

# Mercy Health System's Innovative Care Coordination Program Improves Quality Outcomes

By Whitney McKnight

After a pilot program to track and coordinate transitions from acute to ambulatory care at one campus of Mercy Health's multihospital network dramatically lowered readmission rates, emergency department visits and length of stay in skilled nursing facilities, the program is now being rolled out systemwide.

"Our care transitions program is the right thing to do," said Catherine Follmer, RN, vice president of the care continuum program at the Ohio-based health system. "Health care is extremely complicated to navigate. Our goal is to keep patients at the center and make it easier for them."

Mercy Health (formerly Catholic Health Partners) is the largest health system in Ohio and one of the largest nonprofit health systems in the United States, employing more than 32,000 people in more than 450 health facilities, including 23 hospitals in Ohio and Kentucky.

In May 2015, Mercy responded to the Centers for Medicare & Medicaid Services' call for voluntary participation in its Bundled Payment for Care Improvement (BPCI) initiative. The system's leadership chose to pilot a care transitions coordination program, tracking 90-day episodes at a medium-volume orthopedic facility.

A part-time registered nurse was hired as the care transitions coordinator whose first task was to visit with patients while they were still in the acute care setting. "That way, both the nurse and patient could put a name to a face, and the nurse could say, 'You're going home tomorrow; what time can I call you?'" Follmer said. She credits this face-to-face meeting with a 90% success rate for patients responding when the care transitions coordinator placed the 24-hour post-discharge medication reconciliation call.

Working with the acute care case management team during the inpatient stay and the orthopedic team over the entire 90-day episode, the care transitions coordinator oversaw all post-discharge services, including medication reconciliation and attainment, follow-up physician visit scheduling and patient education on how to recognize symptoms of complications. "The cadence of calls was dependent on patients' needs," Follmer said. "Some patients only needed one or two calls the first week, while others needed to be called every day or every other day."

The care transitions coordinator also helped leadership identify where cost savings and patient outcomes were most vulnerable. Of particular interest was what happened when patients were discharged to skilled nursing facilities (SNFs); in question was whether SNFs were adhering to appropriate rehabilitation goals for patients. To address this concern, the program implemented weekly conference calls between the care transitions coordinator nurse and the respective SNFs. When necessary, a Mercy Health physical therapist joined the conference call to state definitively what the discharge goals were for the patient.

"If the SNF contact said the patient hadn't walked 1,000 feet yet, then our physical therapist might clarify that the goal for that patient was not to walk that far," Follmer said. If, for example, the goal was for the patient to be able to walk and the patient had achieved that goal, transitioning home could be discussed.

This proactive approach, combined with educating members of Mercy Health's entire coordinated care network of SNFs and home care facilities about specific protocols and processes to improve patient care, proved successful. Within nine months, readmission rates at the campus decreased from 20% to just over 8%. Average length of stay at SNFs dropped nearly in half: from 28 days to 16.4 days. SNF utilization rates also were nearly halved, from 68% to 36%, or a decrease of about six days per patient.

## AT A GLANCE

- Mercy Health System relies on care transitions coordination teams to track patients who leave the system for skilled nursing facilities and other post-acute care settings.
- Standardized data-tracking systems help identify systemwide weaknesses and coordination gaps.
- Within nine months, readmission rates at the pilot implementation site decreased from 20% to just over 8%, average length of stay at SNFs dropped from 28 days to 16.4 days and SNF utilization rates decreased by approximately six days per patient.

“That was in a small population, but it worked, so we wanted to build on that success,” Follmer said. During the final quarter of 2015 and into the first quarter of 2016, Mercy expanded the pilot to include population health patients at eight other facilities in the state. They placed special emphasis on the face-to-face encounter in the acute care setting, the 24-hour post-discharge follow-up call, medication reconciliation, appropriate discharge services, seven-day physician follow-up visits and thorough documentation for transition of care management billing. The number and timing of calls to patients in the first 14 days post-discharge depended on whether their score on a readmission risk calculator indicated a moderate to high risk of being readmitted.

If after the initial 14 days the care transitions coordinator determined that a patient was in need of chronic disease management, the patient was referred to an ambulatory care coordination team embedded in Mercy Health’s respective primary care physician practices. Because the discharge period can be “a very vulnerable and confusing time for patients,” Follmer said, Mercy included an ambulatory care pharmacy team for care transitions consultation. “The care transitions coordinator and the pharmacy team collaborate to ensure medication reconciliation and attainment,” she noted.

Results of this second phase of the bundled care pilot program were also significant: Average SNF length of stay plunged from 64 days to 25 days. Readmission rates across the impacted facilities went from 17.5% to 12%.

The impressive results led to the development in late 2016 of a care transitions program for nearly all of Mercy’s Ohio acute care facilities, with plans to eventually include the system’s two Kentucky campuses. One lesson learned from the previous programs is that continuous, personalized coverage is key to success, Follmer said. For this reason, the care transitions coordinator nurses work Monday through Friday, but are on call on weekends so that transition services are available seven days a week, ensuring that all patients receive their 24-hour discharge follow-up phone call. This continuous coverage also supports contact with high-risk patients whenever necessary.

Another initiative has been to actively support Mercy’s extensive network of outpatient primary care providers, helping them educate patients on how best to manage their chronic health conditions.

### Focusing on Quality Improvement

Just how much in direct cost savings the program will net is still an unknown, according to Follmer. “What we’re doing here is not revenue-generating, per se; rather, it’s utilization-saving. How do you quantify that in a reimbursement world that is still driven more or less by fee-for-service?”

Because of this, Follmer is focused on demonstrating that the program is improving quality and decreasing unnecessary utilization, which ultimately contributes to savings. “When we put everything in place, it all has an impact. We have the same struggle as every other health system in the industry. It’s all about quality outcomes for the patient,” Follmer said.

To achieve these dual quality–cost-saving goals, Mercy leadership developed its own Care Management Risk Score to get a granular look at patterns of service utilization and the most common issues they face treating ambulatory-sensitive conditions. “Our goal is that no patient falls through the cracks,” Follmer said.

Toward this end, the care coordination group also works with Mercy’s electronic health records team to integrate and standardize tools and protocols for more efficient data tracking. Follmer’s team is now able to track patients when they receive services outside of Mercy facilities, which is important from a quality standpoint because the system is still held accountable for those patients’ outcomes.

Another innovation in development is a tracking system for patients who present to the ED. “Did the patient trip because she’s clumsy, or is it because of her chronic heart failure? Depending upon what it is, the ED alerts the care transitions coordinator on-site who can intervene and offset any unnecessary ED admissions,” Follmer said.

Prior to these IT innovations, patients had been tracked on an Excel spreadsheet. Now, Mercy leadership is reviewing how to fund an expanded, centralized care transitions team that will use these tracking tools to oversee all the nondomestic services, screen the ED visits, interact with the SNFs, and collaborate with payers to deliver services to patients with complex care needs.

“The goal of the approach to care transitions is to connect all the dots that lead to improved quality outcomes, patient engagement and a decrease in unnecessary utilization,” Follmer said. “Ours is a true team approach that crosses the continuum and meets the patient where they are in the health care cycle.”