



MEDICAID PAYMENT POLICIES AND CARE COORDINATION WORKGROUP

Meeting 2

November 19, 2020

Meeting Agenda

- ❑ Welcome and Roll Call
- ❑ Workgroup Member Presentations on Care Coordination, Discharge Planning, and Appropriate Sites of Care
 - VAHP/MCOs
 - VHHA/Hospitals
 - Emergency Department
 - Primary Care
- ❑ Emergency Department Care Coordination Tool
- ❑ Wrap Up and Next Steps
- ❑ Adjourn

Disclaimer

The primary goal of this workgroup is to provide a report to the General Assembly highlighting data, findings, and policy options in the areas of emergency room utilization and hospital readmissions. As a reminder, this meeting is open to the public and all information shared and presented during workgroup activities, may be made public and/or included in this public report to the Virginia General Assembly.

Public Comment

As a reminder, public comments should be submitted to Rusty Walker (rusty.walker@dmas.virginia.gov) and will be collected for distribution to workgroup members.

Workgroup Meeting Timeline

1

Meeting One: October 27, 2020

- ✓ Overview of workgroup purpose, strategy, and timeline
- ✓ Review ED utilization and hospital readmissions data in Virginia
- ✓ *Homework for Workgroup Members (VHHA/Hospitals, VAHP/MCOs, Primary Care Physicians, and Emergency Department Physicians): Care Coordination Presentations for meeting 2 addressing workgroup topics (i), (ii), and (v).*

2

Meeting Two: November 19, 2020

- ✓ Review of care coordination and discharge practices, as well as access to appropriate sites of care (presentations from workgroup members).
- ✓ *Homework for Workgroup Members:*
 - *All Members: Provide written feedback on any draft report content provided to date, including any draft policy options*
 - *VCHI and DMAS (with assistance from DMAS' Actuary): Prepare presentations on past and current efforts to address ED utilization and hospital readmissions nationally and in Virginia. (iii, iv, vii)*

3

Meeting Three: December 17, 2020

- ✓ Review successful federal, state, and provider interventions to address ED utilization and hospital readmissions (presentations from DMAS and VCHI).
- ✓ *Homework for Workgroup Members:*
 - *All Members: Provide written feedback on any draft report content provided to date, including any draft policy options*
 - *DMAS: Prepare presentation on existing value based purchasing and other financial incentives.*

4

Meeting Four: March 18, 2021

- ✓ Discuss value-based purchasing and other incentives for potential policy options in Medicaid (DMAS presentation).
- ✓ *Homework for Workgroup Members: Provide any written feedback on Meeting 4 content to DMAS.*

Workgroup Report Timing

- ✓ DMAS is drafting sections of the report concurrently with the workgroup meetings.
- ✓ The workgroup report is due on **May 1, 2021**. The entire month of April is reserved for Agency, Secretary, and Governor reviews of the report. This means **all** feedback on the report must be sent to DMAS by the end of **March 2021**.
- ✓ DMAS will share report sections as they are drafted for workgroup member comment and feedback. Below is the proposed schedule for report feedback.
 - **ER & Readmissions Data** sections will be shared after Meeting 2. Feedback requested by **December 10, 2020**.
 - **Care Coordination, Discharge Planning, and Appropriate Sites of Care** (Meeting 2 content) sections based on content from this meeting will be drafted and shared for feedback on **January 29, 2021** (tentative).
 - **Past and Current efforts to Address ER utilization and Hospital Readmissions** (Meeting 3 content) sections will be shared for feedback on **February 26, 2021** (tentative).
 - **Full Draft, including Review of VBP and other Incentives** (Meeting 4 content) will be drafted and shared prior the 4th meeting and feedback will be due by **March 26, 2021** (tentative).



WORKGROUP MEMBER PRESENTATIONS ON CARE COORDINATION, DISCHARGE PLANNING, AND APPROPRIATE SITES OF CARE

Outlining the Care Coordination Landscape in Virginia

- ✓ The purpose of meeting 2 is to establish a baseline understanding of **care coordination, discharge planning, and appropriate sites of care processes and activities occurring across the health care system.**
- ✓ Designated workgroup members (i.e. MCOs/VAHP, Emergency Physicians, Primary Care, and Hospitals/VHHA) have prepared presentations from the point of view of their respective stakeholder groups for both emergency department utilization and hospital readmissions (addressing items i, ii, and v of the workgroup mandate).



VAHP Member Care Coordination

A Holistic Approach

Identification of Members

CCC+

- ▶ All CCC+ members have an assigned Care Coordinator
- ▶ Level of engagement and ratio is dependent upon acuity
- ▶ BH designation if qualifying SMI/SED/SUD diagnosis

Medallion PH:

- ▶ EDCC reports members with 3ER visits within 90 days, or 10 ER visits within a year.
- ▶ UM referrals
- ▶ Provider referrals
- ▶ Member referrals
- ▶ Leverage daily inpatient census
- ▶ Stratification of data to identify high risk members
- ▶ Low Acuity Non-Emergency ER visit report 4 visits or more in the last year

Medallion BH:

- ▶ VSP with acute needs (includes all FC/AA)
- ▶ BH inpatient admission
- ▶ RTP step down
- ▶ BH related ER visit
- ▶ 3 ER visits in 90 days for any reason
- ▶ Provider referrals
- ▶ Member self referrals
- ▶ Observed need via review of program generated data

Key Care Coordination Responsibilities

External

- ▶ Complete assessment
- ▶ Development of a person-centered care plan (*CCC+ members*)
- ▶ Educate on available benefits
- ▶ Troubleshoot around access barriers
- ▶ Coordinate with providers, services, community resources, and SDOH needs
- ▶ Assist with pharmacy and medication issues
- ▶ Assist with securing medical equipment
- ▶ Health Education
- ▶ Recognize and report Quality of Care Issues

Internal

- ▶ Exchange of clinical information with UM staff to ensure appropriate levels of care approved
- ▶ Routine collaboration with interdisciplinary team promoting an integrated whole person approach
- ▶ Present for discussion in weekly rounds as needed to obtain input from MDs, nurses, managers and providers involved in the member's care

Discharge Planning

Traditional Model

- ▶ Review Emergency Department Care Coordination (EDCC) portal and inpatient census daily
- ▶ Attempt to participate in discharge planning day one
- ▶ Post discharge contact within 48 hours post discharge
- ▶ Assist with aftercare placement (SNF, ALF, RTP) and BH/PH follow up appointments
- ▶ Address SDOH needs and gaps in care
- ▶ Coordinate with family and/or providers
- ▶ Arrange transportation for aftercare appointments
- ▶ Monitor post discharge follow up with providers
- ▶ Ensure prescriptions are obtained
- ▶ Benefit education

Embedded Care Coordination Model

- ▶ Access to high need members (previously unable to be reached via telephonic means)
- ▶ Routine sharing of data and information to ensure member needs are identified and met
- ▶ Care Coordinators are integral part of discharge planning process
- ▶ Care Coordinators able to attend provider treatment team meetings
- ▶ UM provided at inpatient facility



Duration of Support

- ▶ Member outreach within 24 hours of an IP admission for all members
- ▶ Medallion provides case management for 30 days post discharge and longer term support as needed
 - ▶ *Note: Medallion PH CM is provided for higher acuity members.*
- ▶ Medallion PH provides case management to our higher acuity members
- ▶ Attempt to participate in discharge planning day one (BH often see members on unit)
- ▶ Discharge planning begins at member's admission. Support continues post discharge with regular routine contact
- ▶ CCC+ members outreached within 24 hours of an ED visit, Medallion members within 48 hours (field visits to ER when possible)
- ▶ CCC+ members served as long as they are a member with shifting intensity levels as warranted

Coordination Across the Health System

- ▶ Routine coordination of care with existing providers
- ▶ Coordination with PCPs regarding IP hospitalizations, ED visits, and ICT meetings for our CCC+ members
 - ▶ Using a combination of telephonic and face to face collaboration techniques to engage our community partners
- ▶ Use of EDCC platform to share information with ER medical teams
- ▶ Communication and coordination with hospital discharge teams
- ▶ Referrals to address lower/higher level of service needs
- ▶ Establishing partnerships with providers to ensure continuity of care (i.e. group homes, nursing facilities, psychiatric residential facilities, CSBs)
- ▶ Leveraging opportunities to increase access to care and SDOH needs
- ▶ Providing education to the member/family/guardian with regards to:
 - ▶ Appropriate level of care, amount of care, location and duration of care
 - ▶ Diagnosis, gaps in care, preventative care
 - ▶ What to expect from a quality provider

Promoting Appropriate Sites of Care

Provider Level

- ▶ **Effective partnerships with quality providers are key**
 - ▶ Value Based Provider Incentive Programs
- ▶ **Review and share pertinent actionable data**
 - ▶ Monitor performance
 - ▶ Improve outcomes

Member Level

- ▶ Care Coordinators connect members with high quality providers
- ▶ Interdisciplinary Care Team meetings
- ▶ Education on disease management
- ▶ Education on medication management
- ▶ Education on preventative care
- ▶ Encourage and educate on self-advocacy
- ▶ Education on appropriate sites for urgent care needs / 24 Hour NurseLines, and providers offering after-hours care
- ▶ Identifying gaps in care and working toward closing gaps
- ▶ Working to close SDOH gaps

Additional Program Highlights

Embedded Care Coordination Model

- ▶ Anthem care coordinators are embedded on site with select higher volume inpatient and outpatient provider groups where they work alongside BH and PH providers to ensure behavioral health, physical health and social needs of members are identified and met in timely manner

Behavioral Health Homes

- ▶ BHH care coordinators and CSB staff work alongside each other to deliver timely outreach and collaborate regarding member care

Disease Management

- ▶ Intensive Care Coordination for high acuity / high-cost members. Goals is to provide member education on disease management, necessary referrals / appointments, and tracking of outcomes to increase follow-up after discharge, participation in preventative and routine appointments, and medication adherence

Measurement of Success

Quantitative Measures

- ▶ Decrease in ER visits
- ▶ Reduction in inpatient admissions
- ▶ Increase in PCP and specialty visits
- ▶ Increase pharmacy Rx fill rates
- ▶ Follow-up with providers upon discharge
- ▶ Decrease in gaps in care and SDOH needs

Qualitative Measures

- ▶ Members whose health concerns are addressed and needs met in an individualized manner (linked and engaged in appropriate care)
- ▶ Members demonstrate a sense of empowerment in taking charge of their healthcare needs
- ▶ Shift from a problem focus to celebration of achieved goals and milestones
- ▶ Members verbalize improved quality of life
- ▶ Member satisfaction

Opportunities

- ▶ Discharge planning is intended to provide patients with information & resources to improve & maintain their health post-discharge & avoid adverse events such as readmissions. Enhancements to this process will improve outcomes & patient success:
- ▶ Pilot “Transition of Care Rounds” between health plans & institutional settings
 - ▶ This forum would encourage same time integration & communication of the member’s health status, treatment responses & care plans to enhance collaboration on discharge planning
- ▶ Clarify communication channels & timelines between health plans & institutional settings
- ▶ Implement recorded personalized discharge instructions to improve patient comprehension & adherence to the plan of care
- ▶ Standardize the use of a discharge planning toolkit for patients & families to encourage participation & prepare patients for a successful transition
 - ▶ CMS offers a discharge planning booklet, which can be downloaded by [clicking here](#)



Medicaid Payment Policies and Care Coordination Work Group

November 19, 2020

LANETTE WALKER

VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION

Care Coordination and Discharge Planning

The Agency for Healthcare Research and Quality (AHRQ) describes care coordination as deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. In the inpatient acute care hospital setting, care coordination is accomplished as part of the discharge planning process.

Hospital Care Coordination and Discharge Planning are Highly Regulated

- Medicare requires discharge planning to be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of patient from hospital to post-discharge care and *reduce the factors leading to preventable hospital admissions*.
- Every patient is evaluated at least 48 hrs in advance of discharge regarding ability for self-care or assistance by other caregivers.
- Discharge plan effectiveness and patient experience with discharge planning process is monitored by CMS through the Hospital consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.
- Joint Commission requires hospitals to have written discharge planning policies and procedures applicable to all patients.
- Discharge planning is regulated by state law through hospital licensure and survey activity. Requires hospitals to inform and educate the patient or their designee about follow-up care, treatment and services.

The Discharge Planning Process Involves Patients, Family Members or Caregivers and a Multi-Disciplinary Team

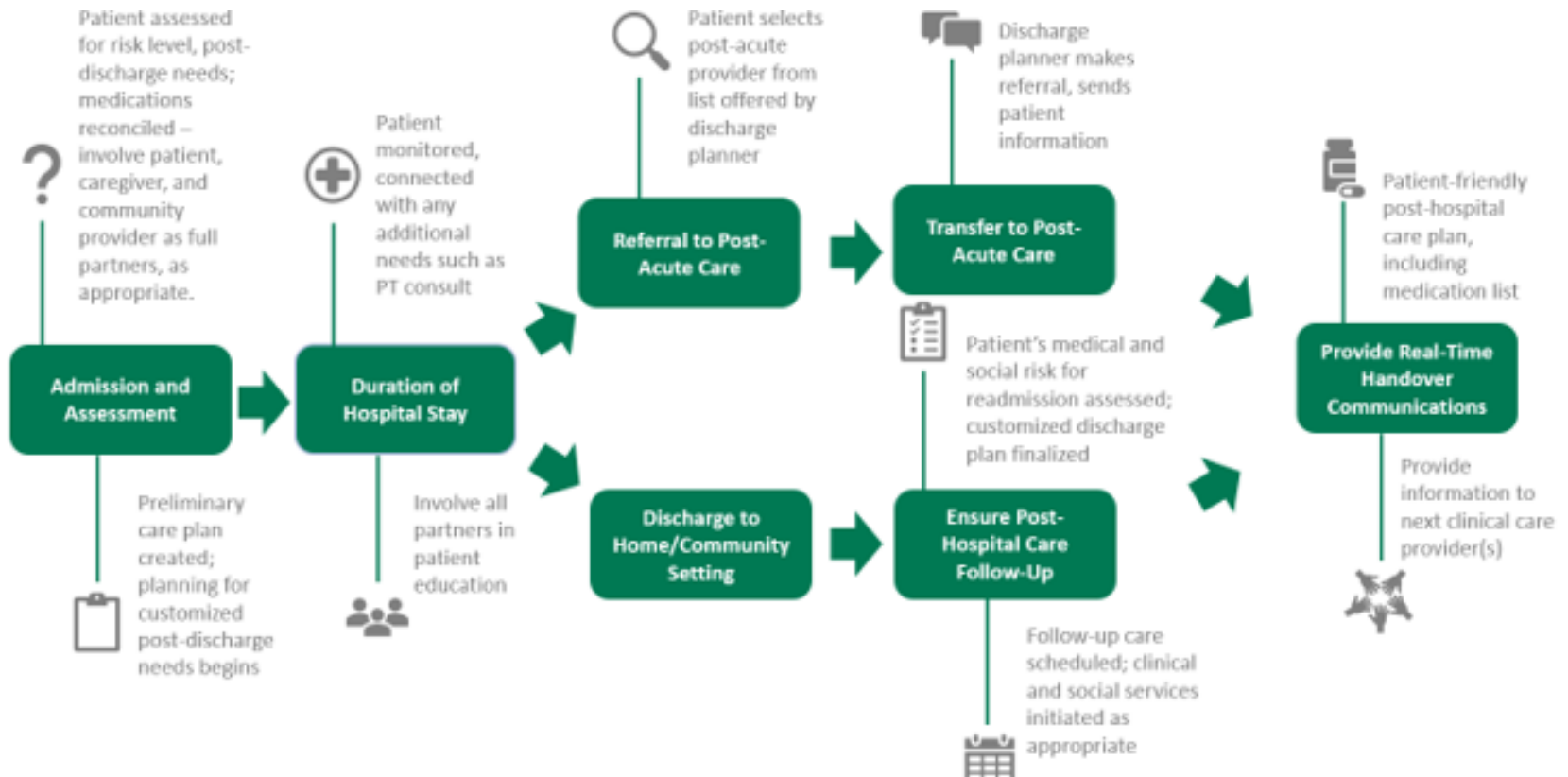
Hospital discharge staff...

- ✓ Perform assessments and identify any needs the patient has for psychosocial or physical care, treatment and services post discharge.
- ✓ Arrange services required by the patient after discharge to meet ongoing needs.
- ✓ Share patient information when the patient is referred to other providers.
- ✓ Involve patient's family, licensed independent practitioners, physicians, and clinical psychologists in the development of a discharge plan.

Common Discharge Team Member Roles

- **Case Managers** – serve as key point of contact to coordinate care with physicians and patient care team
- **Social Workers** – assist patients with psychosocial needs and help patients access benefits and community resources
- **Utilization Review** – manage business functions and payor relations
- **ED Case Managers or Social Workers** – assess patients entering ED and assist with alternative placement for patients that are not admitted to the hospital.
- **Others**

Common Discharge Planning Activities



VHHA Efforts to Reduce Unnecessary Hospital Readmissions

- ✓ In June 2016 the VHHA launched a statewide readmissions learning series titled “*Home Is The Hub*”, facilitated by Dr. Amy Boutwell, a nationally recognized thought leader in the field of reducing readmissions and improving care for high utilizers. A major theme of the initiative was to affirm that the goal of hospital-based healthcare services is to help patients return to, remain in, and thrive in their own homes.
- ✓ The initiative provided VHHA members, as well as post-acute and community-based and payer partners with practical advice, best practices and innovative approaches for working together to reduce hospital readmissions.
- ✓ An additional resources that was introduced and utilized during this initiative was the AHRQ-funded ASPIRE toolkit titled “*The Hospital Guide to Reducing Medicaid Readmissions*”. Dr. Amy Boutwell was the lead author for this work as well.
- ✓ In the Winter of 2017, as part of the “*Home Is The Hub*” initiative, the VHHA partnered with the Virginia Healthcare Association (VHCA) to host regional learning sessions across Virginia to support and enhance collaborative efforts among hospitals and skilled nursing facilities to reduce preventable hospital readmissions. Sessions were hosted in Northern Virginia, Richmond and Lynchburg.
- ✓ The formal initiative “*Home is the Hub*” concluded in 2018 with the publication of the “*Readmissions Reduction Playbook: High-Leverage Strategies for Virginia Hospitals and Health Systems*”, which summarized the learnings that were shared throughout the “*Home Is The Hub*” initiative.

VHHA Efforts to Reduce Unnecessary Hospital Readmissions

- ✓ In Summer 2018 the VHHA partnered with Health Quality Innovators (HQI) to present a learning series titled “*ED Strategies To Reduce Readmissions*”. This six-part learning series focused on the Emergency Department’s role in reducing avoidable hospitalizations, including readmissions. The series also highlighted potential uses of the Emergency Department Care Coordination (EDCC) technology.
- ✓ In Spring/Summer of 2019 the VHHA again partnered with the VHCA in a DMAS funded project designed to reduce avoidable rehospitalizations. This initiative provide training and resources to nursing facility staff and administrators, as well as hospital emergency department and case management staff on tools focused on using early identification, evaluation, and communication about acute changes in condition of residents in nursing facility and other care settings.
- ✓ In 2019, the VHHA also hosted a statewide webinar series focused on work being done in Virginia hospitals to implement the strategies for avoiding preventable hospital readmissions that were shared during the “*Home Is The Hub*” initiative . The webinar series, titled “*Targeted Strategies for Improving Care Transitions and Reducing Preventable Hospital Admissions*”, featured presentations from teams at Virginia hospitals that had implemented improvement initiatives in care transitions that were positively impacting readmission reductions.
- ✓ In early 2020 the VHHA partnered yet again with the VHCA in a second phase of the DMAS-funded project to reduce avoidable rehospitalizations. The effort was to be executed through a series of five (5) regional workshops with hospital and skilled nursing facility staff. Due to the COVID-19 pandemic, however, VHCA placed the project on hold.
- ✓ Throughout 2020, the VHHA has continued to highlight and share best practice examples of Virginia hospitals’ ongoing care transitions and readmissions reduction efforts.

Broad Functions of ED Discharge Process

- What occurred during the ER visit
- Medication list
- Diagnosis
- Treatment plan
- Expected course of illness
- Signs and symptoms to watch for

**Communicate
with & Educate
Patients**



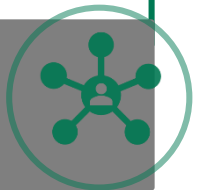
- Ensure patients:
 - Take appropriate medications
 - Stop or avoid certain meds
 - Are capable and able to care for wounds
 - Understand and comply with dietary restrictions
 - Receive appropriate physical therapy
- Discuss
 - Use of medical devices
 - Activity restrictions
- Facilitate
 - Further diagnostic testing
 - Further health care provider evaluation and treatment

**Support Post-
Acute Care**



- Share records and communicate further plans with primary care physician (PCP) and specialists
- Make appointment with PCP and specialists
- Facilitate admission to substance abuse recovery facilities
- Facilitate public housing services

**Coordinate
Care**



Promoting Appropriate Sites of Care

Hospitals also engage in a number of activities geared towards promoting appropriate sites of care for patients and to, in part, avoid unnecessary use of the ED or readmissions. These activities are geared towards engaging patients well in advance of the need for emergent or acute care. Common examples across hospitals and health systems include:

- **“Find a doctor” websites and interactive tools.** These services provide searchable databases of physicians and other providers affiliated with the hospital or health system and often include a link to allow access to scheduling.
- **Nurse help lines.** These services allow around the clock access to a nurse to assess patient needs and direct them to appropriate points of care within the hospital or health system or in the community.
- **Patient engagement tools.** These services are designed to provide personalized health information to patients, encouraging them to track their health status and seek appropriate care at regular intervals.
- **Patient navigators.** For complex patients or patients with chronic conditions, patient navigators are engaged to proactively contact patients about the need for follow-up and routine care.
- **Personal health records.** These services allow patients to schedule appointments and exchange secure messages with their physician or a nurse regarding their health care and the need for services.
- **Telehealth services and consultation.** These services allow convenient access to a physician or licensed independent practitioner on an urgent basis without appointment.
- **Emergency Department Care Coordination (EDCC) Program.** The EDCC connects EDs to facilitate near real-time communication and collaboration among health care providers, health plans, and clinical and care management personnel for patients.

Promoting Proven Strategies to Reduce Reliance on EDs

“Experience and research suggests that narrow strategies to reduce ED usage by attempting to distinguish need on a case-by-case basis have had limited success in reducing expenditures to date, due in part to the very reasons for higher rates of utilization by Medicaid beneficiaries including unmet multiple health needs and the limited availability of alternative health care services.” CMS Informational Bulletin (2014)

Strategy 1: Broaden Access to Primary Care Services

Ensure network adequacy

Two-thirds of emergency visits occur after business hours (weekdays 9am-5pm)

Strategy 2: Focus on Frequent ED Users - “Super-utilizers”

5% of the Medicaid “super-utilizers” = 40% of resources

Enhance and integrate the Emergency Department Care Coordination (EDCC) program

Strategy 3: Target needs of people with behavioral health challenges

Invest in outpatient community resources - fully fund STEP-VA

Execute Behavioral Health Enhancement (DBHDS and DMAS led)

Leverage existing programs seeking to address social determinants of health including:

Unite Us Program - public health infrastructure that connects health and social care

Partnering for a Healthy Virginia - VDH and VHHA partnership

Drivers of ER Utilization



Societal Factors Contribute to Unnecessary Hospital Readmissions and Overutilization of the ED

20% of a person's health and well-being is determined by having access to healthcare. The other 80% is due to the social and structural conditions that influence health: housing and neighborhood conditions, education, and employment opportunities and the environment.

Leverage Existing Programs to Address Population Health: *Partnering for a Healthy Virginia*

Partnering for a Healthy Virginia - VHHA partnership with VDH, local health departments, local jurisdictions, the medical community, and other stakeholders to address population health

Relevant Projects

Health Begins learning collaborative to promote proven methods to address population health and the social determinants of health with an emphasis on decreasing unnecessary ED visits, avoidable hospitalizations, and readmissions.

Conducted assessment of screening tools for social determinants of health and e-referral systems and found the need for standardization and a statewide e-referral system that helps connect Virginians, particularly vulnerable populations, with needed resources.

Example: Recognizing a link between diabetes and food insecurity, health system information from health-related social need (HRSN) screenings that include assessment of food insecurity is used to identify individuals at-risk.



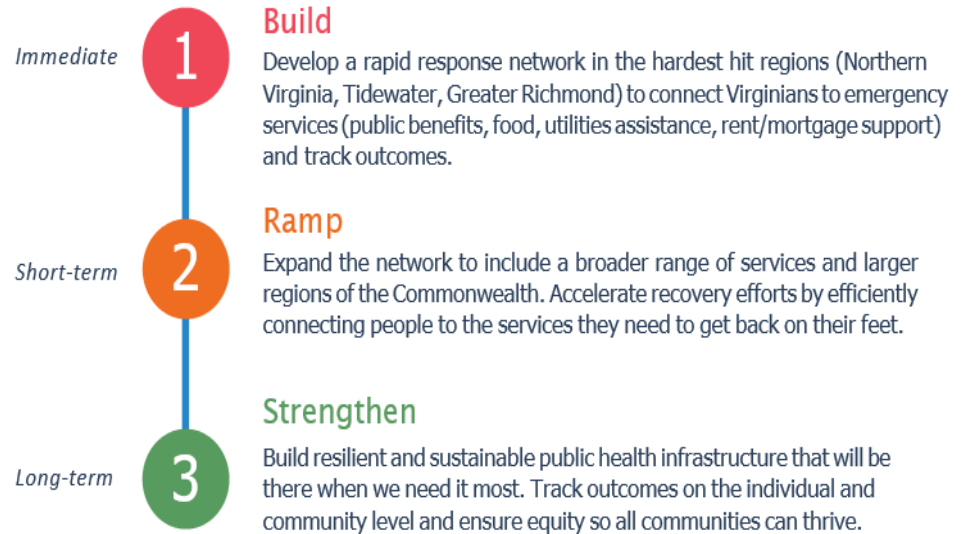
Leverage Existing Programs to Address Population Health: *Unite Us*

Outcome-focused technology to support coordinated care networks of health and social service providers to address social determinants of health

Unite Us creates public health infrastructure that connects health and social care and assists states in their effort to address the social determinants of health.

Public health experts work deeply with each community to build coordinated care networks of health and community services.

Through these networks, the state can connect Virginians to critical services, track the outcomes delivered, evaluate the gaps in services, and direct resources where they're needed most.



Key Takeaways

- ✓ Hospital care coordination and discharge planning activities are highly regulated.
- ✓ The discharge planning process is extensive and involves patients and family members or caregivers in all aspects, including post-discharge care and care coordination.
- ✓ Discharge planning and care coordination is multi-disciplinary and entails several coordinated functions both within the hospital and outside the “four walls” with other health care providers and community partners.
- ✓ Hospitals have committed to reducing unnecessary readmissions and have made tremendous strides in improving outcomes in this area.
- ✓ Care coordination and discharge planning in the ED is an even more specialized function and plays a critical role in promoting patient access to appropriate sites of care.
- ✓ Unnecessary hospital readmissions and overutilization of ED care can be attributed to several societal factors indicating that a broader, more comprehensive approach is needed to address these shortcomings.
- ✓ Current initiatives aimed at addressing population health and social determinants of health can be leveraged to help reverse these trends and align with Medicaid cost savings initiatives.

Optimizing Transitions of Care

11/19/2020

Melinda Hancock, CPA, FHFMA
Chief Administrative and Financial Officer
VCU Health System



Care coordination has emerged at the forefront of healthcare redesign and population health



“While care coordination isn't a population health strategy, it's a fundamental aspect of overall population health and allows organizations to shift their focus from a "diagnose-and-treat" mentality to optimize what happens between episodes of care.”

Source <https://www.beckershospitalreview.com/patient-engagement/how-care-management-can-drive-success-in-value-based-healthcare.html>

Care coordination and social work functions have expanded to a more holistic patient care model

In many cases, this means care coordinators addressing social and wellness aspects of patients' lives outside the healthcare system (including social determinants), such as:

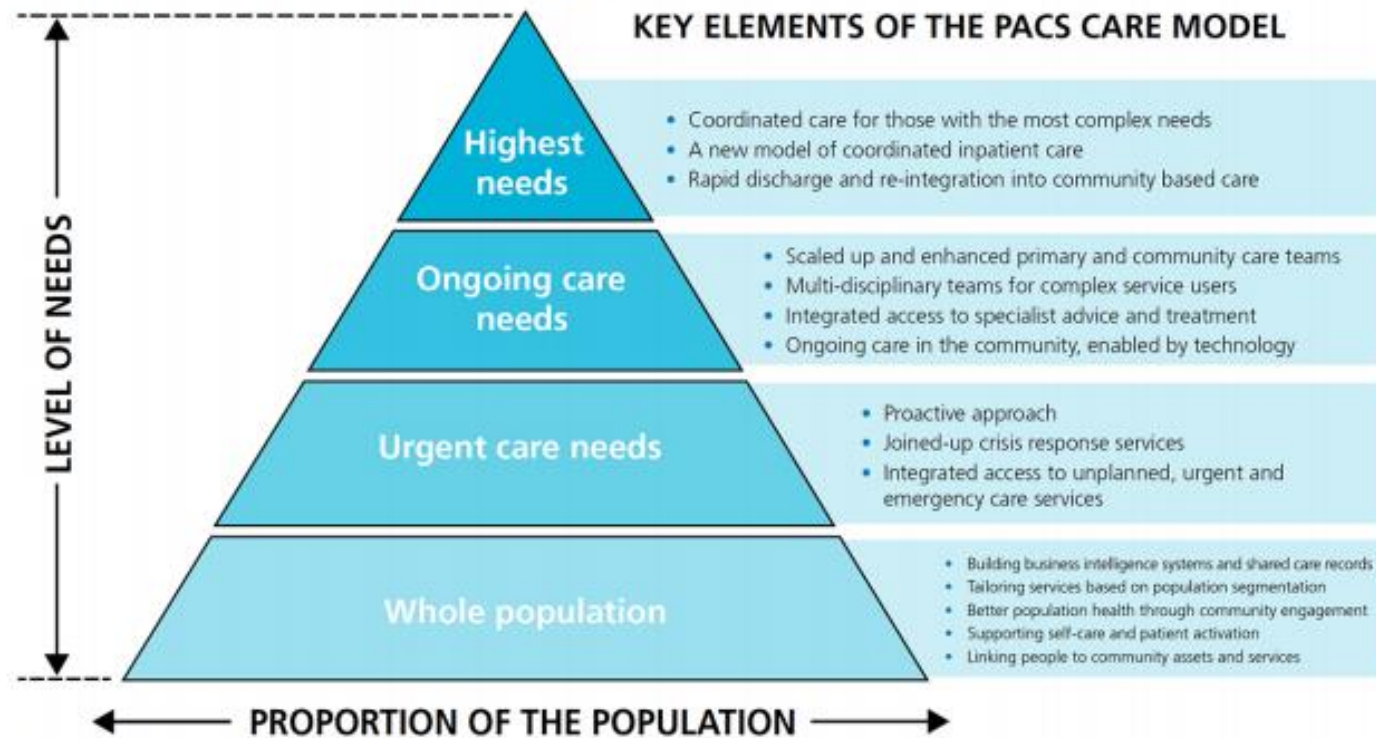
- *Income and social situation*
- *Adherence to medication protocol*
- *Access to healthy food*
- *Housing situation*
- *Employment and working conditions.*
- *Education and literacy*



Appropriate alignment of resources to risk is key to success

Primary and Acute Care Systems Framework (PACS)

Figure 2: The Four Levels of the PACS Care Model.



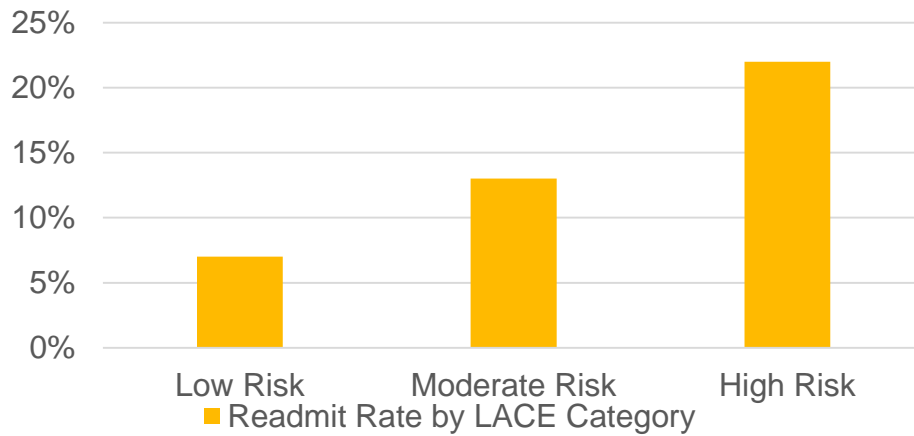
Source: NHS England (2016), p. 9

Patient Identification/Risk Stratification: LACE+

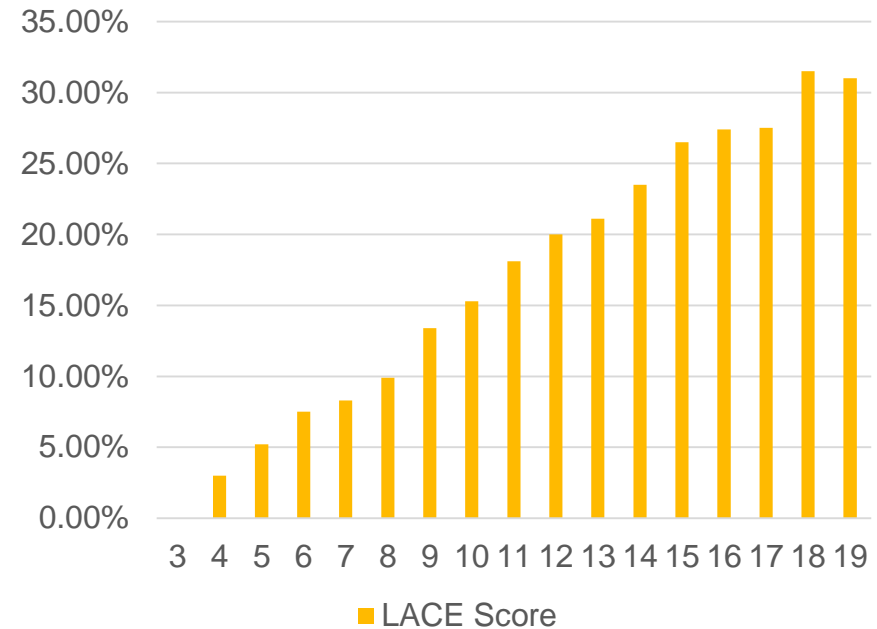
Use of data and predictive analytics to identify individuals at risk:

- Data dashboards
- LACE score
- SDOH screening

Readmit Rate by LACE Category



Readmit Rate by LACE Score

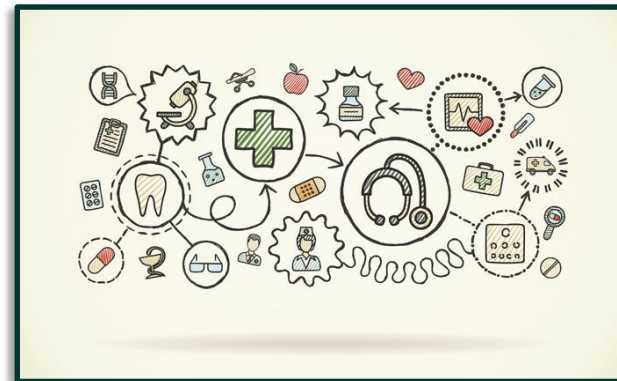


- (L) length of Stay
- (A) acute/emergent admission
- (C) Charlson Comorbidity Index
- (E) number of ED visits within 6 months

FY21 Primary Areas of Focus

VCUHS Readmission Steering Committee identified four strategic areas of focus for FY21:

1. Timely follow-up appointments/services
2. Transition of Care navigation
3. Medication reconciliation @ discharge
4. Goals of Care discussions



Key Initiatives to address the 4 primary areas of focus

- C3Rx Home Based Medication Program
- Continuum Integration Center
- SNF Navigation Team
- Remote Patient Monitoring
- Partnerships to address Social Determinants of Health
- Medicare Health Coaching (with Capital Agency on Aging)
- Intersection of Housing/Healthcare (VA Supportive Housing, Caritas, The Daily Planet Medical Respite)
- Anthem Hem Onc Project



Key Initiatives addressing primary areas of focus

C3Rx – Home Based Medication Program

- Home based medication reconciliation, education, and management
- Available to patients with polypharmacy, high risk medications, Moderate/High LACE, Bundle patients, CMS readmission penalty diagnoses, and/or Provider referral
- 30 mile radius from facility but also down to South Hill
- Currently enrolling 150 patients/month with a 10% readmit rate
- **Goal 1: To expand enrollment to 175 patients/month in Q3 and 200 patients/month in Q4**
- **Goal 2: To increase program acceptance rate and 2nd visit rate by 15%**

Key Initiatives addressing primary areas of focus

Care Management “Continuum Integration Center” *“Air Traffic Control”*



- Nursing
 - Social Work
 - Care Coordination
 - MD/APP
 - 24/7
-
- **CIC Mission:** to prevent avoidable readmissions and improve alignment between services, programs, and capabilities for patients discharged from, and aligned with, VCU Health System
 - Patients are managed by a 24-7 team to avoid automatically being sent to the ED

Integrating Care across the Continuum

Continuum Integration Center (CIC)



300
patients served

- CIC Teams**
- *Transitional Care & Remote Patient Monitoring
 - *Skilled Nursing Facility
 - *Bundles
 - *Hospital Medicine Post Discharge



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Trusted Partners in our Continuing Care Network

Partnerships supporting our efforts to serve the Greater Richmond area



Dispatch Health



Daily Planet



C3Rx - Care, Collaboration, Compliance



Senior Connections



Caritas

VCU Center for Advanced Health Management (CAHM)

Community-Based Programs



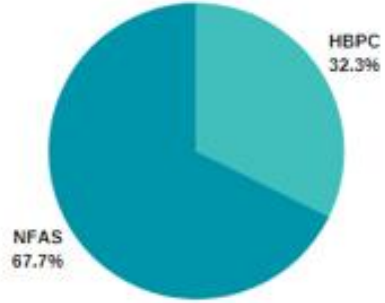
Home Based Primary Care (HBPC)



Nursing Facility Attending Service (NFAS)

1,317

patients managed annually



Key Initiatives addressing primary areas of focus

Post-Acute SNF Navigation Team



- Began January 2019 to bridge patients from acute to SNF
- One Social Worker and one RN Care Coordinator virtually follow patients discharging into 13 partner nursing homes
- Round virtually and follow patient progression to provide additional support and select case management interventions as needed

Key Initiatives addressing primary areas of focus

Remote Patient Monitoring (RPM)



Early Success

Since beginning the program in April:

- >300 patients have completed the RPM program
- 1/3 have been COVID+
- 1.8 days reduction in hospital ALOS in top 3 dx*
- 32% readmission reduction in top 3 dx*

* For mod/high risk patients versus defined compare group

Service Line 3-year goals (strategic drivers)

1. Improve patient throughput and ALOS
2. Reduce avoidable readmissions
3. Succeed in Fee-for-service while preparing for value-based payment
4. Promote business sustainability

Key Initiatives addressing primary areas of focus

Ancillary domains of care to address SDOH

VCUHS has established preferred partnerships in these important categories in the Richmond market



Key Initiatives addressing primary areas of focus

Medicare Health Coaching – (with Capital Agency on Aging)



- Health Coaches employed by Senior Connections (Capital Area Agency on Aging)
- In-home health coaching that begins 3-5 days post hospital discharge...(a modified version of Dr. Eric Coleman’s CTI Model)
- Program criteria:
 - 55+ years of age
 - Within 15 miles of main campus but also covering Community Memorial Hospital area
 - Has at least one qualifying condition:

Qualifying Conditions for Health Coaching Program	
CHF	COPD
ESRD	Diabetes
CAD	HTN
A-fib	CKD/AKI
Falls	TIA/Stroke

Key Initiatives addressing primary areas of focus

Intersection of Housing and Healthcare



- VCUHS grant funded collaboration with Virginia Supportive Housing to permanently house and case manage 10 high utilizing individuals with chronic disease and chronic homelessness
- Selected 5 patients from our Complex Care Clinic and 5 patients from our Sickle Cell Clinic
- Goal: Improve quality of life, reduce healthcare utilization and cost

 VCU Health.

CCC & Sickle Cell
Patients

10

% Difference in 5 months Pre
and 16 months Program Avg

Total Cost

17% decrease ▼

3 Day ED Returns

35% increase ▼

30 Day IP Return

81% decrease ▼

IP Visits

39% decrease ▼

ED Visits

249% increase ▼

Avg. IP LOS

14% decrease ▼

*Based on 5 months pre program
and 16 months post program*

Other Initiatives

Improving Care Transitions FY21	
SQS Priority Projects:	7 Day HUG (Follow up and Care Transitions)
	Care Continuum- Navigation and Transitions (Nurse Navigation)
	Readmission Reduction for High Risk and Serious Illness Populations (Goals of Care)
Ambulatory Projects :	Ambulatory Team-based Care Model
	Primary Care First Model Participation
Surgery QAPI:	C7: Readmission Review (readmission analysis)
Medicine Readmission Committee:	COPD Care Improvement Initiative (in development)
Solid Organ Transplant (QAPI):	Readmissions (readmission analysis)
HemOnc QAPI:	Supportive Care Solid Tumor
	Supportive Care newly diagnosed Acute Leukemia age 50 & over
	Avoidable Admissions
CT and Vascular Service Group Work	Discharge Phone Calls
	Post-Op Visits with APP
	Retrospective Reviews of Patient Follow-up Visits (home health)

MEDICAID PAYMENT POLICY WORKGROUP

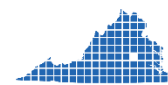
Emergency Dept Care Coordination

Todd A. Parker, MD, FACEP, FAAEM



ED WORKFLOW

EMTALA and the flow of an ED visit

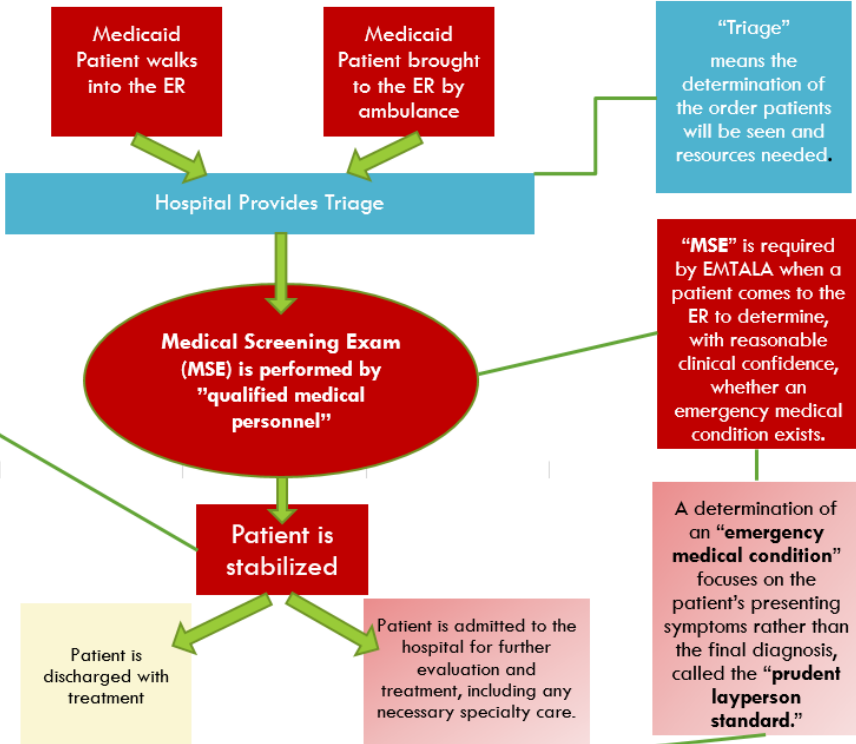


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ED WORKFLOW

ER VISIT



"Stabilization" is required by EMTALA and means that medical treatment is provided to treat the emergency condition as is necessary to assure within reasonable medical probability, that no material deterioration is likely to result after discharge or transfer.

"Triage" means the determination of the order patients will be seen and resources needed.

"MSE" is required by EMTALA when a patient comes to the ER to determine, with reasonable clinical confidence, whether an emergency medical condition exists.

A determination of an **"emergency medical condition"** focuses on the patient's presenting symptoms rather than the final diagnosis, called the **"prudent layperson standard."**

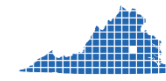
WHAT IS EMTALA?
 EMTALA stands for the Emergency Medical Treatment and Active Labor Act. It is a federal law that governs treatment of all individuals and/or transfer of an individual when they come to an emergency department in a hospital that accepts Medicare/Medicaid funding. It was enacted in 1986 to protect indigent and uninsured patients.
 EMTALA requires that all patients who come to the ER receive a medical screening exam (MSE) to determine whether or not an emergency condition exists and requires that a patient be stabilized before being transferred to another department, another facility or being discharged. Fines are \$105,000 per violation per person/entity, for hospitals and physicians.

■ Required by law

The **"prudent layperson standard,"** which is both federal and Virginia law, means that a person, who reasonably believes they could have an emergency condition, is entitled to medical treatment in the Emergency Department, and that reimbursement for their care cannot be based on final diagnosis but rather must take into account presenting signs and symptoms.

KEY QUESTIONS

KEY QUESTIONS



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1. How does your group identify people for care coordination

- Provider referral / Case Management (CM) rounds in ED at regular intervals
 - EDIE Icon- Providers/CM can open Care Alerts
- Risk-stratification tool in EMR called LACE+.
- High LACE+ Score:
 - Timely assessment or outreach
 - Initiation of Home Health services or Palliative Care if needed
 - Ensuring appropriate follow-up appointments
 - Ongoing Care Coordination or Complex Care Management (CCM).
- ED Tracking Board monitored by CM. A “boomerang” icon identifies bouncebacks/frequent fliers
 - Return visits automatically reviewed by CM and flagged for CCM
- RED flag potential readmission
- Medicare-Focused Diagnoses: Sepsis, AMI, CHF, Stroke, PNA - high-risk for re-admission.
- Daily meetings - Complex Care Management post discharge options assessment.
- Social Determinants of Health- Nursing Assessment on admission and CCM follows.
- Other flags: referring providers, self-pay, Medicaid, frequent fliers

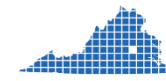
TRACKING BOARD

[Sign In](#)
[Edit Shifts](#)
[Tg Team](#)
[Comments](#)
[Pt Rad Status](#)
[Refresh](#)
[Add'l Tools](#)
[Visit Contacts](#)

My + Unassigned (7)
My Pts (9)
All Pts (49)
My Team
More Views

Bed	Patie	Complaint	A	Call In	Sepsis	TT	Rad Status	Lab Status	Urine	RN	MD	MID	Note Sta	Dispo	Admit Order	Comments	Pt Rad Status	Recent	FYI	EDIE
1440 01	...	Psychiatric Evaluation; Aggressiv...	2			25:07		[3/3]		RB	CC		✓			Transfer Center doing bed search.				
HALLJ2	...	Psychiatric Evaluation	2			14:54		[8/9]		LG	CC		✓	Transfer to RBHC		To RBHC pending Covid				
1442 01	...	Suicidal	2			12:55		[9/10]		RB	CC		✓			To RBHC pending Covid				
1439 01	...	Psychiatric Evaluation	2			12:01		[2/3]		RB	CC		✓	Transfer to Accepting P...		TDO pending Covid				
OTF	...	Abdominal Pain	3			10:18	○ [2/3]	↓ [15/21]		KL; CW	CC	JMM	✓	Admit	✓	garrett				
1408 01	R...	Dizziness	3			09:49	✓ [4/4]	[5/6]		KM	JEA	AD	✎				Back in ED			
1441 01	R...	Psychiatric Evaluation	3			08:10		[3/4]			CC	JDH	✓	Transfer to RBHC	✓	To RBHC pending Covid				
1406 01	G...	Pacemaker Problem	2			07:04				KR	JEA	AD	●	Admit						
1418 01	Br...	Altered Mental Status	3			06:18	✓ [2/2]	[5/7]		AG	CLL		✎	Admit		PAGED	Back in ED			
1414 01	...	SANE	3			05:53				SR; KK	JAS	JB	✓			SANE on the way				
1425 01	B...	Headache	3			05:14	○ [1/4]	↓ [2/6]		CC	CLL		●			MRI	-- (pls call mri...			
1431 01	N...	Weakness - Generalized; Shortn...	3			04:44	✓ [1/1]	[8/10]		SB	JAS		✎	Admit		hosp paged				
1405 01	H...	Weakness - Generalized	2			04:26	✓ [3/3]	[5/7]		KR	JEA	AD	●							
1409 01	R...	Abnormal Lab	2			04:14	✓ [1/1]	[12/13]		KM	JEA	CW	✎			Are we starting blood ?				
HALLE1	E...	Flank Pain	3			04:12	✓ [1/1]	↓ [4/4]		KL	CLL	JDH	✎	Discharge		Pending CT	Back in ED			
OTF	Ni...	Chest Pain; Shortness of Breath	2			04:10	✓ [1/1]	[6/8]		SB; RB	CC		✓	Admit	✓	otto				
1429 01	W...	Generalized Body Aches; Head...	3		!!	04:06	✓ [1/1]	[8/10]		NL; MA;...	CLL		●							
1424 01	D...	Abdominal Pain; Chest Pain; Na...	3			03:51		[7/8]		CC	CLL		●							
1438 01	L...	Sore Throat; Cough; Shortness o...	3			03:46	○ [1/2]	↓ [7/17]		KL; CW	GSK		✓			Lab has throat swab but no nasal s...	-- (ct ready)			
1404 01	K...	Weakness - Generalized; Fall	3			03:30	○ [1/2]	[12/12]		KR	JEA	CW	✎				-- (ct ready)			
1412 01	K...	Syncope; Dizziness	3			03:21	○ [2/2]	[4/7]		SR; KK	JAF	JB	✓			Pend head CT	Back in ED			
1419 01	C...	Shortness of Breath	2			03:19	✓ [1/1]	[5/6]		AG	CLL		✎			--				
1428 01	P...	Hypertension	2			03:16		[4/6]		MA; AS	JAS		✎	Admit	✓					
1423 01	M...	Chest Pain; Shortness of Breath;...	3			03:14	✓ [2/2]	[7/7]		CC	CLL	BB	✎				Back in ED			
1413 01	S...	Abscess; Abdominal Cramping;...	3			03:12	○ [1/2]	[5/5]		SR; KK		JB	✓			Pend CTAP	Pt In Img			
1410 01	L...	Head Injury; Abrasion; Wrist Pain...	2			03:04	✓ [8/8]	[7/9]		KM	JEA	CW	✎	Admit	✓		--			
1437 01	V...	Abdominal Pain	2			02:52	○ [0/1]	↓ [5/8]		CW	GSK		✎			---	-- (US ready)			
1433 01	D...	Chest Pain; Dizziness; Nausea;...	3			02:46		[0/3]		SB	JAS		✎			Pass po challenge				
1407 01	T...	Rapid Heart Rate	3			02:19	✓ [1/1]	[2/3]		KM	JAF	JF	✎	Discharge						
HALLB1	P...	Rapid Heart Rate; Abdominal Pai...	3			02:07		[0/1]		KL	JAF	JF	●			OB @bedside				

KEY QUESTIONS



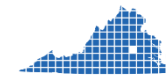
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2. What are the key responsibilities for your Care Coordinators?

- Highly variable depending on resources
- Identify key areas of opportunity
- Provide a patient-focused assessment and a highly individualized plan of care, then manage administration of the plan
 - Plan is developed considering the patient's unique situation and existing resources
 - Goal is for the plan to exist in context of the patient's actual experience
 - Includes:
 - Outreach in a timely manner
 - Home Health initiation
 - Access to Medication
 - Social Determinants of Health
 - Ensuring timely and effective follow-up appointments
 - Addressing barriers (i.e. transportation)

KEY QUESTIONS



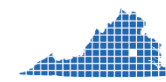
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3. How describe group's role in care coordination and discharge planning

- Providers and Care Managers raise concerns when a patient is in need.
 - Home Health and Hospice Liaison
 - Inter-disciplinary Team: Clinical and psycho-social discussion daily
 - CCM communicates with providers regarding the DC plan and anticipates needs that will occur after the DC from acute care
 - Goal is "Warm Hand-off's" in transition to other levels of care.
- These are positions of need! Most small Eds/Hospitals cannot afford dedicated case management. Larger hospitals understaffed (\$) and pool of qualified personnel)

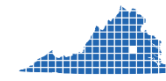
KEY QUESTIONS



4. What is the timeframe for care coordination/discharge planning and how long to patients receive support?

- Care Coordination and Discharge planning begin in the ED, prior to admission.
- First look at efficacy of patient remaining in the community (avoid admission)
 - Safety
 - Likelihood of bounceback
 - Are there adequate resources and support systems to remain as an outpatient?
- When admission is medically necessary, discharge planning begins immediately.
- Care Coordination is ongoing at larger hospitals
 - Complex Care Management follows patients as long as there is a need for support and resources.
 - Minimum is 1 month, with weekly or more calls as needed.
 - Frequency of support is determined by the needs assessment done by the CCM who can increase or decrease frequency based on patient's needs and responses.
- Most smaller/underresourced hospitals do not have the resources to continue to follow the patients after they are discharged, can only set them up at discharge

KEY QUESTIONS



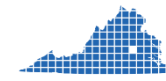
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5. How do Care Coordinators and discharge planners coordinate with others?

- Ambulatory referrals to Care Management
- Extensive electronic communication internally through EMR
- Relationships with already-established Care Managers with MCO's
- Develop relationships with outside organizations and coordinate actions
 - Providers and Therapists
 - DME companies
 - Mental Health resources
 - United Way/Catholic Charities, Center for Excellence in Aging and Lifelong Health, Paramedicine program, etc

KEY QUESTIONS



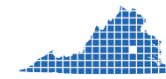
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6. How do you promote appropriate sites of care for patients?

- PCP appointment line to ensure the patient has an appropriate Medical Home.
- PCP automatically notified of visit and electronically receives a copy of the ED/hospital chart.
- Providers alerted when a patient has a re-admission.
- Navi-Health, which is a secure system for referrals to facilities and Home Health, as patients require changing levels of care.
- Various Nurse Lines (non-proprietary)
 - Nurse based triage
 - Directs patients to the most appropriate care site based on symptoms using validated software
- Life Coaches from Catholic Charities

KEY QUESTIONS



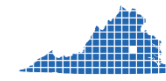
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7. What patient/member and family support is provided related to ER utilization, discharge planning, and appropriate sites of care?

- Provider Conversations (EMTALA/Patient centered care compliant) – electronic/telephone conversations with PCPs
- The Care Manager ensures
 - Patients have access to care and medications
 - Teach and inform the patients of the level of care.
 - Formal notification required for Observation status and for Medicare Important Messages, which are notices given before a patient can be discharged. We inform the patients of their rights and options, including rights to appeal.
- We teach ED avoidance measures and how to handle the current situation if it arises again in the future.
 - Utilizing the Coleman Model, patients are empowered and equipped to develop skills to utilize in the future when they are faced with the same or a similar issue.
- Seeking sites of care---We encourage patients to utilize Nurse Lines, Medicare Compare sites, star ratings, and to visit the actual facilities to ask questions before placing a family member in the facility.
- Handouts at discharge promoting appropriate care sites (ie PCP, urgent care. ED)
- Identification of barriers preventing access to appropriate sites of care (ie transportation)

KEY QUESTIONS



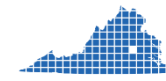
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8. How do you know if follow up plan is successful?

- Many hospitals/EDs do not! (resources)
- Post-discharge follow-up calls and Patient satisfaction surveys.
- Weekly follow-up calls from the Complex Care Manager, with the Goal of ED Avoidance and utilization of Outpatient Resources.
- Metrics:
 - Decreased 30-day re-admissions.
 - Decreased LACE+ score and risk level.
 - Eventual decreased 6 month hospital and ED re-admissions.

KEY POINTS

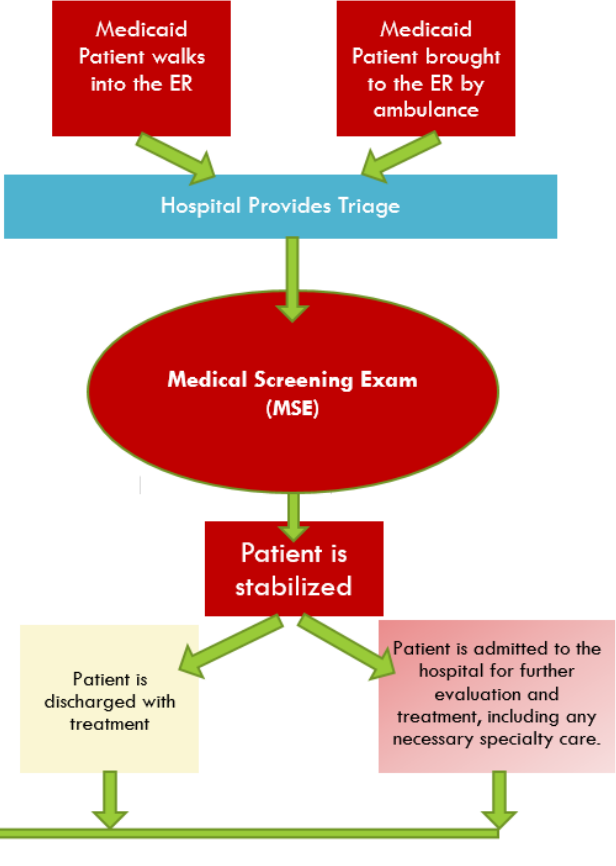
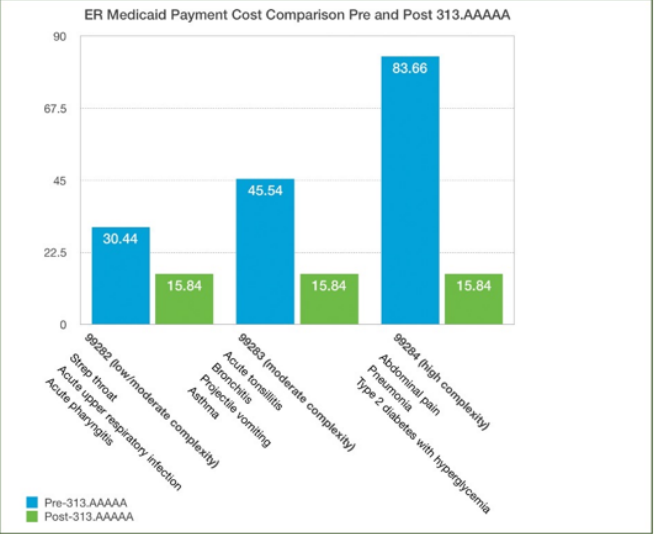


- Weekly Case Reviews on DMAS re-admissions and High ED Utilizers, with Top Diagnosis: Diabetes, Sepsis, HTN, CHF.
- Track data on ED Utilization and considering Score cards for utilization per practice.
- Expanding care coordinators to outpatient settings. Care Managers in PCP offices can coordinate ongoing strategies with Complex Care Manager in the ED for ED Avoidance measures.
- How we teach patients is critical to their overall success.
 - Ensure that they really understand “Next Steps” and “Where we go from here.”
 - Must have ongoing support and contact information to reach out to a Resource person or Care Manager when they reach a barrier. Metrics and measures to identify learning needs must be accessible.
- Presenting a highly individualized plan which is in proper context to the patient’s reality and healthcare experience critical to avoiding repeat ED visits.
 - Deep dive into the actual underlying issues is crucial, in order to work toward the goal of resolving the underlying risk factors and improve social determinants of health, in addition to modifying behaviors and responses.
 - Ongoing coaching and support by Care Managers if resourced to do so

ED WORKFLOW

HOW A MEDICAID ER VISIT IS PAID UNDER 313.AAAAAA

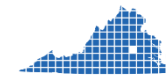
THE IMPACT ON THE PHYSICIANS TAKING CARE OF MEDICAID PATIENTS



If the emergency is on the "preventable" DMAS list of 790 codes

■ Required by law

NEW INITIATIVES

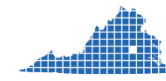


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- Coordinated Medication Delivery to ED or Patient Home:
 - “Meds to Beds” program - patients can receive their medications before leaving the ED or home delivery if transportation is a barrier.
- Mobile Integrated Healthcare Program/Pilot CHF Readmission Prevention Program :
 - Coordinated Community effort with Fire Dept., EMS, CMO, and Complex Care Manager.
 - Post Discharge from ED or IP:
 - DAY 1---“Door to Door” Approach to ensure that patients are seen by Paramedicine within 24 hours of DC from the ED. Assessment and Care coordination with Complex Care Manager.
 - DAY 2---Home Health arrives
 - DAY 3 to 5----Telehealth appointment.
 - Limited by resources – hope is to expand to all high-risk discharges
- DISEASE-SPECIFIC ALERTS or BUNDLES
 - Sepsis, CHF, COPD, adding on dementia

TAKE HOME



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- Hospital systems and provider groups invest tremendous resources in ensuring appropriate levels of care and connecting with outpatient resources
- **Need improved care coordination with MCO's care coordinators- they have access to far more data**
- **We cannot bill for complex care management! This care is "uncompensated overhead" designed to prevent penalties**
- **State/Medicaid MCOs must invest resources in public health infrastructure/primary care/outpatient Complex Care Management**

Primary Care Coordination

Charles O. Frazier, MD, FAAFP

Treasurer and Past President

Virginia Academy of Family Physicians

Diversity

- The primary care practices across the Commonwealth of Virginia are a diverse group of practices composed of
 - Independent practices
 - Independent practice groups
 - Health system owned practices
 - Federally Qualified Health Centers
 - Free clinics

Patient-Centered Medical Homes

- Many practices are recognized as using a physician-lead, team-based model, centered around the patient and employing care coordination and population health
- 282 practices, comprising 1,343 providers, are recognized as PCMHs by NCQA in the Commonwealth of Virginia
- Additional practices may be certified as PCMHs by other organizations (AAAHC, TJC, URAC)

Care Coordination

- Just as the primary care practices across the state are diverse, the care coordination is also diverse
 - Most common model is comprised of clinical staff (nurses, CMAs) performing care coordination in addition to their other duties
 - Some practices may employ dedicated nurses as care coordinators or health coaches
 - Health systems may employ centralized care coordinators (case managers, complex case managers)
 - Nurses
 - Other clinicians (e.g., pharmacists)
 - Support systems are also diverse – paper-based to EHR to dedicated population management software

Care Coordination

- Much is built around care gap closure
- Some EHRs have a variety of risk scores to stratify patients
- Notification of ED and hospital A/D/T drives a lot of the coordination
- PCMHs are required to have materials available that address appropriate site of care
- Some EHRs have cost and utilization reports to monitor success of these efforts

Recommendations

- Continue to build and expand Emergency Department Care Coordination Program (EDCCP/EDie) efforts
 - Downstream notification – encourage primary care practices to connect to EDie
 - Care Insights – every patient who is a high utilizer or is at risk of high utilization should have Care Insights entered into EDie
 - Data shows a >50% decrease in ED visits for patients with Care Insights in EDie
 - Care Insights should be entered by primary care practices and/or MCOs
- Increase communication/collaboration between MCO care coordinators and primary care practices (through Direct messaging, fax, or letters)
- Develop non-branded print and digital “Call Us First” content that can be used by primary care practices

Recommendations

- Continue efforts to reach parity of Medicaid reimbursement for primary care providers to expand the number of PCPs that take Medicaid patients and the number that each practice/provider manages
- Increase the per-member-per-month fee to cover care coordination efforts, to increase resources in the practice dedicated to care coordination

Other Recommendations About ED Payment Policy

- The LANE analysis utilizes a retrospective approach that looks at the outcome of a required diagnostic process to determine the appropriateness of that very same process; such an approach is illogical
- The list of ~790 diagnosis codes needs to be refined to eliminate those codes that denote clinical syndromes that can have significant adverse outcomes; e.g., chest pain, abdominal pain, asthma, COPD, etc.

Emergency Department Care Coordination Tool & Data Follow-Up from Meeting 1

Follow up on Requested ED and Inpatient Information

Slides prepared by VHI for November 19th meeting of Medicaid Payment Policies and Care Coordination Work Group

ANNIVERSARY

Agenda

1. Overview of EDCC and Current uses

25
ANNIVERSARY

Overview of EDCC

25
ANNIVERSARY

Emergency Department Care Coordination (EDCC) Program Overview

- The 2017 General Assembly established the **Emergency Department Care Coordination (EDCC) Program** within the Virginia Department of Health (VDH) to provide a single, statewide technology solution that connects all hospital emergency departments in the Commonwealth to facilitate real-time communication and collaboration among physicians, other healthcare providers and other clinical and care management personnel for patients receiving services in hospital emergency departments for the purpose of improving the quality of patient care services (re: § 32.1-372).
- **ConnectVirginia, now a program of Virginia Health Information,** was contracted by VDH to fulfill the requirements of this legislation.
- **Collective Medical** was chosen as the EDCC Program technology partner.

ANNIVERSARY

EDCC Program Milestones

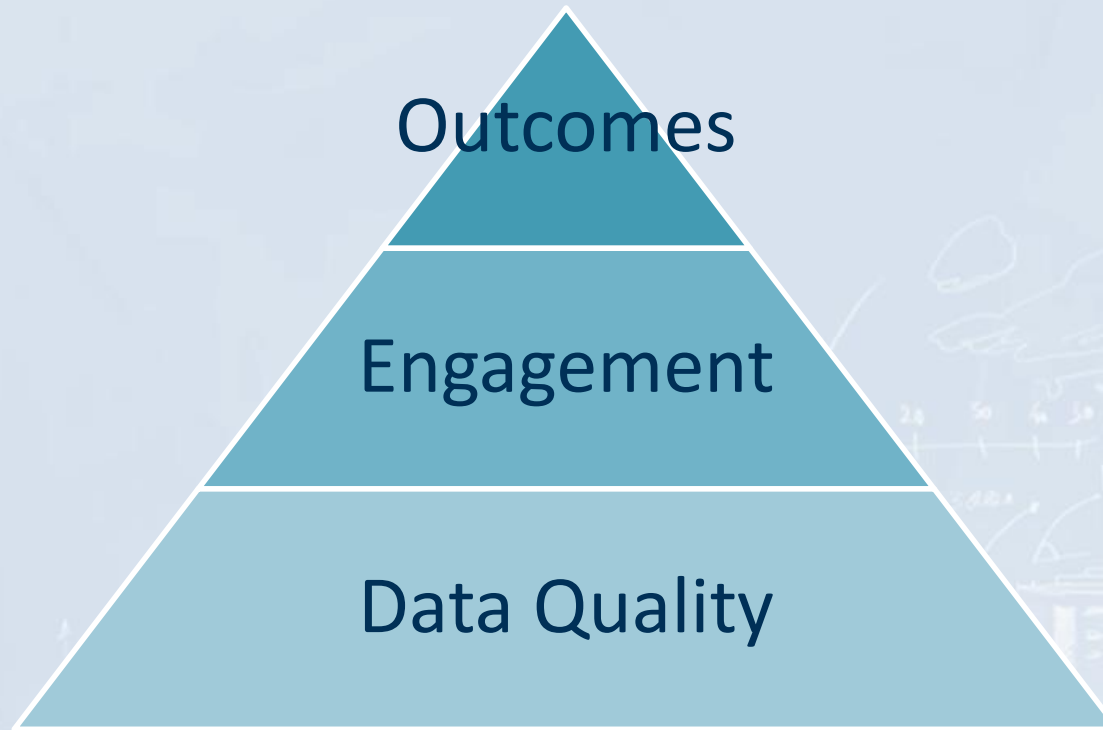
Legislatively Mandated – as of 6/30/18

- 106 Hospital EDs in Virginia receiving real-time alerts using Collective Edie (All but 3 health systems are EMR integrated)
- 6 Medicaid MCOs using Collective Plan
- Prescription Monitoring Program (PMP) data integrated into the ED notification
- Advance Healthcare Directive Registry data is available on the EDie notification


Legislatively Mandated – as of 6/30/19

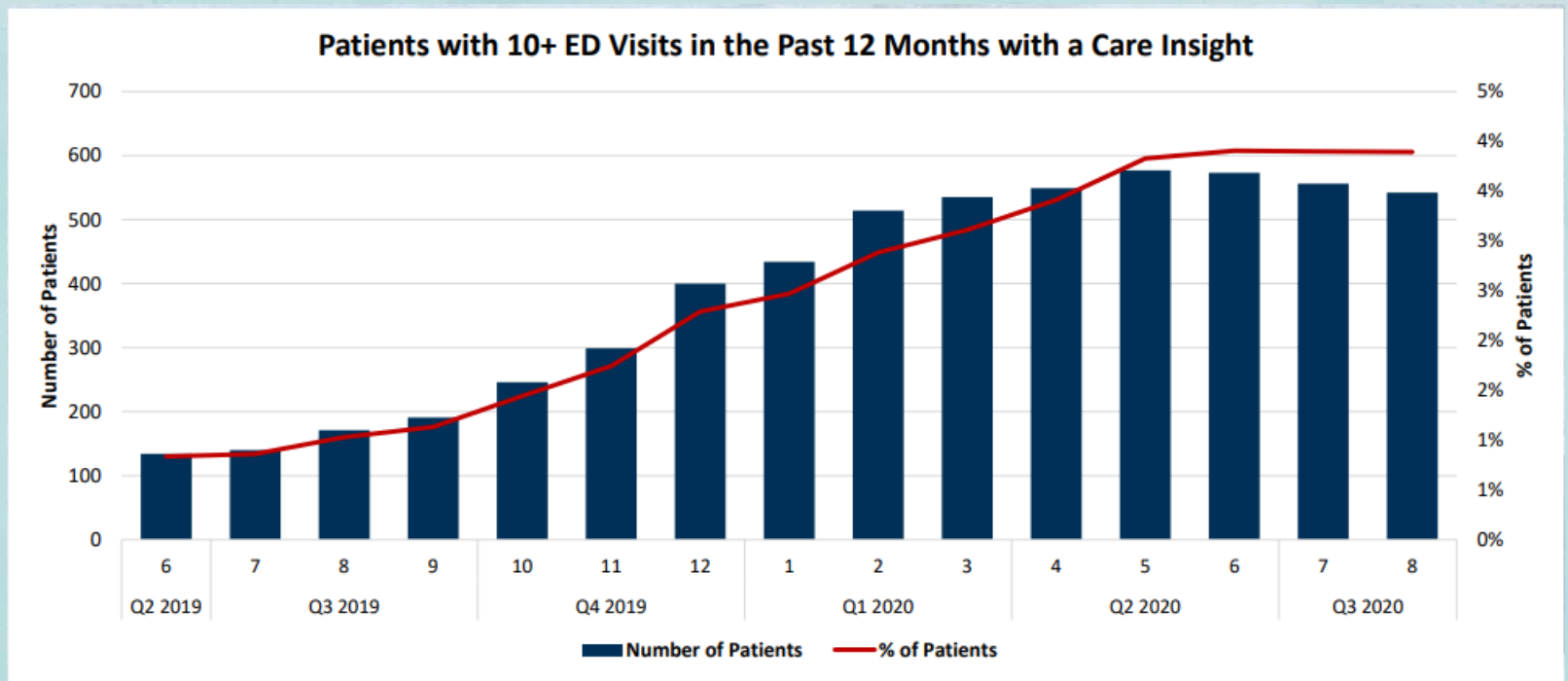
- On-board all State Employee Health Plans, Medicare, and Commercial plans operating in VA (excluding ERISA)
- Ongoing, on-board downstream providers including primary care, Community Services Boards (CSBs), Federally Qualified Health Centers (FQHCs), nursing facilities, post-acute, social workers, specialty care, behavioral health and long-term care

Metrics Philosophy

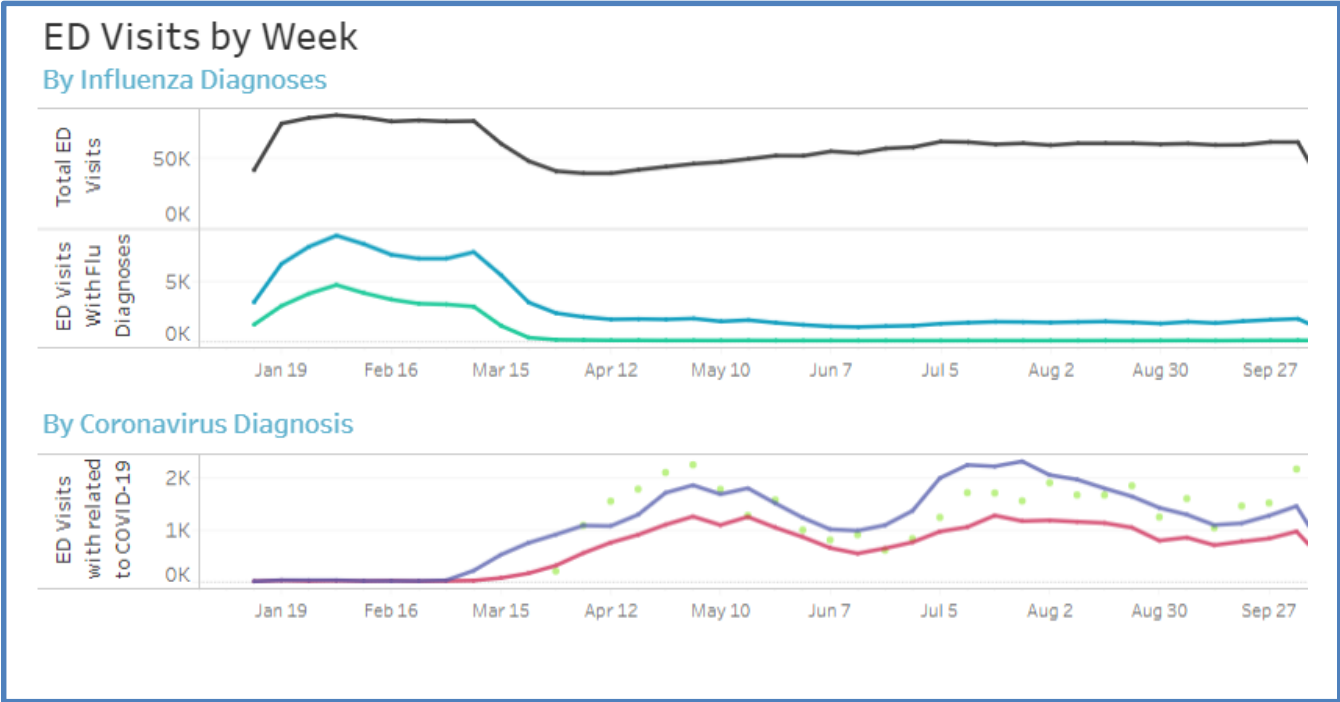


Engagement: Number of Downstream Providers

Objective- Increase 



COVID-19 and Flu Trends

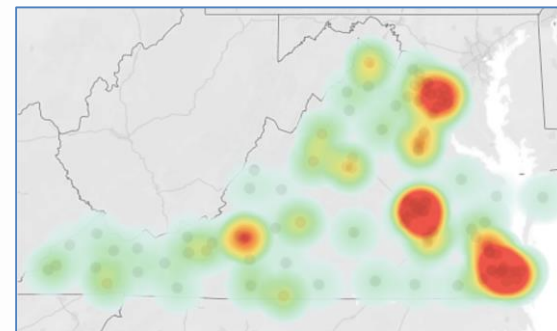


- Diagnosis at Visit**
- ED Visits with Influenza
 - ED Visits with Flu Like Symptoms
 - Total ED Visits
 - Patient Tested Positive for COVID-19
 - ED Visit with Chief Complaint Coronavirus
 - ED Visit with Presumed Coronavirus Diagnosis


Patients with patterns of high ED utilization

Patients with at least one visit in Virginia from July 2019 - June 2020

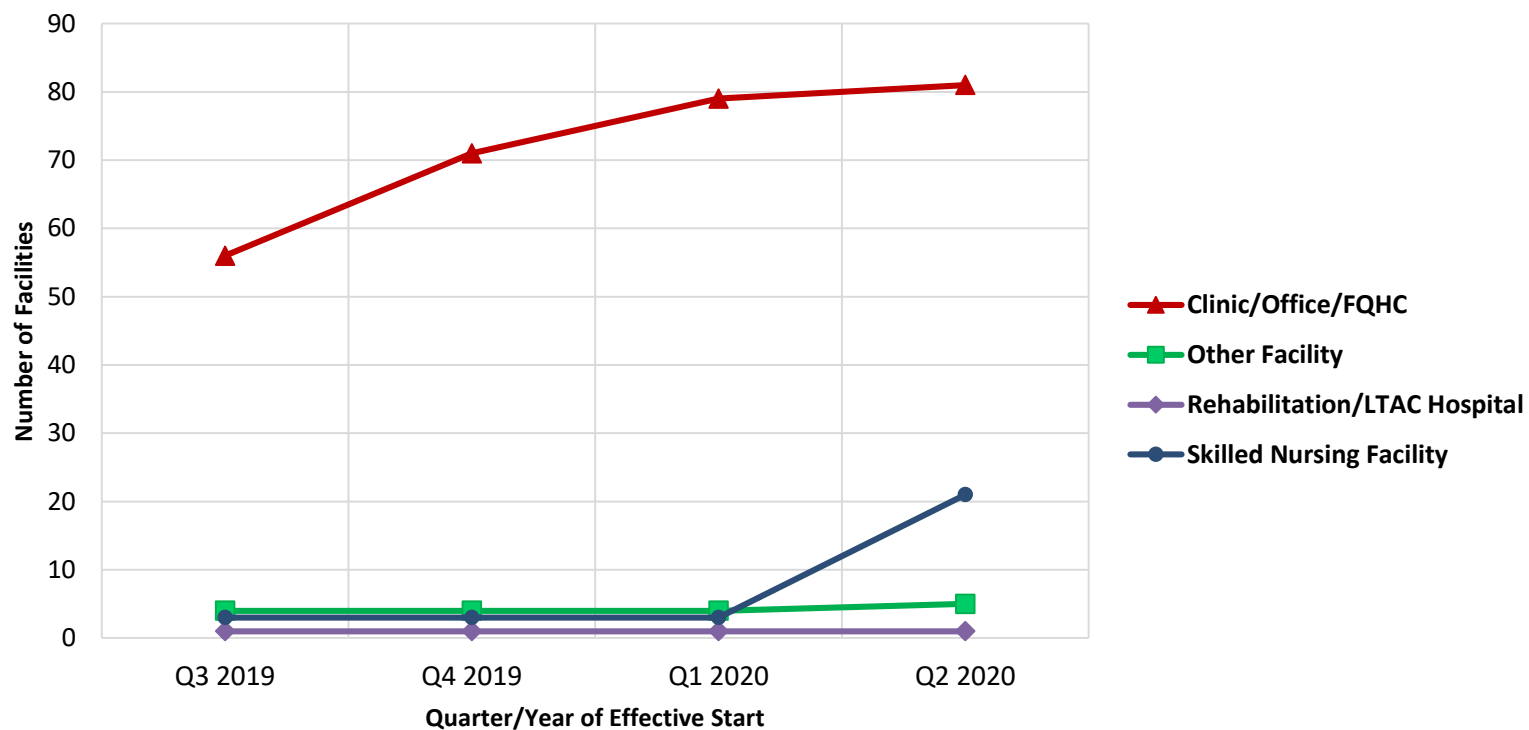
Collective Utilization Category	Visit Count in 12 Months	Number of Patients	Total ED Visits	Median ED Visits	Total Inpatient Admissions	Median Inpatient Admissions	Average Length of Stay (Days)	Percent with a Behavioral Health Diagnosis	Percent that are Suspected Homeless	Percent with Care Insight
Rising Risk	10 - 14	11,678	133,312	11	19,479	1	3.8	65.5%	0.3%	3.4%
	15 - 19	3,152	52,291	16	7,104	1	3.6	73.7%	0.4%	5.4%
High Utilization	20 - 29	1,797	41,851	23	5,130	1	3.5	81.0%	0.6%	10.2%
	30 - 49	732	27,062	36	2,887	2	3.3	87.3%	0.7%	14.8%
Super Utilization	50 - 74	207	12,315	59	947	3	2.7	89.4%	1.0%	19.8%
	75 - 99	68	5,742	82	319	3	2.9	91.2%	1.5%	23.5%
Extreme Utilization	100 +	72	9,855	129	324	2	3.9	97.2%	4.2%	36.1%
Grand Total		17,706	282,428	12	36,190	1	3.7	69.9%	0.4%	5.3%



Engagement: Number of Downstream Providers

Objective- Increase 

Downstream Providers by Provider Type



CSB CASE STUDY

Meeting Compliance Standards and Coordinating Care for Vulnerable Individuals



Rappahannock Area Community Services Board

Partnered with Anthem's Virginia Medicaid health plans, RACSB runs a behavioral health home initiative for individuals who require more care coordination. Each patient is tagged using the platform, and RACSB care teams meet regularly with Anthem advocates to deep dive into finding unique and innovative ways to help support these individuals. The EDCC program in conjunction with the platform helps case managers easily identify the patients with the highest utilization patterns, helping the collaborative team know where to focus their efforts. Williams explains:

"The EDCCP program which provides the Collective platform enables us to have discussions around our most vulnerable patients. In our monthly collaborative meetings, we take a look—going into each patient individually—brainstorming and strategizing about what we can do for these patients. We're all in the same room together, working out strategies and action plans to support each patient from the clinical and the insurance side of things. It's fantastic and exciting to be a part of. And because the platform provides access to those analytics almost immediately, it makes it easier for us to find out the details, reach out to the patient and support the patient with the appropriate level of care, education and resources."

Virginia's EDie Tidewater Collaborative Community



Goals:

- Develop best practice standards of care for multi-visit patients throughout all local health systems and plans
- Improve communication, collaboration and care planning efforts between health systems and community entities
- Develop standardized approach to implement Collective Platform

Key Deliverables:

- Collaborate with community partners to standardize and develop plan for implementation of Collective Platform/rollout to Tidewater hospitals and further partnerships with post-acute providers
- Formalize care plan strategies for multi-visit patients with goals of decreasing readmissions and connecting patients with community resources
- Standardize templates for all health-systems and plans to utilize for care insights
- Work with Collective Medical to leverage SSO feature for all systems and leverage bi-directional flow of information between EPIC and Collective Platforms

Wrap Up and Next Steps

- ✓ **December 17, 2020, 3:00-5:00 p.m.**
- ✓ **Homework:**
 - **DMAS, VCHI, and Mercer:** Develop presentations on past and current efforts at the local, state, and federal level to address ER utilization and hospital readmissions.
 - **Workgroup members:** provide any written comments and feedback on the initial draft of the first report segment, which synthesizes and summarizes information presented in meeting 1, by **Thursday, December 10**. Send all feedback to Rusty.Walker@dmas.Virginia.gov

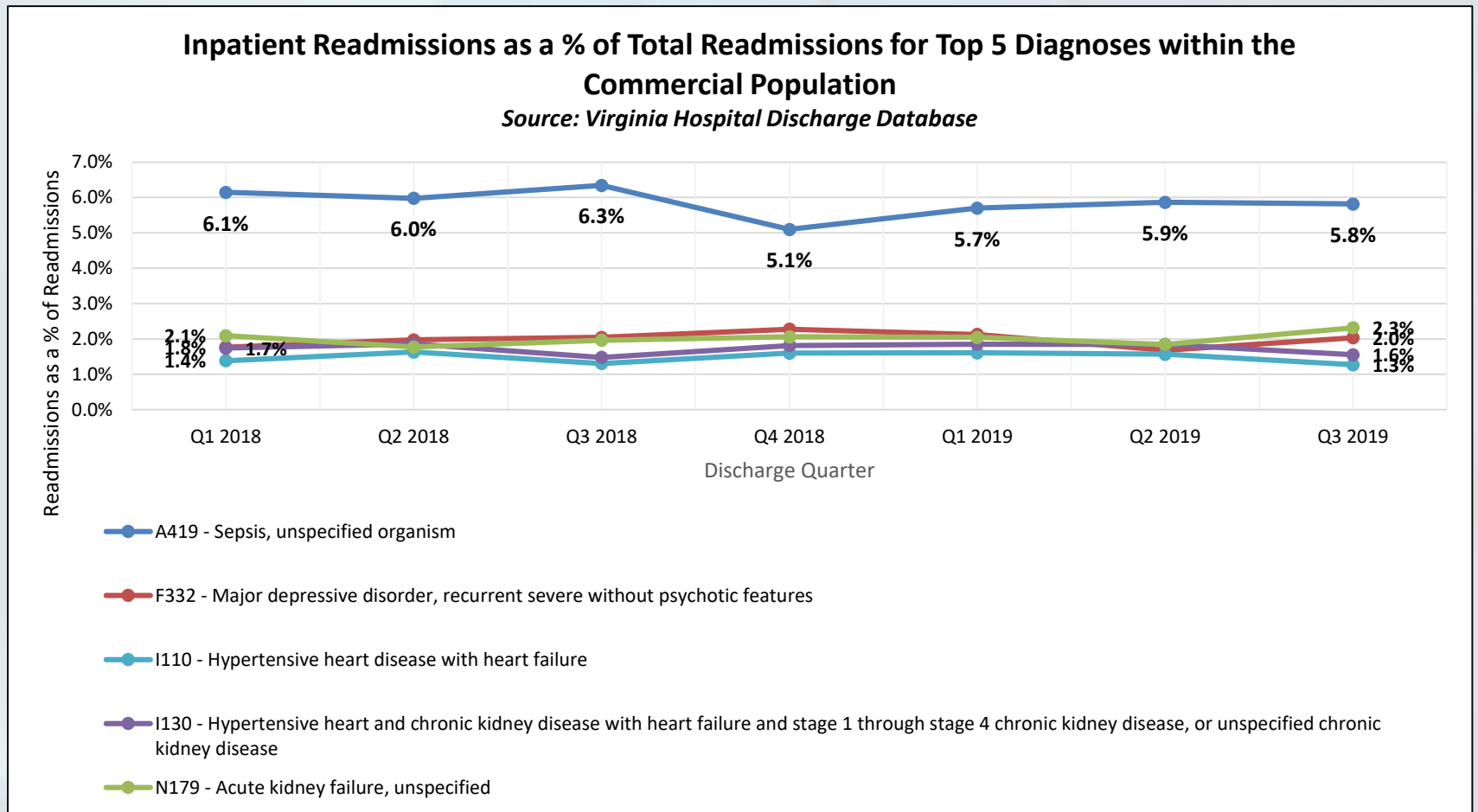


APPENDIX: FOLLOW UP ANALYSES FROM MEETING 1

Readmissions Analysis

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ANNIVERSARY

Inpatient Readmissions as a % of Total Readmissions for Top 10 Diagnoses within the Commercial Population

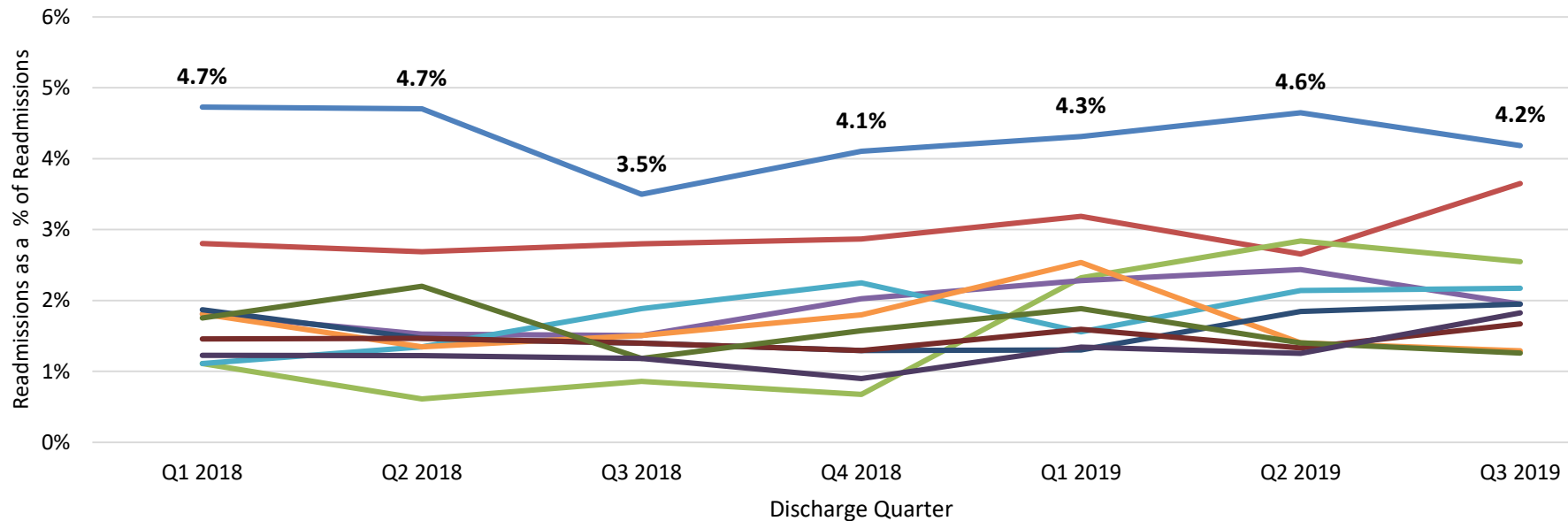


Readmissions methodology based on DMAS Clinical Efficiency Performance Measure Technical Specifications

Inpatient Readmissions as a % of Total Readmissions for Top 10 Diagnoses within the Medicaid Population

Inpatient Readmissions as a % of Total Readmissions for Top 10 Diagnoses within the Commercial Population

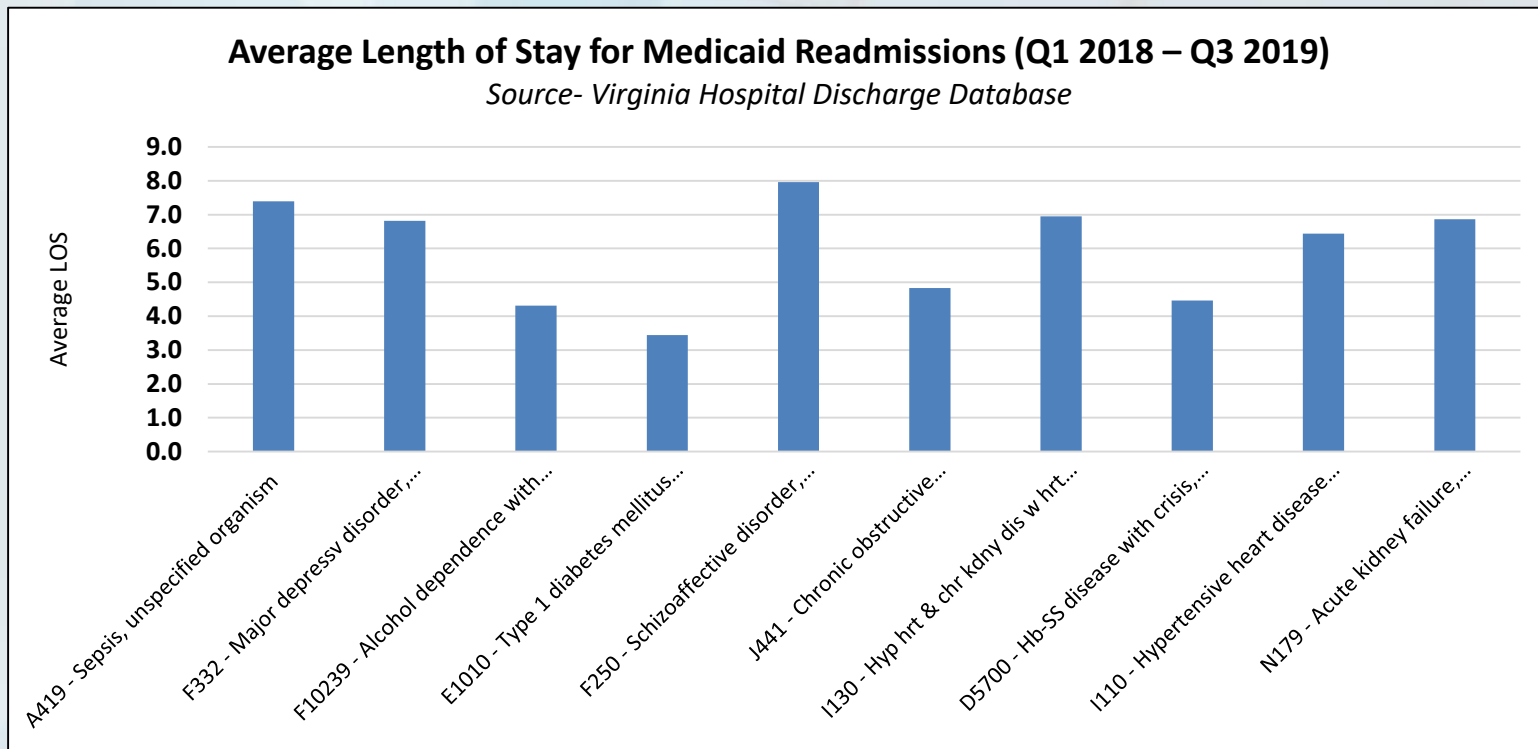
Source: Virginia Hospital Discharge Database



- A419 - Sepsis, unspecified organism
- F10239 - Alcohol dependence with withdrawal, unspecified
- F250 - Schizoaffective disorder, bipolar type
- I130 - Hyp hrt & chr kdny dis w hrt fail and stg 1-4/unsp chr kdny
- I110 - Hypertensive heart disease with heart failure
- F332 - Major depressv disorder, recurrent severe w/o psych features
- E1010 - Type 1 diabetes mellitus with ketoacidosis without coma
- J441 - Chronic obstructive pulmonary disease w (acute) exacerbation
- D5700 - Hb-SS disease with crisis, unspecified
- N179 - Acute kidney failure, unspecified

Readmissions methodology based on DMAS Clinical Efficiency Performance Measure Technical Specifications

Average Length of Stay for Top Medicaid Readmission DX



Readmissions methodology based on DMAS Clinical Efficiency Performance Measure Technical Specifications