Care Coordination Model using the Combination of Population Health and Palliative Care Approaches for Managing Advanced Illnesses

Carol Babcock, MFT, CSSBB
Kerisia Wasztyl, LMFT
Defining the Population

- An analysis of disease specific data revealed a health care disparity with African Americans having a higher incidence of readmissions for both Heart Failure (HF) and Chronic Obstructive Pulmonary Disease (COPD) versus their Caucasian peers.

- The Community Health Assessment completed for Navicent Health had also shown HF as one of the top issues to address in this community.

- Advanced HF was defined as a documented ejection fraction less than 25%.

- The criteria for advanced COPD was defined as a patient who had a primary diagnosis of COPD and had been intubated in the last 3 months or currently using home oxygen.
Identifying Opportunities for Improvement

Lean Six Sigma approach was used to identify areas of improvement to process, timeliness and effectiveness

1) Staff worked from a patient list that was a year old; some of the patients identified on this list were already deceased, and contact information was not always current

2) The population case manager addressed social determinants of health, but not goals of care discussions for these patients coping with advanced illness
Redesign of Screening and Process

LACE Screening Tool using Technology

- Length of stay
- Acuity of the admission
- Comorbidity is assessed by type and number of comorbidities
- Emergency room visits during the previous six months

Outcomes
Healthy Communities Care Coordinator
Behavior Modification for Serious Advanced Illness

- Physical
- Psychological
- Social
- Cultural
- Spiritual
- Legal Ethical
Outcomes of Project

Decrease in Avoidable Admissions

- Studied sample of 58 patients out of total 359 (16%)
- Average # hospitalizations decreased from 2.9 to 2.0 (0.9 ~ 31%)
- Average # admissions avoided: $359 \times 0.9 = 323$
- Average cost of avoided admits: $6,436 \times 323 = \$2$ million
- Reduction is statistically significant (Chi-square test, p-value = 0.0023)
Patients in 2018: 25,972
High risk patients: 5% x 25,972 = 1,299
Admissions avoided: 1,299 pts x 0.9 admits = 1,169
Savings: 1,169 admits x $6,436 = $7.5 million
Questions?

Thank you to our Teammates:

Khalid Y. Aram; Mary Hoey, RN, PhD; Chevonnia Jones, MPH; Angeline Doh, MS, CRC, MFT; Monique Davis-Smith, MD, MPH