Project Description

PCC's quality improvement project used care management to target individuals who access the emergency department with a goal of increasing access into a primary care home and decrease emergency department utilization rates. Care management at PCC is a collaborative process with a goal to provide options and health services to meet individuals' and families' comprehensive health needs. PCC's Care Management Department collaborated with the Performance Improvement Department in this project to improve patient access to preventative care with a primary care provider while improving health outcomes.

Successful Outcomes

PCC identified a strong internal candidate to attend to this quality improvement project. Maria Novillo, RN is a bilingual Clinical Care Manager stationed at PCC Salud Family Health Center. This Clinical Care Manager assesses patients' risk and needs, monitors patient care plans, and engages family members to help facilitate transitions from the hospital. She also provides referrals to community resources and attends community-based visits with patients.

PCC's Clinical Support Services Manager, Heather Morales, LCSW, oversaw this project. Throughout the first portion of this project, Heather assisted with the development of new and enhanced workflows. She also attended monthly networking meetings with Medical Home Network's (MHN) Accountable Care Organization (ACO) partners. She helped to establish contacts with hospitals outside the MHN ACO. The Clinical Support Services Manager collaborates with the Care Coordination Manager under the department of Population Health. Chief Population Health Officer, Katherine Suberlak, AM, LCSW, met with various hospital networks to share strategies and plan project development. Katherine continues to participate in MHN's monthly networking committee and clinical committee.

Corey Hooper, Performance Improvement Assistant, performed quality evaluation for this project. Corey assisted with the troubleshooting of the *Clinical Integration Quality Dashboard* that was addressed in the interim report. The solution to that challenge – manual data audits – was completed by Corey. Under the supervision of Sara Hogue, MSW Director of Performance Improvement, Corey compiled monthly status reports summarizing performance in respect to project indicators which were disseminated to key program staff. Corey also played a pivotal role in generating the final quality evaluation for this project.

Perhaps the most successful outcomes have been our improved cross-care coordination with hospital partners. The development of personal relationships with on-site staff at hospitals allows greater dividends in patient care and use of lower resources at the medical home.

Objective Measurements

As described in the interim report, PCC intended to utilize MHN's *Clinical Integration Quality Dashboard* as the primary data source for our grant report; baselines were established for three out of four objectives using dashboard data. However, after PCC submitted the Illinois Community Health Foundation grant proposal for Quality Improvement, MHN stopped production and dissemination of the *Clinical Integration Quality Dashboard* as a result of data discrepancies affecting patient panels in their system. In light of this challenge, the Performance Improvement team worked collaboratively with the Clinical Care Management team to rework the project evaluation plan. The teams agreed it would be most useful to establish new baselines starting with April 1, 2016 and would report data on a monthly basis thereafter. This process required the Performance Improvement department to pull inpatient and Emergency Department visit data for CountyCare patients via the MHN portal each month, conduct manual audits of these patients using PCC's Electronic Health Records (EHR), document and code outcomes of outreach efforts, calculate results, and share findings

internally. The adjusted evaluation process provided more accurate outcome data as there was less reliance on double data-entry and external reporting tools.

Outcome Objectives:

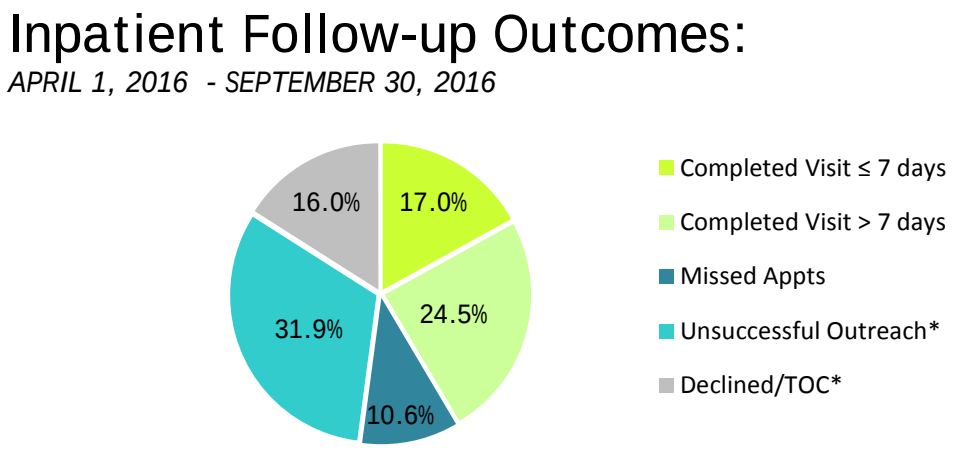
Objective 1: Increase percentage of PCC-assigned patients who have established care with a primary care provider at their medical home.

Revised Indicator 1: 65% or more of patients with inpatient visits in ACO network scheduled a follow-up appointment (baseline 57.1%).

Summary of Outcomes:

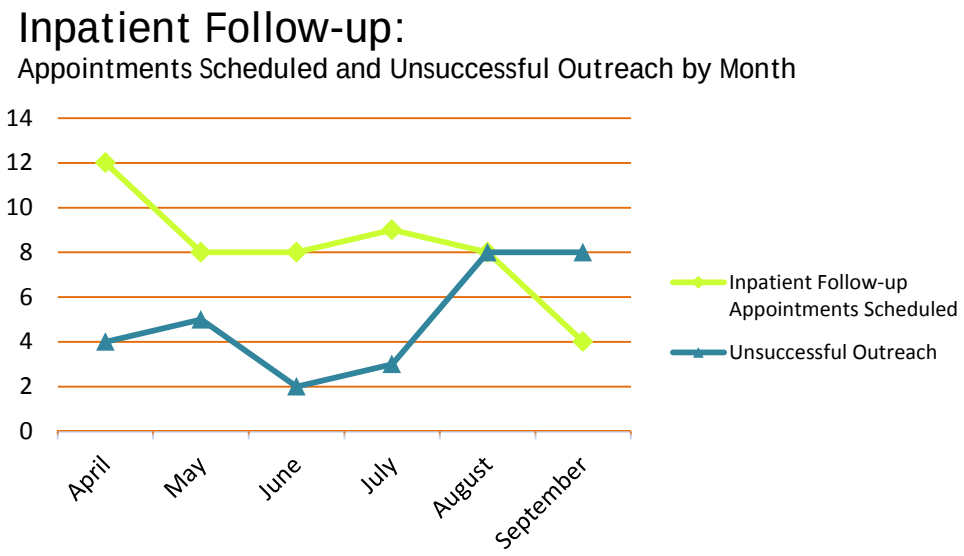
- Overall, the average percentage of patients who had a follow-up appointment scheduled during the reporting period was 52.1%, which is 5 percentage points lower than our original baseline of 57.1%.
    - "*Follow-up appointment scheduled" includes the following categories in the pie chart below: Completed Visit ≤ 7 days, Completed Visit > 7 days, and Missed Appointments.*
- No consistent trends occurred during the six month period

We believe these findings were impacted by our implementation of a new EHR. The preparation, training, and go-live of the new system negatively impacted access to appointments at our facilities. We did not anticipate this external impact when planning for appointment completion; therefore, we see significant variation in success from 30.8% to 68.2%.



* "Unsuccessful Outreach" includes disconnected numbers, inaccurate contact information, voicemail messages, no answer
** "Declined/TOC" includes patients who reported not wanting or needing f/u appointment or those who reported going elsewhere for care

Follow-up Appointments Scheduled by Month	
	Percent of patients w/ Appt scheduled
April	57.1%
May	40%
June	66.7%
July	69.2%
August	47.1%
September	30.8%

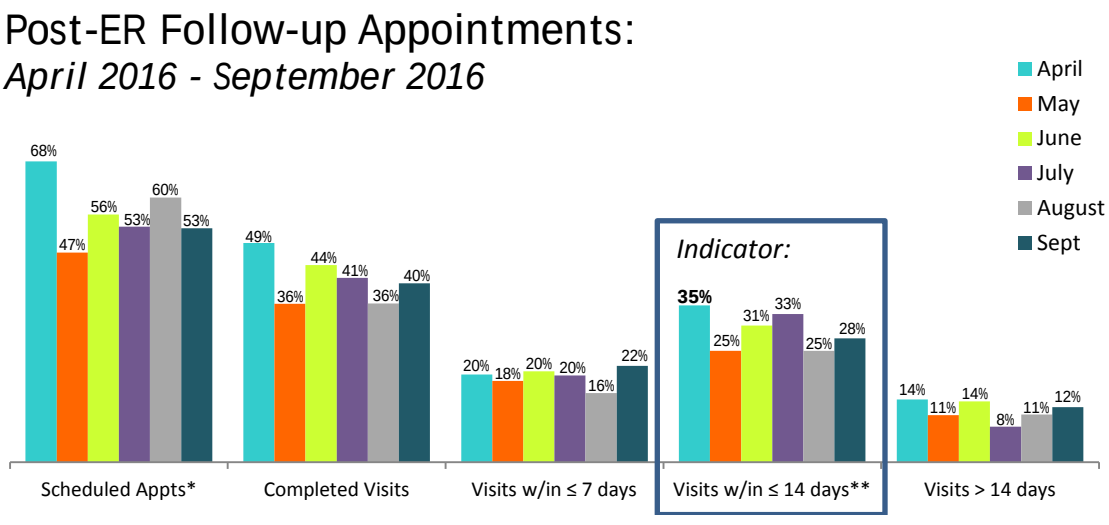


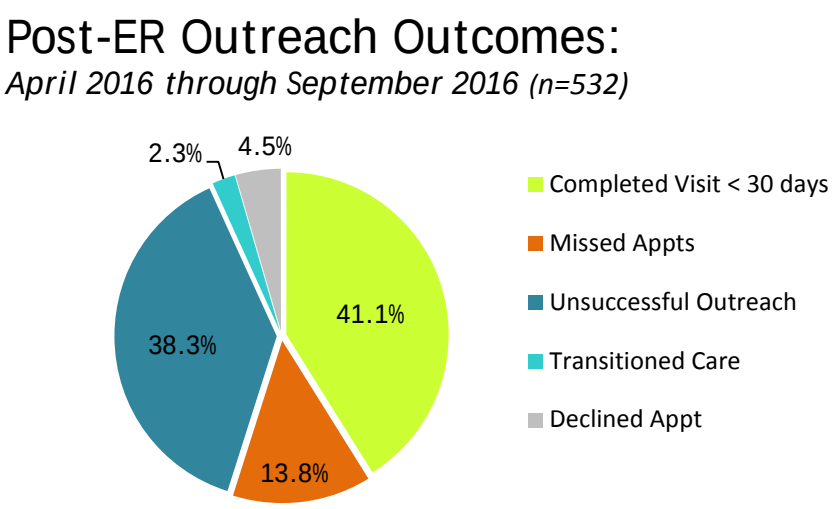
Revised Indicator 2: 40% or more of patients with emergency department visits have completed follow-up visits within 14 days of discharge (baseline 35.2%).

Summary of Outcomes:

- Overall, the average percentage of patients who had a follow-up appointment completed within 14 days of discharge during the reporting period was 29.2%, which is 6 percentage points lower than our original baseline of 35.2% (*Range: 25% to 35%)*
- Approximately 40% of patients were unreachable
- Over 60% of patients had a follow-up visit scheduled; two-thirds of these patients attended their follow-up visit within 1 month of discharge.

As mentioned previously and demonstrated in the data for the month of September, we learned that the implementation of a new EHR system greatly decreased the availability of appointments. Sites were operating with at least half the available sessions of provider appointments during the month of September, thus decreasing our overall average. Simultaneously, we saw an increase in unsuccessful outreach. Not being able to reach the patients did not give us the ability to link them to care. We have since evaluated our outreach models considering non-traditional methods for reaching patients such as campaign auto calls and texts using our new HER system. Some patients with whom we spoke reported not wanting to engage in follow-up care because they felt their need was met during the Emergency Department visit. This reflects a need for increased patient education for establishment of care in medical home and long term prevention.





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** "Declined/TOC" includes patients who reported not wanting or needing f/u appointment or those who reported going elsewhere for care

Objective 2: Reduce rate of patients' emergency department visits (targeting avoidable visits).

Revised Indicator: Emergency department utilization rate less newly established baseline of 11.25 per 1,000 patients).

Summary of Outcomes:

- Mean ED utilization rate from April to September is 16.03 per 1,000 patients; this is 4.78 patients greater than our baseline of 11.25.

As a result of decreased access in the centers related to EHR transition, we believe patients sought care in the emergency room when they otherwise would have entered the center for routine care. The period of time monitored shows increase in emergency department use trending the opposite direction we predicted. We did not anticipate the negative impact on access that occurred as a result of a new technology change.

Process Objectives:

Objective 3: Establish cross-setting care coordination between PCC's and hospital care management departments

Indicator: Develop a comprehensive database depicting vital connections and resources at local hospitals in surrounding communities.

PCC successfully established a transition of care protocol and workflow over the initial quarter of the project. Implementation and training amongst staff allowed a team-based approach within our medical homes. Weekly phone calls with institutions where patients were frequently hospitalized allowed for bidirectional information sharing and improved patient connection prior to discharge from hospital. PCC acknowledges these protocols as crucial to achievement of our care management objectives.

Please accept the following attachments as cited documentation for achievement of this indicator:

- *PCC Care Transitions Workflow*
- *Care Transitions Workflow – Emergency Department*
- *Care Transitions* Workflow – Inpatient
- *Inpatient Workflow*
- *Hospital Contact List*

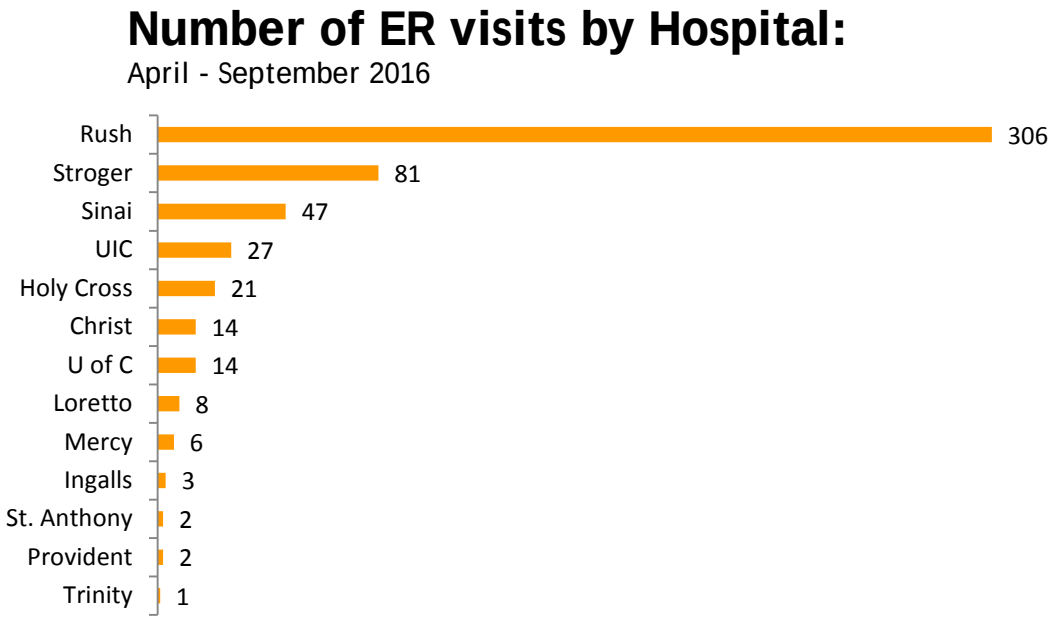
Objective 4: Establish operational baselines for project in order to build future programming.

Indicator 1: Identify the hospitals most frequently visited by PCC patients based on trend analysis of emergency department visits per every 1,000 patients

Summary of Outcomes:

- On average, the emergency department at Rush University Medical Center saw the most activity with a utilization rate of 8.9 patients per every 1,000; this is 6.5 patients greater than John H. Stroger Jr. Hospital of Cook County which had the next highest utilization rate of 2.4 patients per every 1,000.

Investing in this granular research of the data has provided our greatest lesson learned of where our patients are going for care. We have identified that our patients are visiting out-of-network partner hospitals that are geographically difficult for us to engage in on-site care coordination. However, this information enables the care management team to develop cross-care setting relationships with hospital staff. For example, by sharing this data with our partners at Rush University Medical Center's emergency department, we can collaborate to target PCC patients with education, redirection, and prevention. Likewise, we hope to have the emergency department staff work with PCC's team before the patient is discharged from the hospital for an appointment. Accomplishing this will allow us to engage with patients who are hard to reach once they leave the hospital.



Indicator 2: Determine medical cost per patient using population health management analytics framework.

Based on 2015 UDS data, PCC's baseline for medical cost per medical patient is $180.93. We look forward to the completion of our next UDS report which will provide us with PCC's comparative data for 2016.

Use of Funds

Grant funds were utilized for personnel costs associated with creating a new, part-time clinical care manager role. Due to actual salary rate, the balance of personnel funds was allocated to benefits for this position. Foundation funds were also used to purchase a laptop with battery for the clinical care manager.

Expenditure of Grant Funds Related to the Project

Expenditure Category	Description	Total Amount Budgeted	Amount Budged to Applicant	Amount Requested from Funder	Grant Funds Expended
Equipment	Laptop and battery	$850.00	$0.00	$850.00	$850.00
New Software	n/a	n/a	n/a	n/a	n/a
Personnel	0.5 FTE Clinical Care Manager	$15,600.00	$0.00	$15,600.00	$14,282.47
	0.5 FTE Performance Improvement Assistant	$15,600.00	$15,600.00	$0.00	$0.00
	Benefits (16.5%)	$5,148.00	$4,998.00	$150.00	$1,467.53
Consultants	n/a	n/a	n/a	n/a	n/a
Training	Continuing Education Units (CEUs)	$600.00	$600.00	$0.00	$0.00
Other	n/a	n/a	n/a	n/a	n/a
TOTAL		$37,798.00	$21,198.00	$16,600.00	$16,600.00

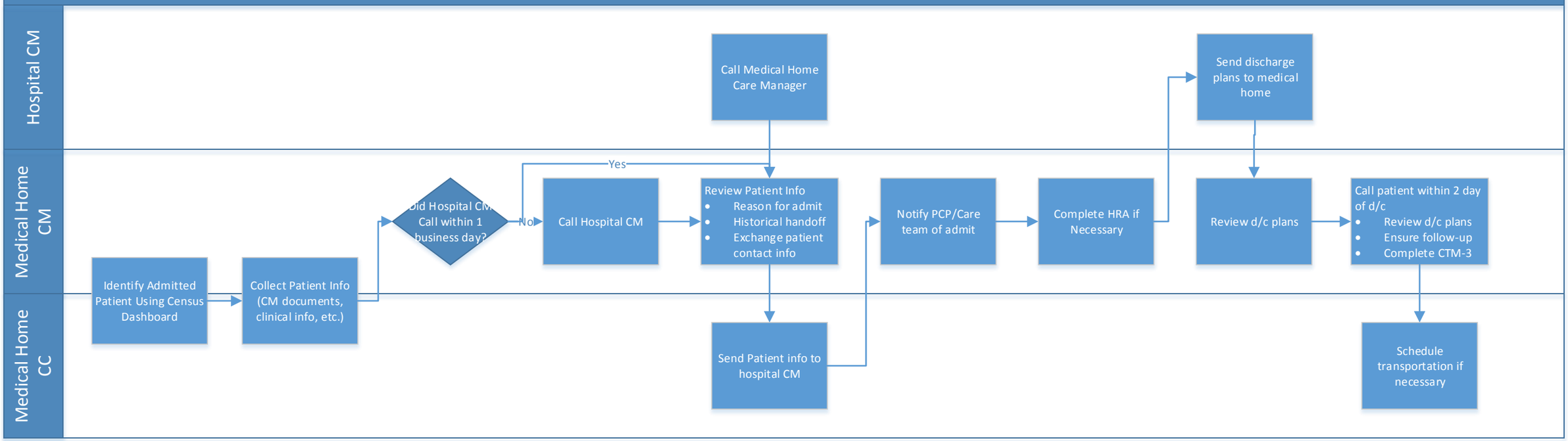
Attached Photos

Accompanying this report are four photos of some project staff:

- Katherine Suberlak, AM, LCSW, Chief Population Health Officer
- Sara Hogue, MSW, Director of Performance Improvement
- Corey Hooper, Performance Improvement Assistant
- Heather Morales, LCSW, Clinical Support Services Manager

PCC Care Transitions Workflow

Draft 4/18/16



Attachment 1: Care Transitions Workflow

CM to follow up on all Patients in MHN census dashboard

Inpatient:

A. If hospital does not call CM within 1 business day, CM is to call the hospital to get a verbal report from CM and complete HRA if needed. (Please refer to contact list)
B. If patient has established care at PCC-
    1) Send hospital CM the patient's Care Plan, med rec and any disease specific information via fax.
C. If patient has not established care at PCC-
    1) Speak to the patient while in hospital (via phone or ask hospital CM to do so). Ask patient if they are currently receiving care elsewhere; if so ask for facility information. Inquire if they want to continue at that facility. If so, give patient number to County Care to change PCPs and help patient schedule follow up appointment at that facility.
    2) If patient wants to receive care at assigned clinic, introduce medical home and be prepared to schedule follow up appointment upon discharge. CM must create a chart for patient and document phone call.

I. **Discharge:**

A. CC/CM will receive a call from hospital when patient is ready for discharge.
    1) CC/CM will collaborate with patient and hospital CM to schedule 7 day follow up appointment.
    2) CC/CM will coordinate transportation for any specialty clinic appointments patient may have after discharge.
    3) Once discharge summary is received, CM will log receipt in MHNConnect.
    a) In MHN portal click ***Census Dashboard*** then ***Inpatient Disch***
    b) Find patient's name and click the icon under ***F/U***
    c) Under Select New Status click ***Inpatient Records Received from Hospital***
B. CM will call patient within 2 business days of discharge to check in, review meds, review care plan, and ask CTM-3 (Care Transitions Measures) questions and appointment reminder.
    1) Log in MHNConnect
        a) In MHN portal click ***Census Dashboard*** then ***Inpatient Disch.***
        b) Find patient's name and click the icon under ***CTM-3***
        c) Log patient's answers to each question
C. If patient does not attend follow up appointment, CM will follow outreach protocol to reschedule appointment and document attempts in both Centricity and MHNConnect.
        a) In MHN portal click ***Census Dashboard*** then ***Inpatient Disch.***
        b) Find patient's name and click the icon under ***F/U***
        c) Under Select New Status choose the appropriate status of the phone call
D. CM will follow up with patient weekly for 1 month.

Care Transitions Workflow- ED

	Admission	Discharge
Care Coordinator		Ensure transportation is scheduled for patient. Make sure the patient is aware of transportation. • Make transportation plans • Record the information in MHNConnect and EMR. Locate discharge documents received from hospital and provide to Clinic CM and PCP Complete any processes delegated by the Clinic CM
Clinical Care Manager	Contact ED Case Manager to review the following: • Reason for admit • Brief historical handoff • Ensure HRA completed • Exchange patient contact info Send patient info to hospital • CM documents • Disease specific information	Review discharge summary/ instructions Update care plan and medication reconciliation with new information obtained from hospital care manager Ensure follow-up is scheduled for patient. Make sure patient is aware of appointment. • Record the appointment in MHNConnect Reassess risk (if needed)

Care Transitions Workflow- Inpatient

	Admission	Discharge
Clinical Care Manager	Identify admitted patients using census dashboard • Analyze patient status (established, CM documents, advanced directives, past utilization) Hospital CM should call within 1 day (if not, call the hospital) Please refer to contact list Review patient info with hospital CM • Reason for admit • Brief historical handoff • Ensure HRA completed • Exchange patient contact info Send patient info to hospital • CM documents • Disease specific information Ongoing communication with hospital CM **Notify PCP/care team of admission and document**	Review discharge summary/ instructions and send to PCP Update care plan and medication reconciliation with new information obtained from hospital care manager in EMR and MHNConnect Ensure follow-up is scheduled for patient. Make sure patient is aware of appointment. • Record the appointment in MHNConnect • Schedule transportation for any next day appointments • Forward any transportation request for future appointments to site CC Follow-up call to patient within **2 business days** • Complete CTM-3 • Review Care Plan and Med Rec • Appointment and transportation reminder Reassess risk (if needed) **Weekly check-in for 4 weeks**
Care Coordinator	Assist CCM with delegated tasks in preparation for call with hospital CM.	Ensure transportation is scheduled for all patients received from CCM CC will follow up with hospital CM for any missing discharge summaries Complete any processes delegated by the Clinic CM

Hospital Site	First Contact	Telephone Number	Second Contact	Telephone Number	Third Contact	Telephone Number	Fax
Cook County-Stroger Hospital **FFHC** **RUMG** **Alivio** **Esperanza**	Cheryl Berganos	312-864-7595	Peggy Jones	312-864-0674			312-864-9413
Cook County-Stroger Hospital **CFHC** **LCHC** **SMG** **Erie**	Micah Fry	312-864-7599	Peggy Jones	312-864-0674			312-864-9413
Cook County-Stroger Hospital **PCC Wellness** **PrimeCare** **Aunt Martha's** **La Rabida**	Crystal Bellaby	312-864-7599	Peggy Jones	312-864-0674			312-864-9413
Rush University Medical Center-ED (Post Discharge)	Greda Erazo	312-942-3090					312-942-6136
Rush University Medical Center-ED (During ED Visit)	Case Manager	312-947-0187	Patient Navigator	312-947-3090	Charge Attending	312-947-0170	
Rush University Medical Center-Hospital Transitions	Sarah Abalos	312-942-8755					312-563-4003
Mount Sinai Hospital	Precious McClendon	773-257-6042	Veronica Huante	773-257-6272	Raquel Castrejon	773-257-6049	
Holy Cross Hospital	Phyllis Martiny	773-884-1675	Leah Jones	773-884-1731			

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December 29, 2016

Illinois Community Health Foundation
500 S. Ninth Street
Springfield, IL 62701

On behalf of PCC Community Wellness Center (PCC), I would like to submit our end term report regarding PCC's quality improvement project. Through this project, our Care Management Department and Performance Improvement Department collaborated to address avoidable emergency department utilization and reviewed strategies to direct patients into a primary care home. We look forward to the continuation of this important work as we move into 2017.

We greatly appreciate our partnership with the Illinois Community Health Foundation. Thank you for your interest and investment in PCC. If you have any questions, please contact Toni Bush, Director of Development at 773-295-3341 or at tbush@pccwellness.org.

Sincerely,

Robert J. Urso
President and CEO