CPCPracticeSpotlight20

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

Focused Care Management and Coordination Reduced Emergency Room Visits for Patient

Group Health Associates – Springdale, Cincinnati, Ohio System (TriHealth), 14,000 patients

Sept. 5, 2014

This strategy addresses CPC Milestones 2 and 6.

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Situation: Weekly visits to the local emergency department (ED) were routine for "Martha,"* an elderly patient who suffers from multiple co-morbidities. Martha depends on portable oxygen, takes more than two dozen medications and lacks significant family support and resources. She also struggles with managing her chronic pain.

Strategy: ED utilization reports brought Martha to the attention of the care management team at **Group Health Associates' Springdale practice.** Within 72 hours of Martha's ED visit, a care management team member contacted her to discuss her reasons for seeking care at the ED and to identify her follow-up needs. This phone call sparked collaboration between her physician and the care management team to initiate intensive care management in response to Martha's complex medical needs and barriers stemming from her social support needs.

In addition to scheduling Martha's follow-up appointments and coordinating any needed referrals, the RN care managers' outreach also revealed Martha would benefit from home health nursing. Although the care managers would call frequently – sometimes daily – to check on Martha's condition, the home health nurse also maintained constant communication with Group Health Associates' care managers.

Tenets from Springdale's "It takes a village" strategy:

- Collaboration among multiple disciplines is essential.
- Clear and frequent communication among all team members keeps everyone on task.
- Care coordination is fundamental to the patient's success.
- Patients return to the center of the care continuum when their barriers to treatment are addressed.

The team's assessment of her need for social support led to contacting local community-based agencies that offered services Martha could use, such as making her home safer and a healthier environment and helping her with other resources.

Springdale care managers tracked Martha's progress through their care management dashboard. Along with ensuring office visits are completed, the dashboard showed how frequently outreach occurred and when the next communication was scheduled. Any notes from the home care nurse were documented here as well.

Martha began to recognize that consistent monitoring was stabilizing her conditions, and the frequent check-ins helped her build new-found trust in her care team. She became engaged in contributing to her treatment plan and was willing to learn about better managing her symptoms. As Martha gained confidence that help would be available when she needed it, her trips to the ED decreased significantly and eventually stopped. Martha made no visits to the ED for more than a year.

**Name changed to protect patient privacy.*

TMF Health Quality Institute

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