Anne Arundel Health System

Reducing Preventable Readmissions by Enlisting Community Resources

A Local Health System Forges Nontraditional Partnerships

Anne
Arundel
Medical
Center

LIVING HEALTHIER

TOGETHER

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Electronic
Health Records

Community
Health Center

Improving the health
of our community

Along Came ACA…

- Vision 2020 needs to start happening NOW
- Luckily for us, our community partners are under the same sort of pressure (incentives, penalties)
- Synergy is possible

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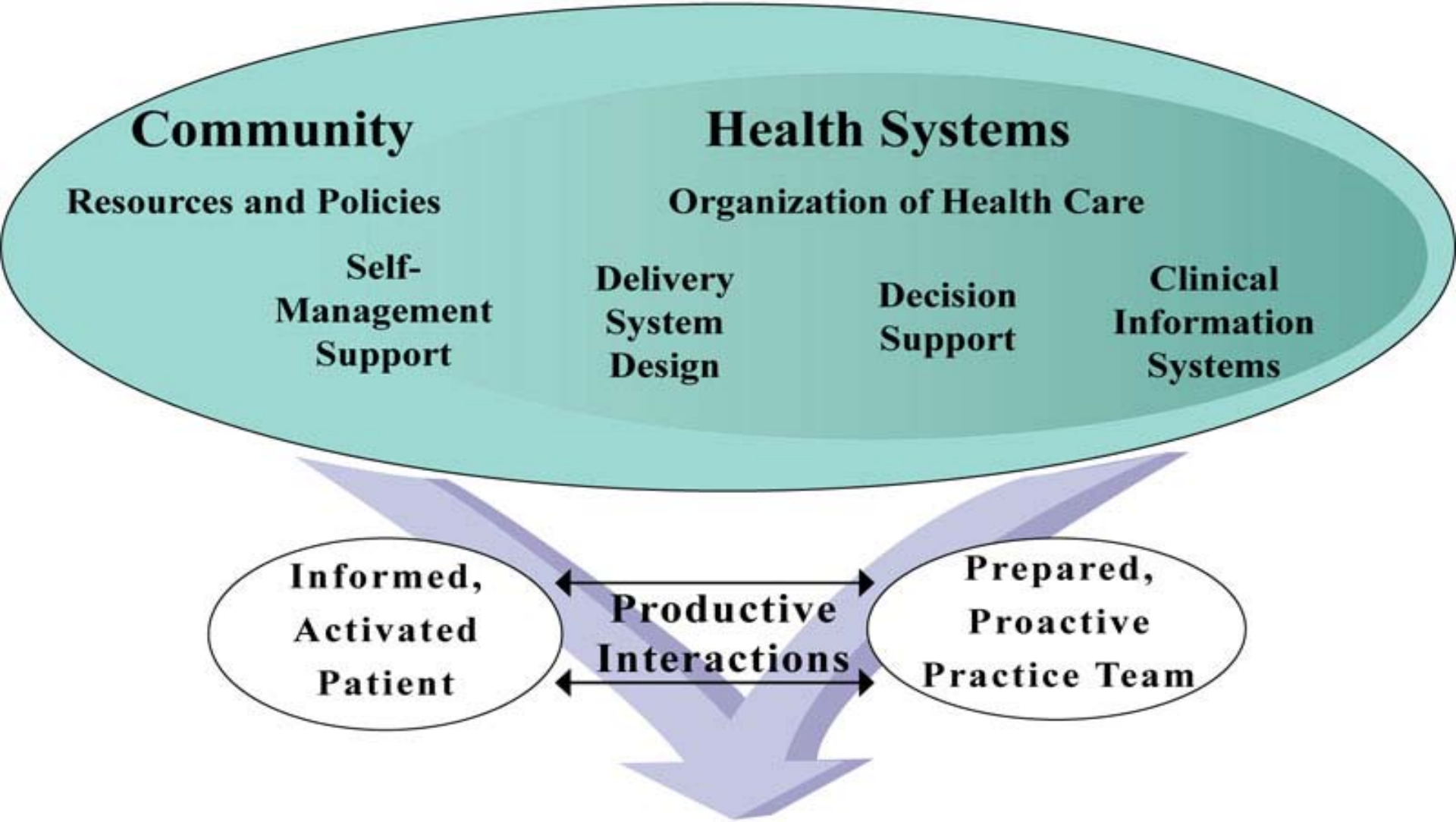
So we started poking around…

- Anne Arundel County Department of Health
- Department of Aging and Disability
- Partners in Care
- Friends of Arundel Seniors
- Self-management courses for patients and families
- Skilled nursing facilities
- Assisted living facilities
- Frequently readmitted patients and families
- Home health agencies
- Physician practices

What We Realized

- Lack of Patient Empowerment
  - Impossible to improve individual and population health
  - Need for redesign of the care delivery system
- Community Resources
  - Outside the “four walls”
  - Significant resources in the community already exist
  - Many of these community partners have been thinking along the same lines
- Opportunities for Collaboration
  - Many have ALREADY developed tested protocols to reach targeted patient populations
  - Many were eager to collaborate and coordinate their efforts
  - A lot of this was just connecting the dots to make a network so that, for our mutual patients, there was “no wrong door”.

The Chronic Care Model



Improved Outcomes

Developed by The MacColl Institute
® ACP-ASIM Journals and Books

Where Did We Start?

- We chose congestive heart failure patients
- Numerous studies and efforts by others suggested this was a low-hanging fruit*
  - CHF is a condition that responds to better self-management
  - ...but even the most empowered CHFers do poorly if clinicians don't provide adequate patient education or care transition

*on a sagging branch – there are other fruits

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A community hospital looks for help from…the community

- Private physician practices – primary, specialty, hospitalists
- Home health agencies
- SNFs and SNFists
- Assisted Living Facilities
- Department of Health
- Department of Aging and Disabilities
- Community-based resources
- Patient and family advisors
- Hospice and palliative care

...and looks within...

- Nurses and physicians
- Dietary/Nutrition
- Pharmacy
- Call center
- Care coordination team
- Marketing and PR
- ED
- Information Technology

The Result

- Evidence-based CHF protocols for clinicians to follow
- Improved transition-of-care protocols
- Emphasis on the home setting – visits and calls
- Emphasis on PCMH care
- Standardized patient education materials across care settings
- Alternative means of engaging patients and families: CHF Camp
- A network with a safety net – the CHF Navigator
- An integrated information platform that works across all care settings

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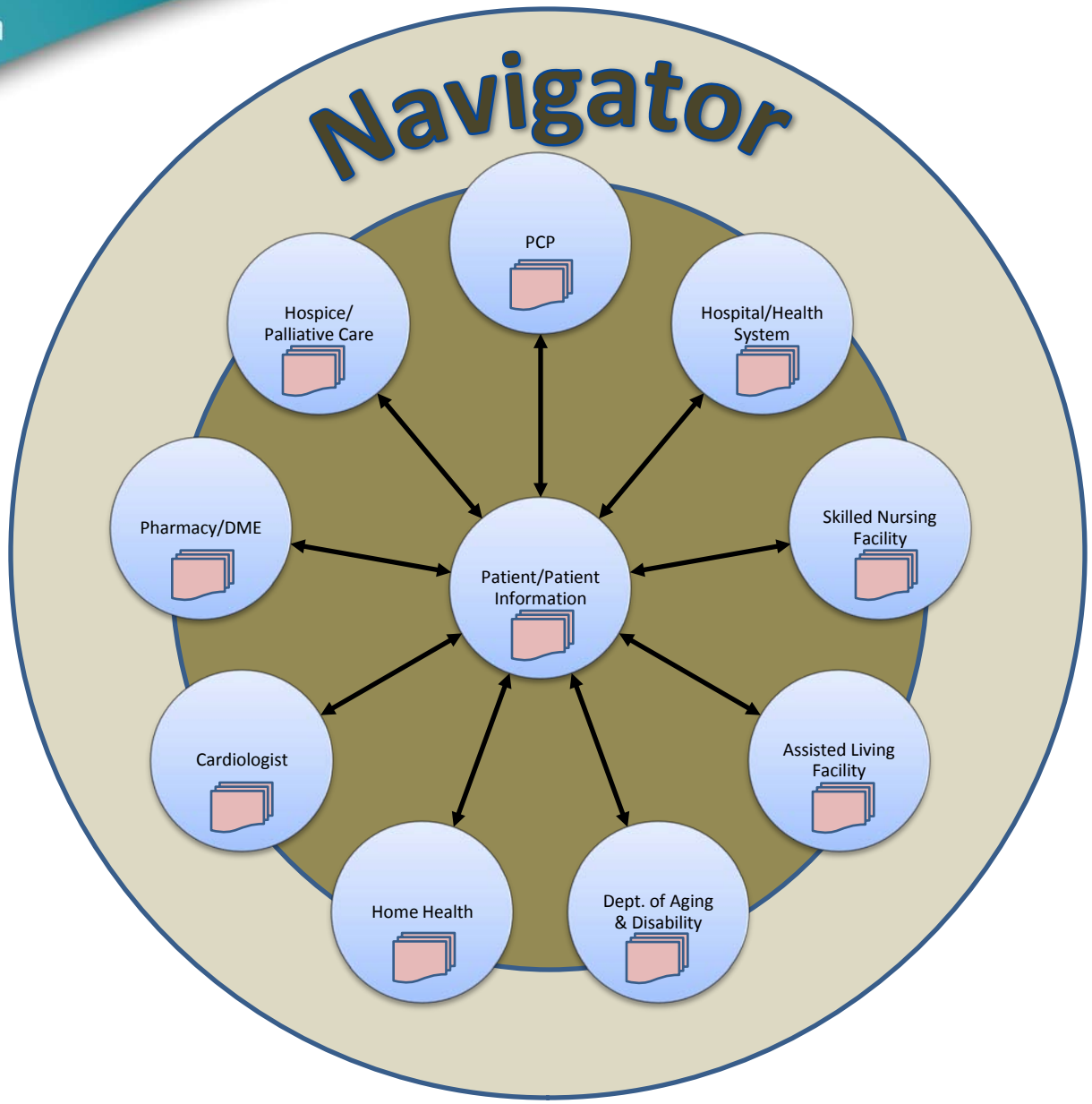
Navigator



Measures

- Outcomes
- Process
- Balance

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What Will We Measure?

- Readmission data
- Quality of life surveys
- Cost of care
- Patient satisfaction
- Clinician satisfaction

And Then What?

- Use the CHF program as a “rapid prototype” experiment
- Choose other vulnerable patient populations within the community
- Recycle and re-use what worked; refine what didn’t
- Likely suspects: COPD, DM, childhood asthma, perinatal mortality

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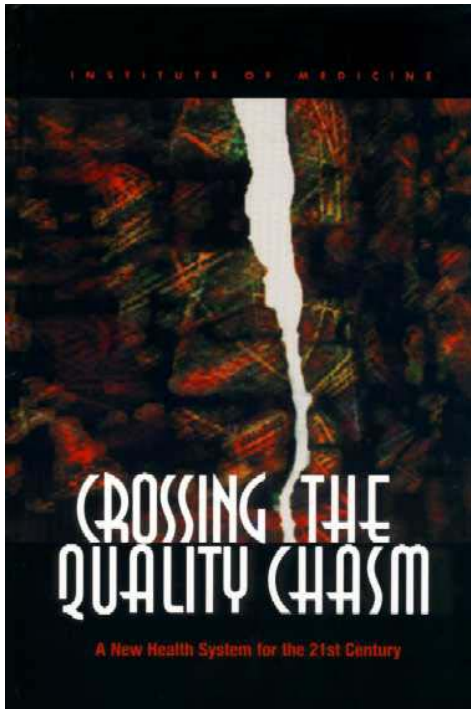

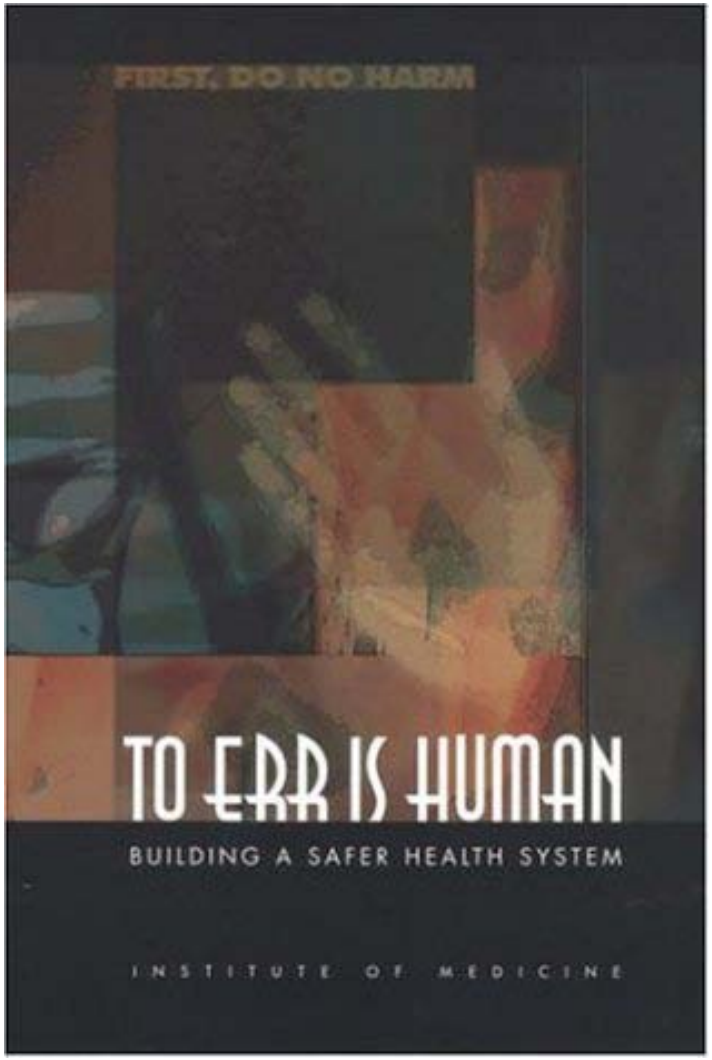

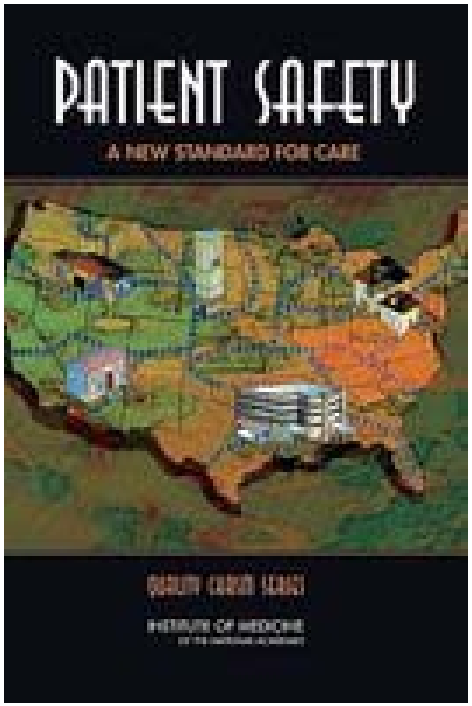

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Questions?