

Preparatory Information for the 10AM – noon Session on September 15, 2009

The 2020 Performance Commission and a potential interface with the Care Transitions Intervention

In 2007, Rochester area hospitals petitioned the state of New York, through the Finger Lakes Health System Agency (FLHSA) to increase the number of inpatient medical-surgical beds because of bed shortages causing delays in admission to the hospital through the emergency room and an increasing and unacceptable number of days when hospital Emergency Departments (ED) were closed to new ED admissions.

In response to this request, the Community Health System 2020 Commission (CHSC) was created to guide the New York State Department of Health's decisions on the bed expansions by the three largest delivery systems. The CHSC, a multi-stakeholder group, deliberated in 2008. Among the Commission's recommendations were: reduce health disparities among populations, better manage the demand for acute hospital services through smart investments aimed at improving community-based system capabilities; thereby reducing the need for expensive investment in expanded hospital inpatient facilities, and create a health care delivery system that focuses on improving broad spectrum performance and emphasizes collaboration. More specific demand management recommendations were then generated and include within four years: a 15% decrease in low acuity visits to applicant EDs, a 25% decrease in the number of admissions for ambulatory sensitive conditions manageable in outpatient settings and a 20% decrease in the number of low acuity admissions to tertiary hospitals in Monroe county of residents from outlying communities that could be managed locally. The CHSC, through the FLHSA, then convened the 2020 Regional Performance Commission, to operationalize and oversee the efforts to achieve the CHSC's stated goals.

The Performance Commission, again with multi-stakeholder representation, began meeting in 2009. The Commission is chaired by Len Redon, Vice-President of Area West Operations of Paychex and vice-chaired by Susan Holliday, President and Publisher of the Rochester Business Journal. The stakeholders created a work group to operationalize the efforts regarding ED and hospital utilization. After three meetings examining local and national data about utilization of ED and hospitals, the group decided to create two sub-groups; one focusing on reducing AHRQ defined Preventable Quality Indicator (PQI) admissions with attendant chronic disease ER use, and the second focusing on reducing treated and released visits, many of which have been found to be preventable.

The sub-group focusing on reducing treated and released ED visits has decided to focus its efforts by joining the IHI Collaborative – Reducing Avoidable Emergency Department Visits. The work group focusing on reducing PQI admissions identified readmissions for chronic disease as the most remediable in the short term. Researching methods to achieve decreased readmissions identified three techniques; improving the hospital discharge

process, incorporating case managers into practices ala Geisinger, and your model of activating patients/families through a well designed coaching program. After reviewing available data and talking with programs around the country, our sub-group remains very interested in the Care Transitions Intervention. When we heard Dr. Bomba had invited you to Rochester, we contacted her and asked if we could create a session that would allow members of the Performance Commission stakeholders group and working sub-groups to meet with you, learn more about your program and have the opportunity to ask questions about your approach and its results. Because the CHSC had the foresight to endorse collaboration and the reduction of health disparities, the coaching model was seen as having special benefits to our community. Certainly, any approach that improves outcomes by creating more informed, activated patients/consumers, can only improve the long term success of our health care system.

Questions the 2020 Preventable Admissions Reduction Workgroup would like Addressed

1. How does this model work in communities with more ethnic diversity? Are adaptations needed and if so, what adaptation is required?
2. Who is best suited to serve as the coach? Can non-medical personnel be trained?
3. Is it best if the coaches share ethnicity with the patients/families being served?
4. How do the hospital discharge planners and home care nurses respond to the coaches? Are they viewed as an intrusion into their relationship with the patient?
5. Please describe the coach training process. How long and intensive is it? What are the attributes of successful coaches? Who has been most successful in identifying the most successful coaches?
6. Please review the approach the coach's use with patients/families. When do they first meet their clients and how are subsequent contacts structured and determined?
7. How does the 3 item discharge survey fit into the program?
8. How do the discharge planners and coaches interact?
9. Are there formal feedback mechanisms to hospital discharge departments if the coaches are not employed by the hospital?
10. Are there other measures of program effectiveness that you have found useful we should integrate into our evaluation plan?
11. We are planning on a community wide focus where the coaches may not be employed by the hospital. Do you have experience with that model? What have been the results?
12. What have been the most important unintended consequences of the program? The impact on smaller community hospitals would seem an important one. Has that been problematic as readmissions and ED visits decrease?
13. How do physician practices respond to more assertive, knowledgeable patients?
14. Is access to care soon after discharge a problem in communities with which you have worked? If so, what strategies were employed to reduce barriers to access?

15. Please share the variety of organizational and funding approaches to the CTI. What approaches work best?
16. The Business Case section on your website is great. Can you review the business case and anticipated ROI based on your programs in other communities?
17. What operational approaches correlate with the strongest ROI?
18. If we would like to employ the CTI in the beginning of 2010, would you have the time to work with us?
19. Can you provide some details about how you work with a community client and what options are available?

Attachments

To help you see where we are now, there are two PowerPoint presentations made to our Work Group that provides data on our community and our sense of the choices we have to make. It includes some information about your program that was shared with the group. We very much look forward to meeting you and learning more about your program.