Creating Clinically Integrated Health System-Based Medical Groups Collaborative Case Study

Advocate Medical Group and Advocate BroMenn Medical Center

Comprehensive Care Program/Readmission Risk Program
Organizational Profile

This case study is based on a program developed between Advocate Medical Group and Advocate BroMenn Medical Center. Advocate Medical Group was established in 1995 and BroMenn Medical Center was established in 1984. In 2010, BroMenn Medical Center, which consists of 221 beds, merged with Advocate Healthcare. Advocate Healthcare is the largest health system in Illinois with nearly 400 sites of care and 12 acute-care hospitals, including a children's hospital with two campuses. They employ 35,000 associates, including 6,300 affiliated physicians and 11,000 nurses. The two local entities serve the Bloomington, Normal, and Eureka areas as well as small towns surrounding these cities. The primary service area covers eight counties with McLean County being the largest, with more than 130,000 people calling those communities home. Bloomington- Normal is also home to Illinois State University and Illinois Wesleyan University, and is corporate headquarters for State Farm Insurance as well as COUNTRY Insurance & Financial Services. The secondary service area covers an additional five counties. The region is rich with commerce, industry, and agriculture, where people are friendly and traditional Midwest hospitality is the norm. While the area is growing at a rapid annual rate, crime is low and its school districts are progressive. Both entities are part of an integrated healthcare organization and are both faith-based, not-for-profit. The Advocate mission is to serve the health needs of individuals, families, and communities through a holistic approach to health care that provides quality care and service, and treats each patient with respect, integrity, and dignity.

Advocate Medical Group, Central Region, employs 70 physicians and 25 advanced practice clinicians over a total of 26 sites of care. Advocate BroMenn Medical Center has 450 physicians on medical staff.

Executive Summary

This project was initiated because emergency department visits and readmission rates are above projected targets. As they move to full risk, these rates will negatively affect reimbursement. They feel they can provide a higher quality of care, safety, and patient satisfaction by keeping patients out of the emergency department for non-emergent conditions and avoiding readmissions. As such, the organizations developed an aligned team from both the hospital and the medical group that began looking at high-risk patients utilizing palliative care and navigation concepts. They began to provide the necessary support and assistance so that these patients received appropriate medical, social, economic, and spiritual care that would assist high-risk patients in meeting their healthcare goals.

Program Goals and Measures of Success

The team began by establishing goals and metrics and creating new care processes to address the above-targeted readmission rates and emergency room visits. Members from both the hospital and medical group identified those high-risk patients and provided support and assistance to achieve their healthcare goals.
The data collection dashboard included:

- Inpatient/Obs PPPM
- ED visits PPPM
- Readmission rate
- Advanced directives
- Percentage of patients seen within 48 hours of discharge
- Total number of patients seen and graduated from the program

**Intervention**

Following this, the team developed a patient screening tool for risk assessment, a system readmission tool, a behavioral health screening tool, and a care management screening tool. Their standards were established using a hybrid of pieces from the Eric Coleman Foundation (transitional care pillars) and the Harold P. Freeman Patient Navigation Institute. The team identified patients by use of a risk score. Once the patients were identified, the subsequent steps were developing care navigation, a comprehensive in-home assessment, personalized goal setting, multidisciplinary participation in patient goals, office appointments with the lead physician, and the creation of a multidisciplinary care plan.

Steps included collecting information at any initial hospital visits before discharge from the hospital, in-home visits that assessed their environment and barriers, and any attendance at office visits meant to discuss plans and coordinate care. The intent was to assure that patient compliance was taking place with ongoing management from the multidisciplinary team as well as the execution of that plan. It also included the graduation from the program when goals were achieved.

Initially, palliative care nurses were used for this program. They found that the job descriptions needed to be rewritten to reflect the transition from inpatient nurses to inpatient/outpatient nurses. Also, the palliative care nurses were integrated into the care management huddle and eventually developed their own huddle. Subsequently, work load balance needed to be evaluated and changed to fit the needs of the program.

It was relatively easy to get the providers on board once they became aware of the gaps in patient care. The team was educated by engaging a consultant for two days from the University of Colorado Public Health balance program. Information was collected by paper documentation and scanned into a medical chart. A care dashboard was used to collect data for the case study. Navigation motivational techniques were additionally used. There was extensive patient education regarding patient medical self-management, dynamic patient-centered health records, community and healthcare resources, as well as red flags to indicate worsening conditions and how to respond. The physicians ended up spending more time with these patients. Communication with the patients at home visits and office visits was the best form of data collection.

**Outcomes and Results**

This program allowed us to reduce admissions in this population, reduce emergency room visits, increase advanced directives, and increase the percentage of patients seen within 48 hours of discharge as indicated in chart.
<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre</th>
<th>Post</th>
<th>Percent Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient/Obs PPPM</td>
<td>0.34</td>
<td>0.11</td>
<td>68%</td>
</tr>
<tr>
<td>ED Visits PPPM</td>
<td>0.12</td>
<td>0.08</td>
<td>33%</td>
</tr>
<tr>
<td>Readmission Rate</td>
<td>27%</td>
<td>16%</td>
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<tr>
<td>Advanced Directives</td>
<td>63%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>% of Patients Seen w/in 48 hours of discharge</td>
<td></td>
<td></td>
<td>84%</td>
</tr>
<tr>
<td>Patients Seen/Graduated</td>
<td>35</td>
<td>35</td>
<td></td>
</tr>
</tbody>
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Cancer patients appeared to do better with the program, as hospice was involved with these patients early in the process.

**Lessons Learned and Ongoing Activities**

Communication with the patient and attendance at home visits and office visits was a very positive experience with good outcomes. Developing agreed-upon measures as well as goals was a difficult process. It was a challenge to get patient feedback at times. It was also a challenge to exchange information with insurance payers. As a result, there was no charge to the patient for this service.

Other challenges included the fact that there was no IT platform for this program, which resulted in paper documentation. There were additional challenges around psychiatric issues with the patients and being able to provide the necessary referral and care for these issues. Every patient needed a behavioral health referral. The risk assessment tool used was not the best for identifying high-risk patients. Thankfully, a patient report was generated to identify high-risk patients.

Initially, the team was obtaining the physician’s approval for their patients to be in the program. The team soon discovered that this was not needed, resulting in unnecessary delay. Overall, the organizations found the program lasted too long. The timeframe transitioned from three to four months to six to eight weeks, with progression ultimately down to 30 days.

This case study was a large time commitment. Data collection outside of our own system and obtaining claim history proved to be a time commitment challenge as well. There was also the aspect of keeping patient interest and physician engagement, which ultimately put a strain on the study. The biggest barrier was within the healthcare organization, itself. Departments put up barriers, and collaboration was often difficult.

The plan is hopefully to add additional offices and increase the number of patients in the system. This should increase knowledge of the benefits of this program and allow a broader collection of data.
References
Eric Coleman Foundation
Harold P. Freeman Patient Navigation Institute

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