Organization: Calvert Memorial Hospital

Solution Title: Calvert CARES: 
Collaborative Activation of Resources and Empowerment Services 
Building Programs to Fit Patients vs. Bending Patients to Fit Programs

Problem:

Remaining innovative and patient centered in the Health Care Reform environment has created unique opportunities for hospitals to embrace new models of care. At Calvert Memorial Hospital (CMH), the Departments of Quality Management and Integrated Care Management looked closely at data reported in the 2014 Community Health Assessment and compared this community snapshot to Maryland averages and goals of the Maryland State Health Improvement Plan (SHIP). Combining this information with overarching expectations of the Affordable Care Act and Maryland Waiver, the following four opportunities for improvement, which are shared by many hospitals, were identified:

- Reduce readmissions and emergency department (ED) utilization.
- Reduce health care spend per capita.
- Improve patient outcomes, experience and engagement.
- Improve access to care, especially for underserved populations in Calvert County, and utilize local resources to more efficiently and effectively to serve the needs of patients.

As a rural community, some Calvert County residents face unique challenges in accessing health care - limited public transportation and a significant shortage of primary care providers top the list of barriers. Additionally, Calvert County is rich in nonprofit agencies and organizations that address a diverse range of local needs; however a structured network did not exist to foster meaningful collaboration to provide greater access to the many health care needs facing the community.

A dynamic care coordination program which was structured to serve needs on an individual basis, utilizing existing community resources and expanded resources at CMH, was presented as a possible promising solution.

Identification:

As a best practice at CMH, specific committees or task forces are formed under the direction of Quality Management and Performance Improvement when an opportunity for improvement is identified through any of the hospital’s performance measurement tools. Using the IHI Triple AIM framework and Maryland HSCRC incentive program, a team from the Integrated Care Management reviewed results of the Community Health Assessment and identified the four areas for improvement listed above. The team felt these opportunities (1) aligned closely with the hospital’s strategic goals, mission and vision, (2) presented significant baseline data and variables for clearly measuring progress, and (3) offered the chance to expand the hospital’s existing portfolio of resources to rapidly address needs and yield results that would create an overall systematic process improvement.
**Baseline data:**

During the initial process of identifying the areas for improvement and clearly defining at-risk/targeted populations, data was used from many sources including all cause and diagnostic information, payer information, spend per capita (from HSCRC), MHAC data, patient satisfaction surveys, and demographics specific to admissions, readmissions, observation visits, and emergency visits/stays.

The team utilized the several variables for establishing a baseline on which to evaluate the success of their solution/s, as well as to identify the most vulnerable and underserved populations to be targeted through these improvements. One of the stronger driving variables was access to care, as this was correlated with readmissions within 14 days post-discharge through our readmission interviews. As noted in our 2014 Community Health Risk Assessment, Calvert County has 50 physician providers and 35 non-physician providers, which compares poorly to the state average. Additionally 33% of our residents age 65+ are disabled, 10% of our African American residents live in poverty and 44% of our youth are Medicaid eligible. In analyzing our readmission data we decided to target all patients at risk for readmission, regardless of payer or diagnosis; but would monitor data for our key target areas.

### Goals:

The solutions formulated would contribute to the overall goals of the organization and included:

1. Reduce readmissions by 10%
2. Reduce Emergency Department visits by 10%
3. Improve technology use, care coordination and hand-off communication
Additional goals, which were to be measured based on feedback from patients, were established to give patients a voice at EVERY visit and to continually provide opportunities for the hospital to modify programs to meet the needs of patients:

1) Attain patient satisfaction with the Discharge Care Clinic (through the use of surveys at CMH Discharge Clinic visits), through patient feedback on understanding of clinic purpose, medication management, health plan strategies and their “to do” list prior to their next physician visit.

2) Identify re-admission trends, through the use of a root cause analysis patient survey at re-admission, to identify trends that cause patients to return (focus on medication management, resource access, care management support, knowledge of illness, etc.)

Process:

With a clear identification of areas to improve and target populations, the team conducted site visits at Western Maryland Health System and Shore Health System, and attended several presentations given by Frederick Memorial Hospital to learn how these systems were addressing care coordination. Based on information gathered, the team at CMH strategized on what elements of these programs could be duplicated, which could be modified to meet the Calvert population, and what would need to be done differently to meet the needs of patients.

When looking at all possible solutions, the team approached the process with the vision that all solutions would be seen as “tools in their toolbox.” The Integrated Care Coordination team would be empowered with not only new resources which serve identified needs, but a user-friendly and timely process to grow resources as additional needs are identified. The team agreed on specific elements of the solution which were critical to the solution/program’s success:

- The tools, or services provided to patients, would first and foremost address specific needs of each patient and, in turn, would result in achievement of the 4 overall goals (readmission/ED reduction, spend per capita, patient satisfaction and access to care).
- Programs would be built around the patient; the patient would not be bent to fit the program.
- Programs would provide enough time for each patient to serve their needs, and would be formulated in a way that would respect patients’ time.

The team identified and targeted patients who were most at-risk for readmission or emergency department overuse based on current patient data as well as barriers to care:

- Chronic heart failure, chronic obstructive pulmonary disease, pneumonia (added in 2015) and other chronic/co-morbid diseases, such as diabetes and behavioral health
- Lacked a primary care provider
- Could not afford medications
- Had limited or no access to transportation

Several initial programs were initiated (listed below). The team felt there was opportunity to realize a significant impact on the overall program goals through creation of a robust group of
community partners dedicated to care coordination and the transition of care. Using a database of local agencies, as well as researching other agencies whose mission aligned with the goals of the program, a CMH social work and care coordinator identified agencies in the community who offered services which addressed needs of the targeted patients. Identified agencies were invited to a kick-off meeting which was very successful, and the group soon became the Partners in Care Coordination and Transition (PACCT). During the initial meeting, the committee charter and goals were developed, yet were enhanced and refined over the first year of PACCT meetings. The membership was expanded through member recommendation and community word of mouth. The structure of the PACCT meetings is innovative and engaging, which has created a culture of trust and sharing. Each meeting allows for a spotlight presentation on a member organization, a case study related to partnering on reducing readmissions and ED use, data related to decreasing healthcare over-utilization, and education focused on an aspect of the health care industry that relates to improving patient outcomes or the patient experience. Additionally, meetings are rotated between partnering agencies to help showcase the various partners foster the standard that this is a community partnership.

After carefully identifying the needs of the community, clearly defining at-risk patients, aligning needs and local resources with the hospital’s strategic goals, and piloting a community collaborative framework through the development of PACCT, Calvert CARES (Collaborative Activation of Resources and Empowerment Services) was formed.

Solution:

The Calvert CARES program was developed through the collaboration and support of leadership at CMH. Development team members included participation from finance, clinical services, pharmacy, IT, ED, CM, physicians, lab, radiology, community wellness, urgent care, respiratory therapy and others. The goal was to be innovative in addressing the care gaps which were identified through the hospitals many evaluation tools. Their target was to meet the patient where they were in their self-care management and to work with them at a slower pace to guide them along towards becoming more adherent with their health management plan.
Calvert CARES is seen as a “community benefit” program, and has taken a multi-faceted approach to meet the post-discharge needs of patients and to assist patients at moderate to high risk for readmission or emergency department overuse. As needs have been identified, staff dedicated to integrated care and the management/expansion of the Calvert CARES program mobilize existing resources and/or work to develop additional partnerships among community agencies which will efficiently serve the needs. Since the inception of the Transitions to Home Program in 2012, and the formal development of the Calvert CARES Program in 2015, the following programs have been built and incorporated into Calvert CARES:

**Transitions to Home (T2H):** Managed by Calvert Memorial Hospital, T2H offers health management coaching and medication management guidance via phone calls and home visits provided by CMH Integrated Care Department nurses; the program expanded in FY 2014 to include a social worker and pharmacist. T2H provides an average of 2000 post-discharge calls, inclusive of assessment, coaching and follow-up, to about 1300 patients per quarter.

**Partners in Accountable Care Collaboration and Transitions (PACCT):** PACCT is a community coalition of over 30 local agencies and health care providers focused on optimizing patient outcomes through improved care coordination, collaboration and communication. Focusing on the transitions between the hospital and home (medical home, skilled nursing, or retirement community) PACCT members have created a forum for sharing best practices, increasing awareness of housing options for seniors, and creating solutions to improve patient outcomes and patient experience.

**Patient Portal:** Developed by the CMH Information Technology Department, the Patient Portal was created to provide patients secure internet access to their hospital medical record and services, such as reviewing lab results, scheduling appointments and paying hospital bills.

**Medication Assistance Program (MAP) / Transportation Assistance Program (TAP):** Utilizing the financial assistance programs provided through CMH, MAP and TAP help patients pay for essential medications, medical supplies or transportation to medical appointments when financial resources and assistive programs do not meet their needs.

**Project Phoenix:** Patients needing mental health and substance abuse services are served through Project Phoenix, a partnership between CMH and the Calvert County Health Department, which launched in August 2015. Care management coaching and medication management guidance is provided via phone calls and in person coaching sessions with a social work case manager. The program is funded by a grant awarded to the Calvert County Health Department.

**Discharge Care Clinic (DCC):** Care management coaching, health status assessment, goals building, intervention planning, medication therapy management, psycho-social support and resource access is provided in a clinic setting through the Discharge Care Clinic. The program, launched in April 2015, is structured to allow patients extended time with the care team (nurse, physician, pharmacist and social worker) to facilitate information processing and dialogue between the patient and the care provider. Patients using the clinic are surveyed at each visit to gain real-time feedback, to address needs as they arise, and to identify gaps in services which can be served by using the network of partners in Calvert CARES.
Services provided by Calvert CARES are offered free of charge. Patients served by the program include those who are unable to schedule a follow up physician appointment within 5 days post-discharge, patients without a primary care provider, patients unable to afford essential medications and/or those who need assistance managing multiple medications, patients who need assistance securing transportation to health care appointments and patients who can benefit from access to an array of post-acute care resources.

Realizing the cost savings associated with the program (through reduced utilization and readmissions), improvements to a safer patient environment (through reduced exposure to hospital acquired conditions by reduced hospital utilization) and improvements to overall patient health (through provision of services in the patient home, care coaching, referrals to partnering service providers and discharge clinic services) the leadership at CMH implemented an Integrated Care Budget for FY 2015 of $417,000. Due to success of the program and the need to serve a larger number of patients, the budget for FY 2016 was increased to $526,000.

**Measurable Outcomes:**

Looking at each element of the Calvert CARES program in comparison to the goals of each, the following outcomes have been achieved:

► **Transitions to Home (T2H):**

*Goal* • < 9% of patients admitted inpatient will be readmitted to any hospital within 30 days of their initial discharge

*Result* • 8.23% of the target patients were readmitted in 2015, reduced from 8.98% in 2014, which is a 12.52% improvement. CMH ranked 2nd best in the state of Maryland for readmissions reduction in FY 2015

*Goal* • Reduce Emergency Department visits through patient access / referral to Urgent Care Centers and Calvert CARES Discharge Clinic

*Result* • 4% reduction in Emergency Department visits from FY 2014 to FY 2015

► **Partners in Accountable Care Collaboration and Transitions (PACCT):**

*Goal* • Improve technology use, care coordination and hand-off communication

*Result* • Implemented Curaspan’s Discharge Central and Ride Central e-products which facilitate the discharge planning and care transitions process. This web-based
product allows our case managers to simultaneously and securely communicate pertinent patient information to multiple skilled nursing and assisted living facilities, home health agencies and ambulance companies, selected by the patient, to decrease delays and miscommunications in patient hand-offs

► **Patient Portal:**

**Goal**
- 50% of patients registered for inpatient admission or outpatient observations stay will be made aware of the portal

**Result**
- 97% of the target patients were made aware of the portal in FY2015

**Goal**
- 5% of patients registered for inpatient admission or outpatient observation stay will be enrolled in / access the portal

**Result**
- 8.7% of the target patients were enrolled in / accessed the portal in FY2015

► **Medication Assistance Program (MAP) / Transportation Assistance Program (TAP):**

**Goal**
- Reduce patient risk of readmission due to medication plan non-adherence (MAP)

**Result**
- 16 patients served between October 2014 and June 2015, for an average expenditure of $116 / patient, covering medications and supplies to manage cardiovascular / pulmonary diseases, diabetes, infections and behavioral health diagnoses

**Goal**
- Reduce patient risk of readmission due to medical visit non-adherence (TAP)

**Result**
- 16 patients served between January and June 2015, for an average expenditure of $62 / patient, covering taxi transportation to physician’s office, clinics, dialysis, Discharge Care Clinic and patient’s home.

► **Discharge Care Clinic (DCC):**

**Goal**
- Reduce patient risk of readmission due to care / resource access gaps

**Result**
- Served 63 patients from April to October 2015, for a total of 119 visits
  - Connected 14 patients with a primary care provider (PCP)
  - Diagnoses: Heart failure = 113, Diabetes = 19, Hypertension = 18, Respiratory = 9
  - Patients feel they know when, how and why to take medications
    - □ 97% strongly agree □ 3% agree □ 0% disagree or strongly disagree
  - Patients feel better prepared to follow their health plan
    - □ 89% strongly agree □ 11% agree □ 0% disagree or strongly disagree
  - Patients feel they know what they need to do between the clinic visit and their next Dr.’s appointment
    - □ 94% strongly agree □ 6% agree □ 0% disagree or strongly disagree

► **Project Phoenix:**

**Goal**
- Reduce patient risk of readmission due to care / resource access gaps

**Result**
- Received 67 referrals since program initiated August 19th
  - 47 patients participating in program = 70% rate of participation
Outcome highlights:

- By avoiding admission/readmission, patients (many with co-morbidities) avoid the risk of a hospital associated complication (MHAC). We believe there is a correlation between our simultaneous reduction in readmissions and our reduction in MHACs.

- Diabetes has not been one of our top readmission diagnoses; but is one of our top PQI diagnoses. We proactively reach out to all newly diagnosed diabetics to invite them to the Discharge Care Clinic or to link them to our Outpatient Diabetes Program.

- Our Emergency Department (ED) utilization has decreased by 4% to a target of 10%. We believe this may be due in part to the Medicaid expansion program. We are hopeful the addition of Project Phoenix will help lower avoidable ED use.

- Our observation cases and hours have increased by 4.3%, rather than decreasing by 10%. We believe this increase is directly correlated with the 2 Midnight Rule and the addition of our observation stay order sets. We continue to work diligently to reach our goal, using Milliman Care Guidelines to determine appropriate level of care combined with ongoing physician / physician extender education.

- Our Nursing Home readmissions have decreased significantly. We continue to work with our SNF / ALF PACCT partners to sustain and improve on that decrease. Our FY 2016 initiative is facilitating the implementation of INTERACT in our partner skilled and assisted living facilities.

- Behavioral health / substance abuse diagnoses have risen to be one of our target areas. Project Phoenix’s social work case manager is currently working with some of our patients who have the highest rate of recidivism.

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Sustainability:

Calvert CARES was implemented using a phased approach – the group started small, studied their work, provided changes as needs were identified, and then continued to grow. Taking the approach of scaling the program to the hospital’s patient population created a solution to care coordination which was comfortably sustainable for the organization. Calvert CARES continues to grow their resource base through the addition of community partners and the group has become recognized in the community as the premier local network of innovation and collaboration for quality service to patients.

With an initial investment by CMH of approximately $250,000, a return on investment of over $800,000 has demonstrated the financial significance and impact of Calvert CARES; combined with decreases in readmissions, increased patient satisfaction and better utilization of local resources, the leadership of the CMH is pleased to sustain and grow Calvert CARES.

Collaboration and Leadership:

Calvert CARES was embraced by the leadership and Board of Directors of Calvert Memorial Hospital. The program was selected as the beneficiary of the 2013 Harvest Ball which annually raises funding for a promising program or department of the hospital that addresses an urgent community need as identified in one or more of the hospital’s evaluation tools.

The formation of Calvert CARES was successful thanks to the dedication and talent of leaders from across the hospital including finance, clinical services, pharmacy, IT, ED, CM, physicians, lab, radiology, community wellness, urgent care, respiratory therapy and others. Each brought valuable insight and solutions which collectively and completely addressed identified needs. As ambassadors for the program the development team continues to share a dedication for the success and growth of Calvert CARES.

Innovation:

The philosophy behind the development, operation and expansion of Calvert CARES is quite simple:

1) Knock down barriers and build bridges to care – learn what your patients need, draw upon existing resources to serve those needs, and remain dedicated to finding resources for unmet needs that will enhance Calvert CARES’ ability to serve the needs of every patient.

2) Listen actively and listen often – provide patients with the opportunity to be heard at every visit. This helps to identify issues and needs early.

3) Mobilize your TEAM – know what agencies and organizations exist in your community and create a forum for them to flourish. Take the motto “together everyone achieves more” to new heights by inviting everyone to come together and offer their services to those served by one another.

4) Keep it “real time” – don’t wait for data to serve a patient. Create an environment that
fosters action today and empowers your team with the confidence to make decisions that serve the patients right away.

5) Grow as you go – if an element of the program needs to be changed, change it; if an element is not working, get rid of it. Remain flexible and welcome change into the program so that action is not inundated and hindered by process. Encourage ongoing team education and professional growth.

Additionally, at Calvert Memorial Hospital we realize that Calvert CARES is our investment in our patients and our community. Readmission reduction is just one indicator of success. Our return on investment is, ultimately, the improved outcomes of our patients’ health.

**Related Tools and Resources: Please see attachments**

- PACCT Charter
- Calvert CARES Logic Model
- Calvert CARES Referral / Follow-up Forms
- Project Phoenix Referral / Follow-up Forms
- Discharge Care Clinic Communication Tool

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