Howard County Community Integrated Medical Home Model

Program and Initiatives

Community Integrated Medical Home

- Utilizes population health strategies to decrease preventable hospital readmissions
- Partnership with The Horizon Foundation, Howard County Health Department, Healthy Howard, and Howard County General Hospital
- Based on principles of the State Innovation Models (SIM) program

Essential Components

- Strategic use of data - hotspotting data analysis
- Community Care Team
- Transforming Primary Care Practices

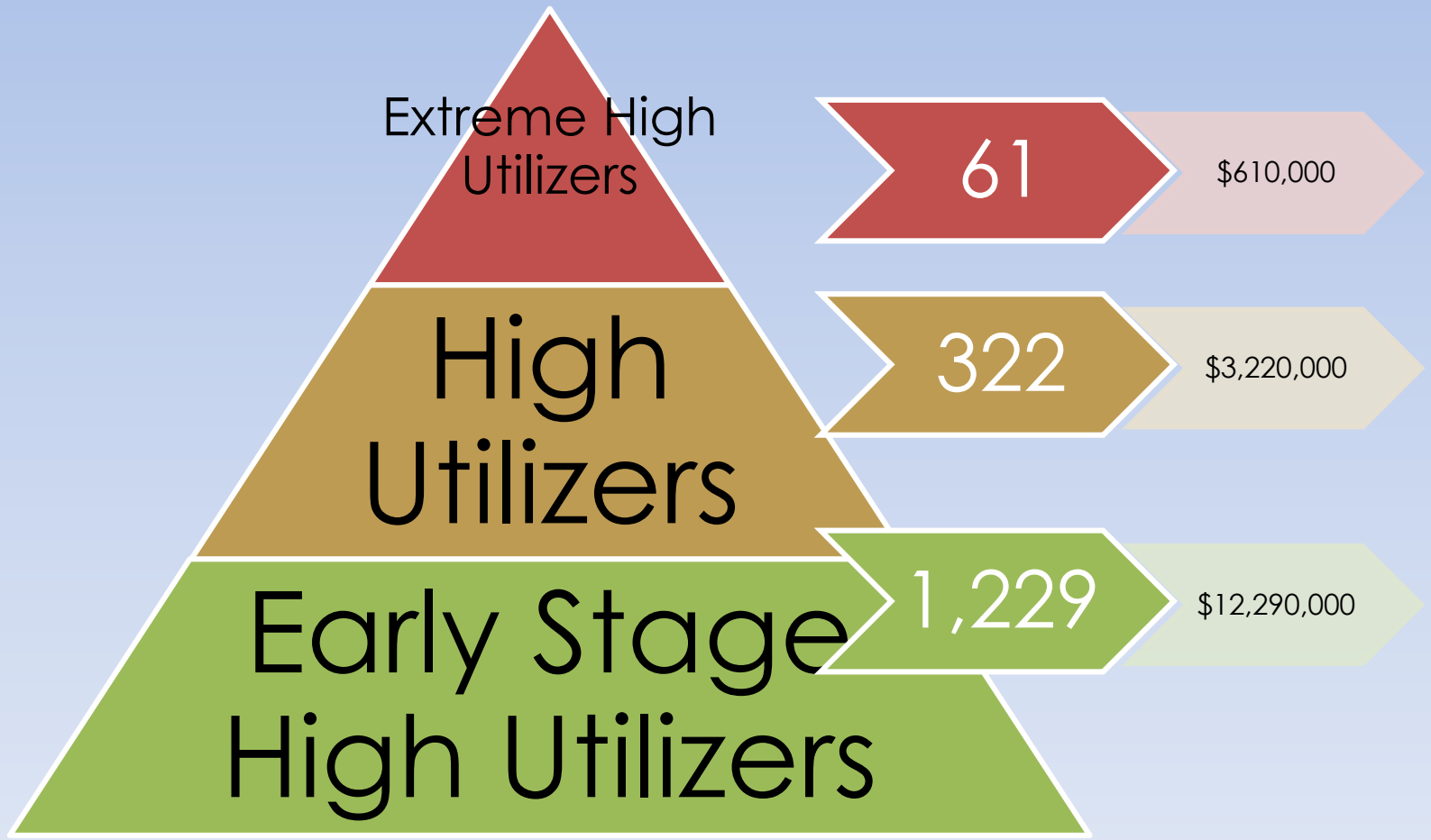
CIMH Model's Beginning

- SIM work group meetings
- The Horizon Foundation work with the Camden Coalition and Howard County General Hospital to map out "hot spots" of high health care utilization
- Grant opportunity through the Community Health Resources Commission to support enhancement of the Local Health Improvement Coalition (LHIC) as the hub for data and community involvement
- CHRC support of Advanced Primary Care Practice

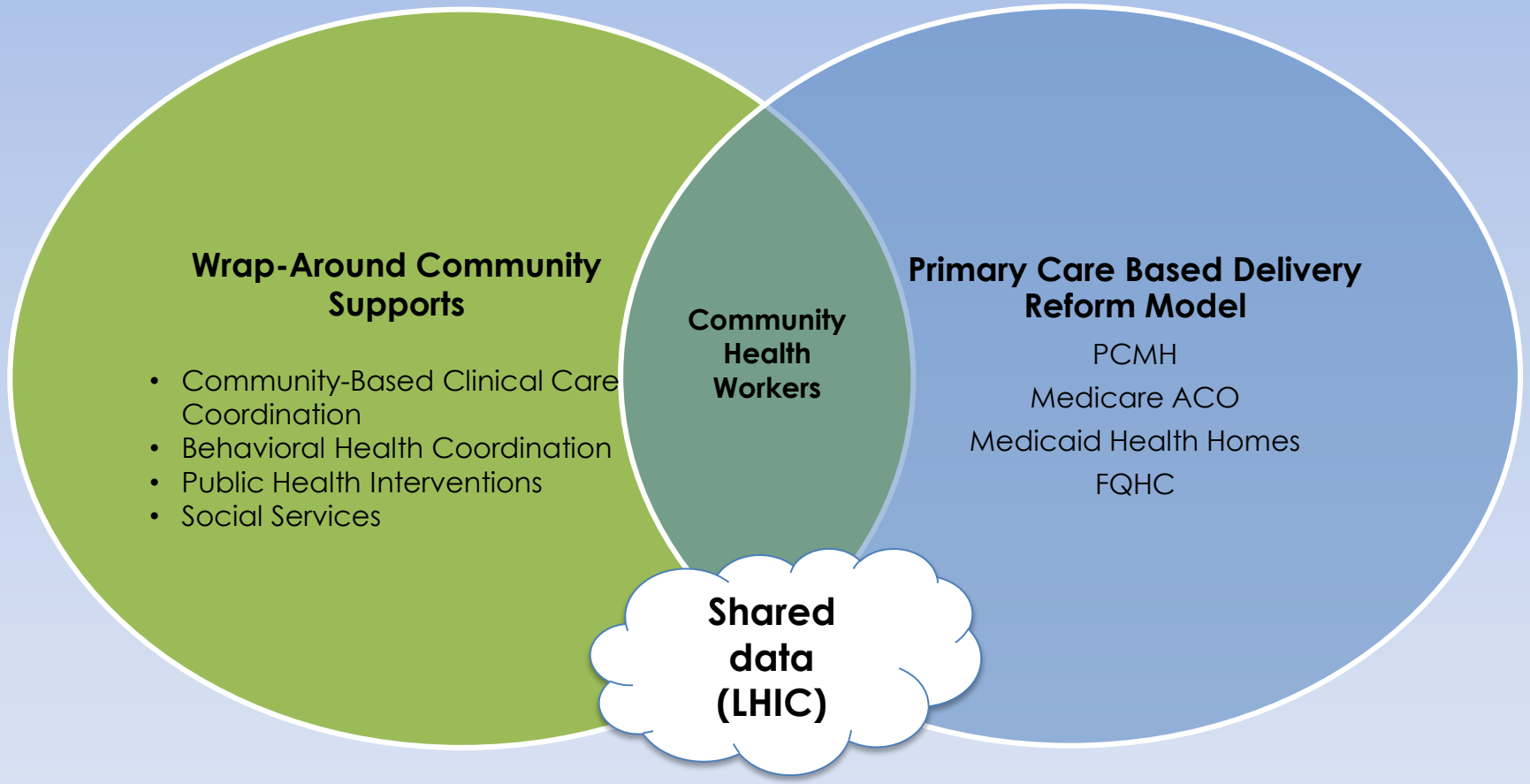
Hot-spotting Analysis

	Year	Early Stage High Utilizers	High Utilizers	Extreme High Utilizers
Median IP Visits (year)	2012	2	3	6
Median ED Visits (year)	2012	1	2	4
Unique Patients	2012	1,229	322	61
Total Charges	2012	$29,330,377	$15,541,161	$4,591,567
% of Total Unique Patients	2012	3.18%	0.83%	0.16%
Charges (% Total)	2012	19.28%	10.21%	3.02%
Median Total Charges Per Patient	2012	$18,761	$38,466	$69,214
% ED Avoidable	2012	5%	6%	8%
% ED Mental Health/Substance Use	2012	23%	33%	54%
% IP 0-60 Day Readmissions	2012	29%	48%	67%

Potential Savings



Community-Integrated Medical Home Model



Role of Community Care Team (CCT)

- Goal

To reduce unnecessary hospitalizations among Howard County's high-utilizers by delivering cost-effective community interventions

- Rationale

Costs to treat high-utilizers represent a disproportionate amount of the County's health care costs

Patients who are connected with primary care receive better coordinated care

Closing the communication gap between hospital and outpatient providers leads to less fragmented care

CCT Intervention

- Provide hands-on transitional care coordination at time of discharge
- Connect clients with primary care and other health care providers
- Provide in-home medication reconciliation and chronic disease management education
- Coordinate transportation to and from appointments as needed
- Connect with community services and assist with other social service needs
- Facilitate client's ability to manage their health conditions on their own

Role of Howard County General Hospital

- Provide hospital admissions and discharge data.
- Electronic Health Record (EHR): HCGH generates daily reports using its EHR. Reports identify patients eligible for the CCT.
- Case Management: Case managers are sent EHR reports and review the patient's medical record to assess and confirm patient eligibility criteria. Case managers refer eligible patients to the CCT.
- Data Analysis: HCGH staff partnered with CCT members to better understand HCGH readmission patterns (i.e. diagnoses, by unit, by discharge disposition).

Advanced Primary Care Pilot Program

- Goal
  - Promote primary care practice redesign across Howard County to implement principles of patient-centered care
- Rationale
  - Lack of follow-up among patients can lead to poor outcomes and unnecessary hospitalizations
- Expected Outcomes
  - Improved care coordination and care transitions
  - Better patient outcomes and management of chronic conditions
  - Fewer preventable hospitalizations

Advanced Primary Care Pilot Program

- Components
  - Maryland Healthcare Innovations Collaborative provides onsite and group learning
- Integration with Community Care Team
- Utilizing CRISP to identify high utilizers of inpatient and emergency department care
- Three practices
  - Large, small, and FQHC

Role of LHIC in CIMH

- Serve as hub for Howard County health data
  - Comprehensive database for health-related Howard County data
    - Howard County Health Assessment Survey
    - Hospital admissions/ED Use
    - Vital Statistics
- Make recommendations and identify gaps in services
- Engage the community in improving the quality and length of life of Howard County residents

CCT Outcomes - 54 Participants

Metric	Percent	Goal
Clients with a Care Plan Created at First Home Visit	92%	100%
Clients with an Initial PCP Visit within 7 days of Hospital Discharge	33%	30%
Clients with an Initial Home Visit within Three Days Post-Discharge	55%	60%
Clients Successfully Graduating	86%	70%
Metric	**Average Time**	**Goal**
Average Number of Days until Graduation	82	90 days

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CCT Successes

- Developed relationships to coordinate complex program
- Built trust and received input from community stake holders from the outset
- Access to hospital data (EPIC Care Link) process was developed for CCT to access patient data
- Use of technology to receive referrals and follow client post intervention (Real-time CRISP notifications for enrolled clients); Track Via database to collect and analyze program data
- Evaluation built in from the outset
- Flexibility among partners to adapt the pilot as lessons are learned

Other HCGH Readmissions Initiatives

- Pharmacy Medication List Review
  - Hospital pilot using pharmacy residents to review patient medication lists of patients admitted to HCGH.
- Discharge Specific Condition Pathways
  - EHR discharge summary templates for conditions that comprise a large percentage of HCGH readmissions: Sepsis, Pneumonia, CHF
- Evaluating Multidisciplinary Rounds
  - Restructuring rounds with a focus on family and patient centered care
- Redesigning social work and case management departments
  - Using Lean methodologies to better understand and determine necessary resources for departments

Final Thoughts