

THE Value Initiative

Members in Action: Redesigning the Delivery System

Meadville Medical Center – Meadville, PA *Care Coordination for Adults and Children*

AHA's *Members in Action* series highlights how hospitals and health systems are implementing new value-based strategies to improve health care affordability. This includes work to redesign the delivery system, manage risk and new payment models, improve quality and outcomes and implement operational solutions.

Overview

The Meadville area, approximately 90 miles north of Pittsburgh, is nestled in the rolling hills of the lake lands in northwestern Pennsylvania. The population of Meadville and the surrounding area is approximately 35,000, with the hospital's service area covering about 75,000 residents. Meadville Medical Center (MMC) has 178 inpatient acute care beds and 32 skilled nursing beds. MMC reports annual inpatient admissions of approximately 7,600 and more than 242,300 outpatient visits. The emergency department (ED) sees more than 35,000 visits yearly, and approximately 650 babies are born at MMC each year. MMC has a medical staff of more than 100 physicians across 37 medical and surgical specialties, including an extensive primary care foundation.

MMC views care coordination as an important aspect of fulfilling its mission as an independent community health system. Care coordination adds tremendous value to the community by assisting some of its most vulnerable residents, many of whom have complex health care and socioeconomic needs, which go far beyond the traditional scope of acute care services. In addition to advancing MMC's mission, care coordination provides an important framework for the future of health care delivery in the community as MMC evolves services to better align with the overall well-being of the population.

The Community Care Network (CCN) is an interdisciplinary team of dedicated clinicians who work with physicians, health care providers and other agencies to help manage chronic disease conditions, with a focus on meeting patients' health and wellness goals. Services offered in the CCN are provided at no charge and assist in the following areas: appointment adherence, nutritional support, medication reconciliation, prevention and risk, emotional support, community resource access, challenges of daily living, and education on health and well-being. The four diagnoses are hypertension, diabetes, hyperlipidemia and depression. Parenting classes also are part of the CCN. Programming is diverse and may be offered in schools, homes and physician offices.

The CCN has eight core members comprised of registered nurses, dietitians, social workers and counselors, who are augmented in the field by trained health coaches. The team is led by a medical director and works closely with community physicians. The CCN offers internships for graduate students, typically from Pennsylvania's University of Pittsburgh, Gannon University or Edinboro University. Students hired as interns, typically studying counseling,

Impact

The effectiveness of the Community Care Network is scrutinized carefully.

Based on a review of the most recent utilization for CCN patients, readmissions declined by 45% and ED visits declined by almost 25%. On average, spending for CCN patients decreased about 28% per patient, ranging from \$3,731 to \$6,112 per patient, on average, depending upon payer type. While readmissions were reduced, use of outpatient services increased.

social services or a related health science, augment the care team by providing home visits. Similarly, the CCN recruits students from Allegheny College who are preparing for careers in health and human services and trains them as health coaches.

Currently, 40 active coaches visit more than 80 patients in the CCN, including children and their parents. To become health coaches, students participate in a one-semester seminar that provides instruction on chronic disease management, population health management, health law and more. Upon successful completion of the seminar, students receive two credit hours and can participate as health coaches. They receive an additional two credit hours per semester for making weekly home visits, supporting caregivers and patients, and reporting outcomes and findings to the CCN team. The CCN director supervises the health coaches and reviews/modifies their curriculum as needed.



***Patient participating in MMC's
Community Care Network***

Patients are referred to CCN services in several ways including a hospital emergency visit, direct hospital admission or community referral. Potential CCN participants are screened for medications, level of education, psych/social conditions and support at home, among other indicators, and then stratified by risk to determine their suitability for the program. After screening, the team provides patients an initial home visit to determine the appropriateness of care coordination. Those who can benefit from – and who wish to participate in – care coordination will work with the CCN team to establish goals. In this model, it is the patient's goals that drive care planning and progress. The clinical team visits on a weekly, biweekly or monthly basis as long as the patient is enrolled and has care coordination needs.

The multidisciplinary CCN team meets weekly with the medical director to review progress and utilization. Members report on their patients and make determinations about the plan of care and continued service. Interns and health coaches meet with the clinical team weekly to report and discuss their findings as well. Currently, the CCN serves about 350 patients, including 60 children.

Lessons Learned

Keeping patients engaged in their plan of care and to do it as efficiently as possible requires coordinating services not only within the hospital, but across the community as well. The CCN collaborates with the designated area agency on aging: Active Aging, Inc., Meadville, Crawford County Human Services Department, visiting nursing, hospice and others. The county augments the program with support primarily for mental health, early childhood intervention and youth services. The CCN also works with multiple area agencies to address local transportation, food and housing needs.

Future Goals

The goal is to engage patients and help them take ownership of their plan of care and stay out of the hospital. By reducing readmissions and ED visits, as well as keeping patients focused on wellness and health promotion, the CCN improves the overall health of the population while conserving scarce resources and reducing costs. This approach also provides an opportunity to educate and develop career professionals in health and human services by engaging students in the delivery of care. It cannot be done alone: the collaboration between the hospitals, colleges and universities, and community services is exceptional – as are the outcomes of their combined efforts.

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