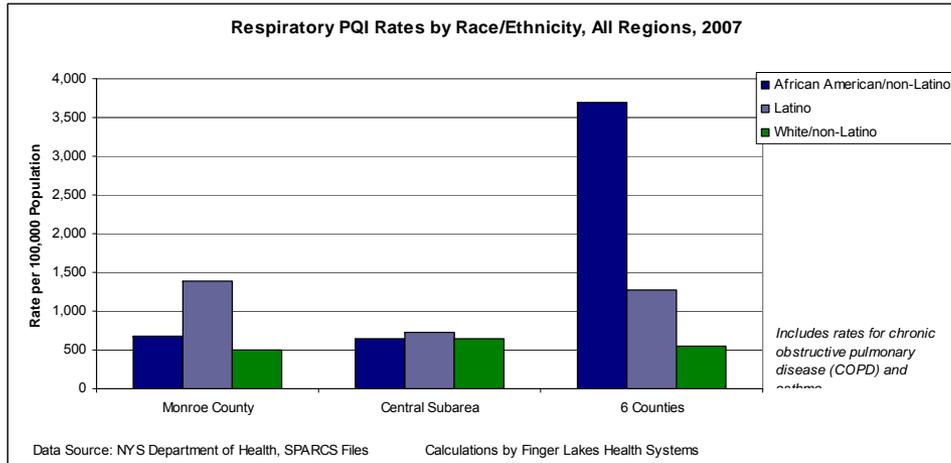
Diabetes PQI Rates & Percentages: SES as a Variable



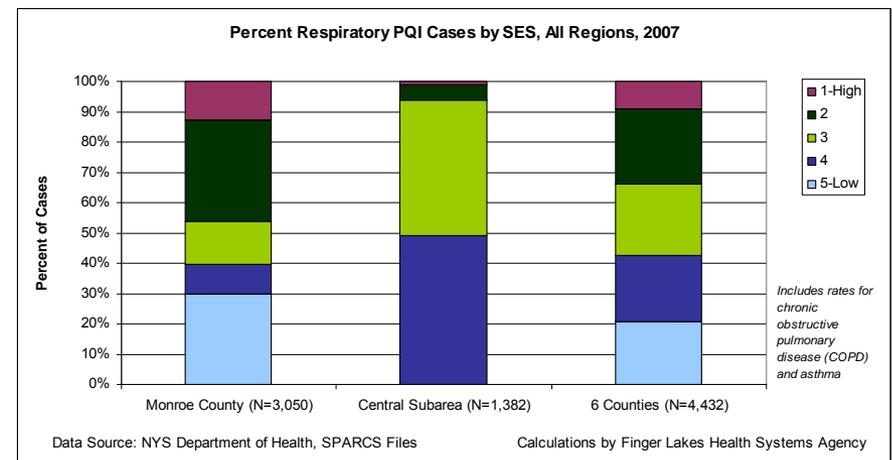
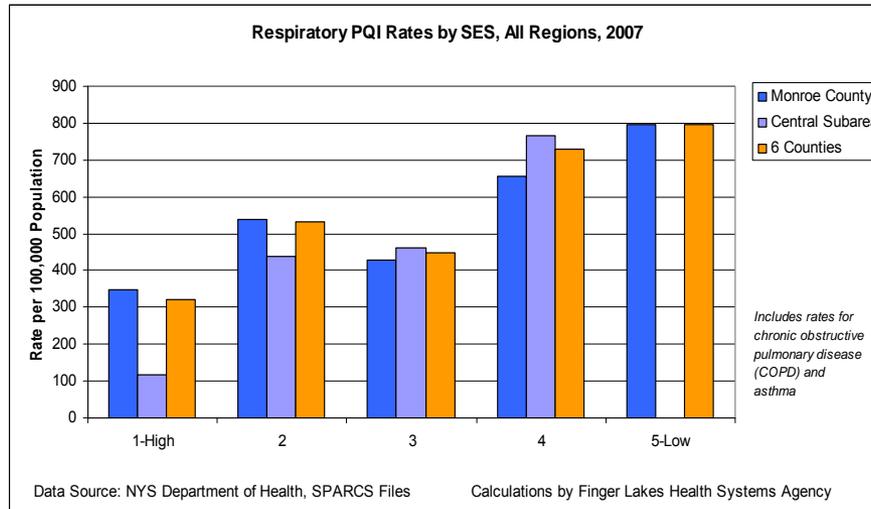
Respiratory PQI Rates & Percentages: Age as a Variable

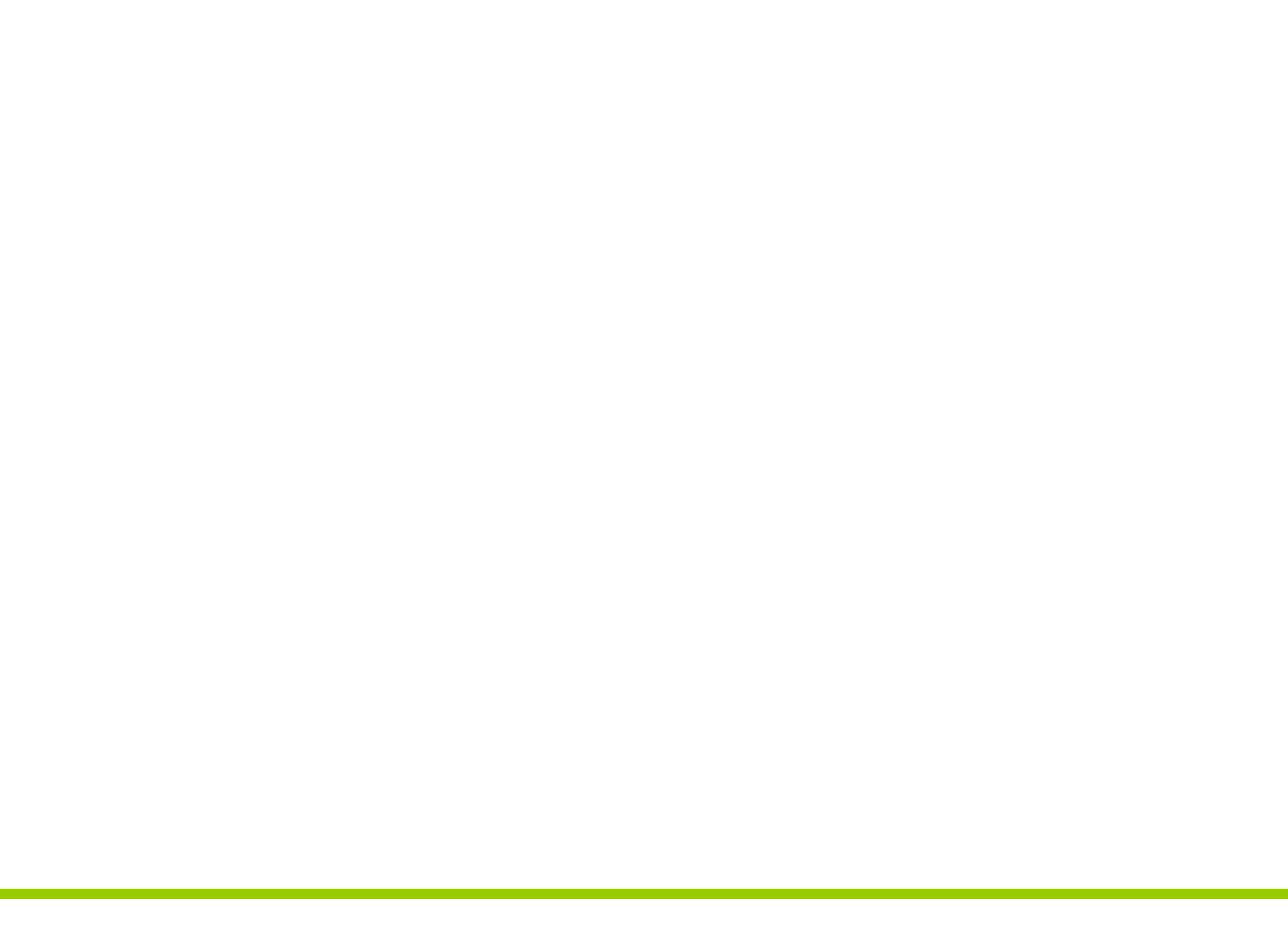


Respiratory PQI Rates & Percentages: Race/Ethnicity as a Variable



Respiratory PQI Rates & Percentages: SES as a Variable





Reducing PQI Admissions - Intervention

- It's all about improving chronic disease management and care transitions.
- The low-hanging fruit is reducing readmission by improving care transitions for Medicare patients with heart disease, respiratory disease and diabetes.
- Three types of interventions have come to the fore.

Reducing PQI Admissions: Potential Interventions

Patient Admitted with PQI Diagnosis

Improved Hospital Discharge Planning

- Hospital-administered
- Includes med reconciliation, condition-specific education, enhanced d/c planning, phone follow-up

Coaching Patients to be More Engaged

- “Improving Transitions in Care” Program, Eric Coleman, MD (3)
- Can be funded by community effort
- Involves pt/family activation using coaching rather than case management
- Can be delivered across hospital settings

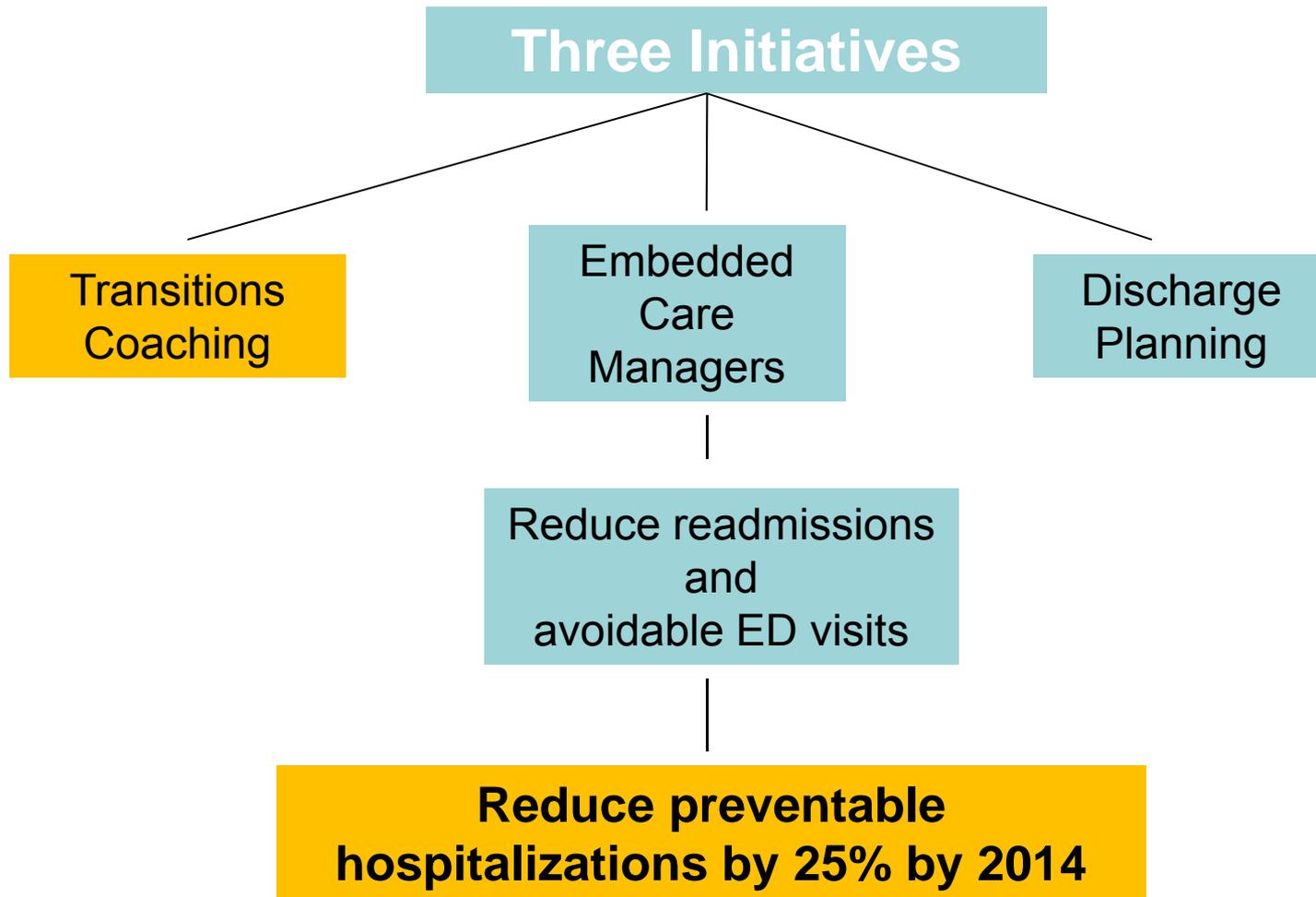
Providing Practice-Based Case Management

- Health plan funded
- Embedded case managers (CM) in primary care practices
- 1 CM/700-800 Medicare pts; 15-20% high risk pt load
- Personalized link to support svcs
- Transitions follow up
- Direct phone line access to CM

Earlier return to treating physician, more engaged patient/family, improved access to practitioners, adherence to evidence-based guideline-directed care

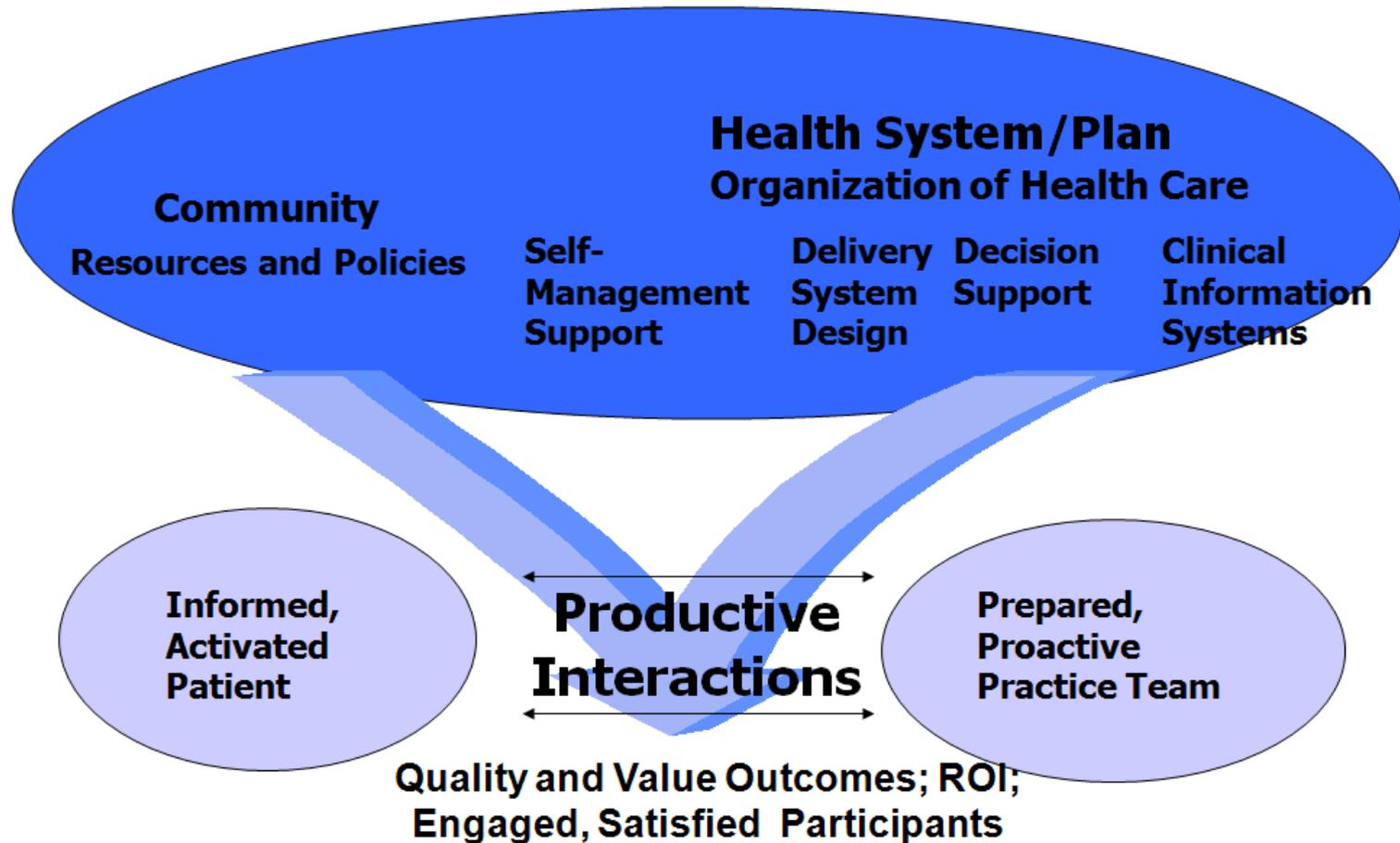
Reduced Readmissions

Reduce Potentially Preventable Hospitalizations



Why patient coaching?

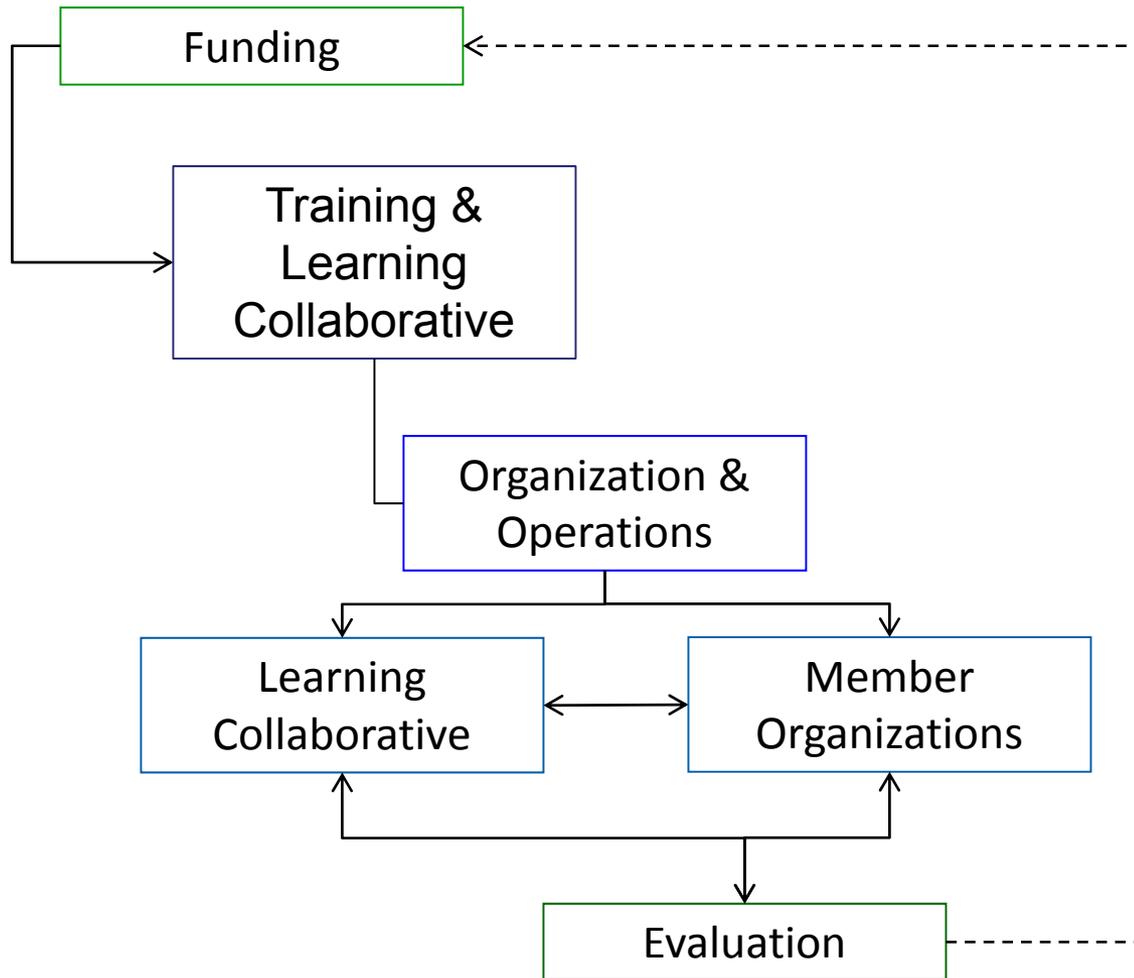
The Chronic Care Model



Care Transitions ProgramSM Description

- A four week program in which patients with complex care needs and family caregivers receive specific tools and work with a “Transitions CoachTM” to learn self-management skills.
- This program has four conceptual domains, or “Pillars.”
- Contact between the coach and the patient occurs in three ways:
 1. The first patient visit in the hospital before discharge
 2. One follow-up home (or SNF) visits (ideally 24-48 hours post-discharge)
 3. Three follow-up phone calls (ideally at 2, 7, and 14 days post-discharge)
 - Each visit and phone call has a specific goal that includes addressing the unique needs / goals of the patient

Schematic of Action Plan



- The implementation of the Coaching Transitions ProgramSM comprises four distinct components:
- Acquiring funding for the project
 - Training patient coaches founding a community-wide learning collaborative
 - Staffing the organization and operations of the learning collaborative and engaging with member organizations to integrate Coaching Transitions ProgramSM into their work
 - Evaluation of the effects of coaching across the community (e.g., readmission rates), quality of coaches, and success of the collaborative

Evaluation Measures

- Care Transitions Measure (CTM-3)^{1 2}
 - Patient Activation Assessment (PAA)
 - Hospital PQI Readmission & ED visit data
 - Baseline
 - Post intervention
 - Risk stratification
 - Age
 - Race/Ethnicity
 - ZIP code
 - Discharge diagnosis
 - Status post-discharge (destination post-hospitalization)
-

Progress to Date

- Training Learning Collaborative – Training for 14 coaches September 2010 - Excellus sponsored
 - Funding – Excellus, MVP and Monroe Plan begin reimbursing for coaching services October 2010
 - Learning Collaborative to continue training – FLHSA December 2010
 - Funding – HEAL grant to begin reimbursing for coaching services to non-covered January 2011
-

Progress to Date

- Organizations involved to date:
Excellus, MVP, Monroe Plan, VNS, Lifetime Care, Ibero, Lifespan, Jewish Family Services

Discharge Planners from Hospitals:

Rochester General, Strong Memorial, Unity preparing

- Community and Professional Education:
Co-Chairs: Nancy Adams, MCMS, Executive Director
William Armbruster, AARP, Associate State Director

Progress to Date

- Evaluation and Specifications

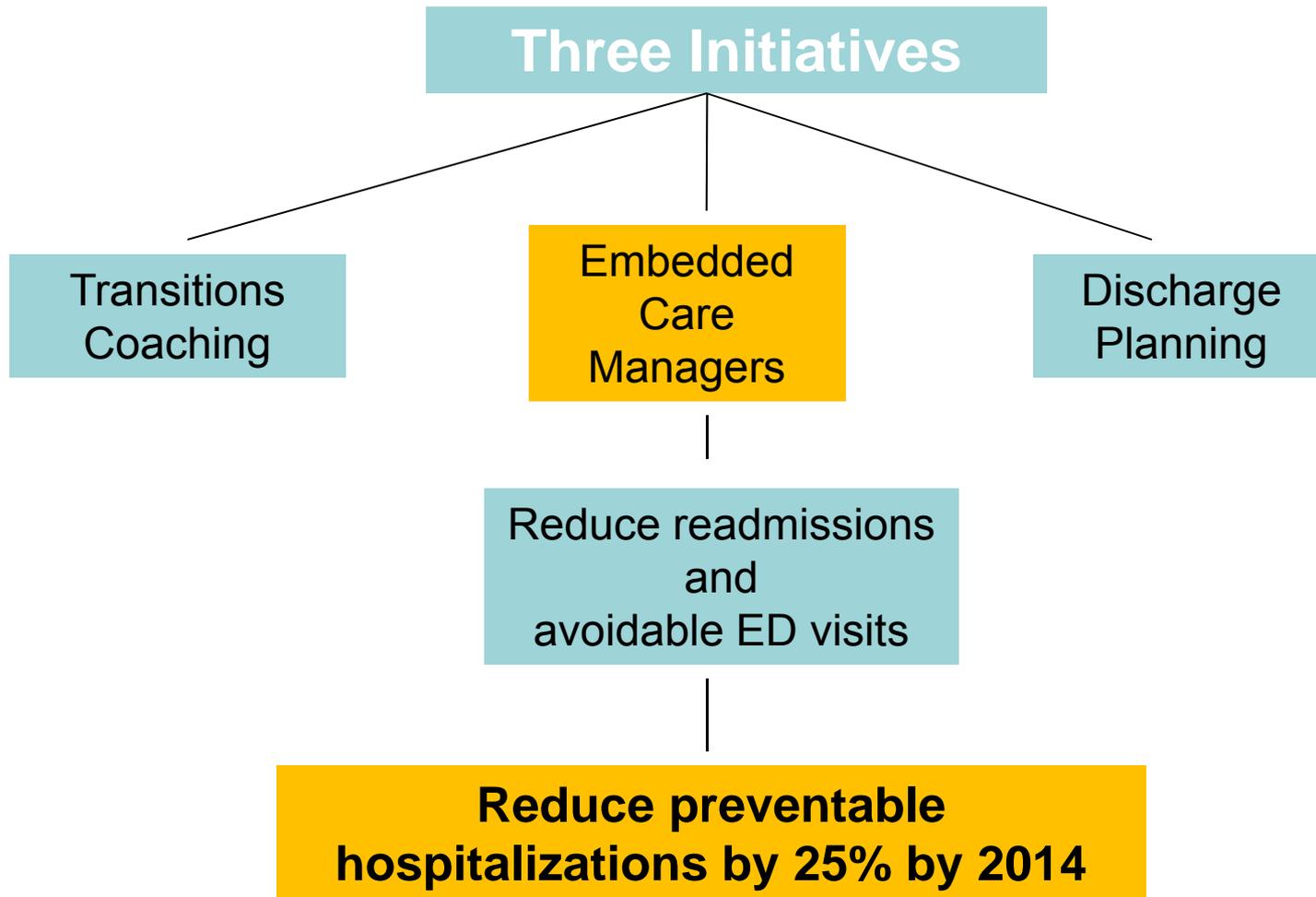
Chair: Patricia Campbell, RN, MPH, Program Officer
Rochester Community Area Foundation

Members from all community organizations involved

Deliverables

- 14 Active coaches by end of 2011
 - 12% reduction in 30 day readmissions
 - Implementation of a community wide Coaching Learning Collaborative
-

Reduce Potentially Preventable Hospitalizations



Charge and Scope of the Embedded Care Management Workgroup

1. Identify ideal characteristics of a practice based case manager
 2. Identify appropriate outcome metrics
 3. Identify community practices
 - Cultural readiness for embedded CM
 - Technical capabilities
 - Sufficient practice volume
-

Work Group Structure

1. Local facilities
 2. Private Practice
 3. Home care
 4. Local FQHC input
 5. Major local payers
 6. Identify community practices
-

Evidence

Discovery into National and International Best Practices

1. Guided Care - Johns Hopkins
 2. Evercare pilot -United Health Care
 3. Community Care of North Carolina (CCNC)
 4. Community Matron Model – NHS (UK)
 5. Physicians Group Practice/ Accountable Care - Geisinger
-

Embedded Care Manager Implementation

- Distinguishing ECM from Rochester Medical Home Initiative Pilot (RMHI)
 - ECM does not require NCQA Accreditation
 - ECM does not require EMR
 - ECM will not be scored based on performance reporting measures
 - Main goal is to promote practice redesign and cultural change in practices unable/unwilling to attain PCMH designation
-

Key Functions of ECM similar to PCMH

1. Identifying at-risk patients
 2. Interface with medical and social support - community services
 3. Medication reconciliation / management
 4. Self-management skills
 5. Caregiver support and education
 6. Coordination with other providers
 7. Provider's "wingman"
-

The Care Manager

- Works in collaboration with all members of an interdisciplinary team of physicians, hospital discharge planners, RN's, CSW and coaches to facilitate the effective transition after hospitalization discharge
 - Serves as the single point of contact for identified patients with chronic conditions that put them at risk for readmission
 - Coordinates services and act as the liaison between the practice and community agencies
-

Progress To Date:

- Secured funding to pilot 5 Care Managers in PCP Setting
 - Projected Hire Date: January 2011
 - Confirming Pilot sites and assessing practice readiness
 - Criteria:
 - Must have mechanism to track and report
 - Must have 1000 Medicare Patients
 - Must have mechanism to Risk Assess
 - Must be connected with a system
-

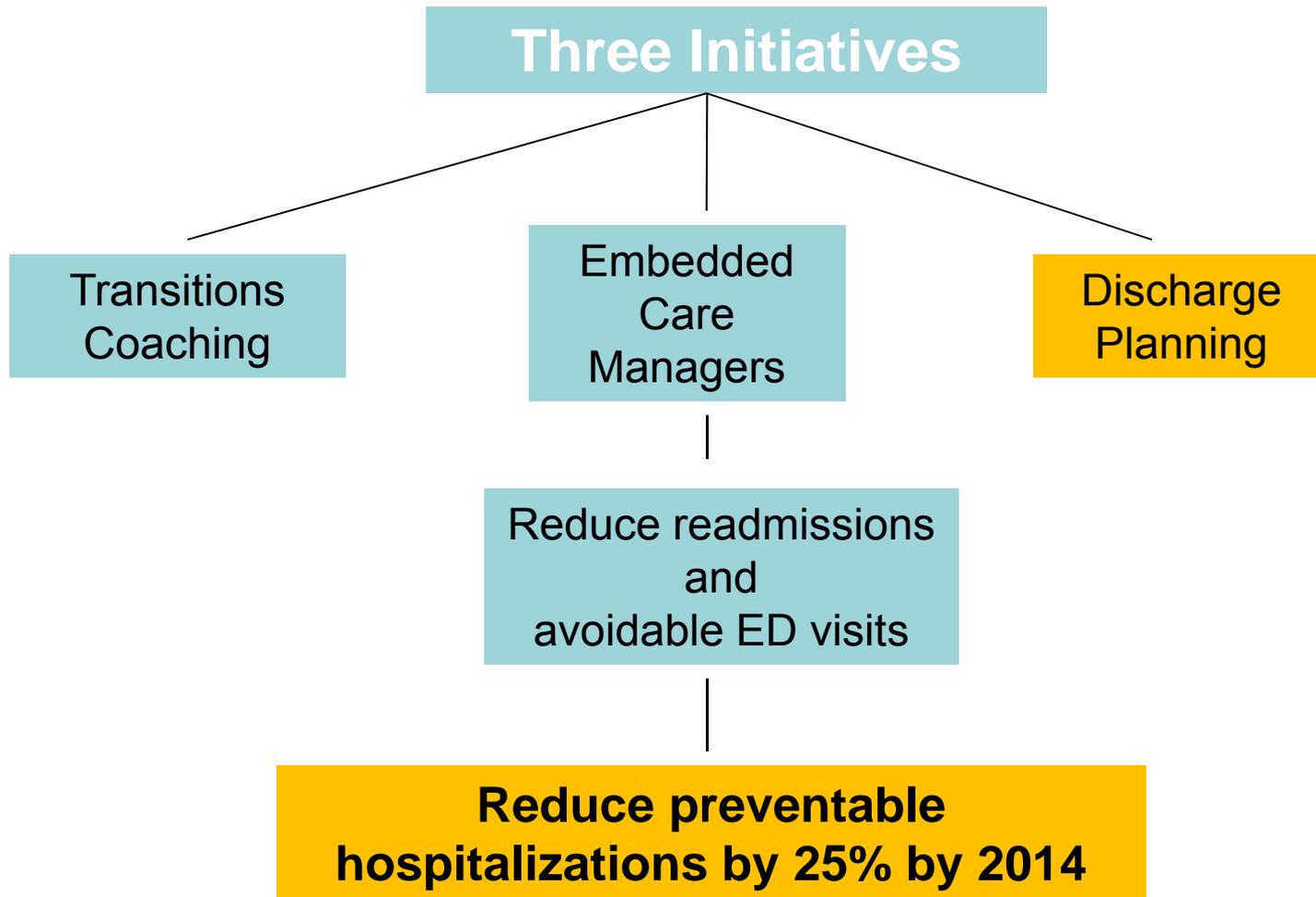
Challenges

1. Effective integration into the workflow of the office
 2. Established office based-case management curriculum
 3. Effective coordination between multiple caregivers
 4. Knowing available community resources
 5. Harnessing the power of IT to manage patients
 6. Finding the right skills to fill the position
 7. Short implementation time
-

Deliverables

- 5 Care Managers in PCP Practices
 - training and maintenance
 - 12% Reduction in Readmissions
-

Reduce Potentially Preventable Hospitalizations



Four Community Standards for Discharge Planning

Creation of a region-wide set of discharge/transition standards that, when fully implemented, will enhance patient safety and safe transition from hospital to community-based setting and lead to a reduction in the number of avoidable hospital readmissions.

Four Community Standards for Discharge Planning

1. Patient/Family centrality to the discharge planning process
 2. Medication reconciliation
 3. Information transfer
 4. Post-discharge follow up
-

Progress To Date

- URMC pilot on complex surgical floor
 - Unity piloting “teach backs”
 - RGH examining readmission circumstances; social, medical, home care plan
 - Risk Assessments
 - Looking ahead: Transportation, Indigent Medications, Patient liason and Transition Coaches Implementation and Risk Assessment
-

Progress To Date

RHIO

- Mapping and loading ADT messages from local hospitals
 - Clifton Springs Hospital is piloting ED Landing Page
 - Subscription Model pilot scheduled for fourth quarter 2010 to inform PCP when a patient is admitted to ED
 - EMS pre-hospital care clinical document is being provided in a standardized format and available on patient virtual health record (VHR)
 - VHR will be available on Smart Phones
 - Senior Summary on VHR documents care provided by social service agencies
 - Piloting patient portal to include Advance Directives
 - Pilot electronic referrals with first EHR vendor
-

Deliverable

Achieve a 15% reduction in 30-day PQI-related readmissions compared to 2009-2010 across the six County Finger Lakes Region



Finger Lakes Health Systems Agency

The triangle represents our agency's role as a fulcrum—the point on which a lever pivots—boosting the community's health by leveraging the strengths of all stakeholders. The fulcrum is also a point of equilibrium, reflecting our ability to balance the needs of consumers, providers and payers on complex health matters. The inner triangle also evokes the Greek letter delta—used in medical and mathematical contexts to represent change—with a forward lean as we work with our community to achieve positive changes in health care.

Give me a lever long enough and a fulcrum on which to place it,
and I shall move the world. —Archimedes

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