

HealthEast Care System – St. Paul, Minnesota

Overview

HealthEast Care System is a non-profit health care organization with four hospitals, clinics, and outpatient services. The system is the largest health care provider in the Twin Cities' East Metro area. HealthEast recognizes the importance of a strong collaboration between its medical staff, community, and HealthEast caregivers. Through this collaboration, they have created the HealthEast Quality Institute and the role of Chief Medical Quality Officer. The Quality Institute helps ensure accountability for providing high-quality care, based on the Institute of Medicine's aims of safe, effective, equitable, efficient, timely, and patient-centered care. As part of its research on how to shift from "episodic care" to "continuum of care," the Quality Institute recognized that the next step and opportunity to improve care rested in the transitions in care. These transitions include between providers and care settings all across the care continuum. Their solution is the care navigation strategy, whose goal is to "care for patients within an integrated and patient-centered model of care that leverages all components of the HealthEast Care System delivering a coordinated and positive care experience."

HealthEast also recognized that this work needs to align with the Institute for HealthCare Improvement's Triple Aim goals of: 1) Improved population health; 2) Reduced cost per capita; and 3) Increased patient satisfaction.

Realizing that reducing readmissions was an area of opportunity for improvement, HealthEast started with a pilot **"transition coach" program** that focused on the transition from hospital to home and was based on the four pillars in the University of Colorado Model by Eric Coleman, MD: medication management, personal health record, follow-up, and red flags. Enrollment criteria included: 65 years and older; have chronic disease; be cognitively intact or have an involved caregiver; not planning discharge to long-term care or hospice; and agree to be part of the program.

A "specialty navigator" nurse manages the transition from hospital to home and follows up with patients approximately two weeks after the hospital stay. Rather than using a top-down approach, the program empowers patients to make the right choices and decisions, and actively participate in their own care.

Impact

From September 2007 to August 2008, 166 hospital patients completed the program; these patients were compared with a control group of 166 hospital patients who also met criteria but were not enrolled. The 30-day readmission rate of the enrolled patients was 7.2% compared with 11.7% for those not enrolled. If the patients were readmitted, the average length of stay for the enrolled patients was 4.0 days compared with 5.4 days for those not enrolled. The transition coach also impacted population health/quality by discovering medication discrepancies in 39.8% of the enrolled patients. In addition, patient satisfaction results show that a majority of enrollees felt better prepared to work with their physicians as a result of the program, and a significant number indicated that they would continue to use their personal health record. Based on these results, this pilot has become a permanent program for HealthEast patients.

Challenges/success factors

The current reimbursement stream has been and remains the biggest barrier, as transition coaching and other care navigation programs are not currently reimbursed. Further, by improving the health of its patients and reducing admissions and readmissions, HealthEast is taking away from the core of its funding stream—its hospitals. Program leaders are grateful for the support of HealthEast leadership, who have funded much of the work because they see it as part of the organization's mission and as an investment into the future. Grants have also been helpful in several areas.

Communication across the system has been a key success factor. Program leaders found that they needed to take the time to ensure that all staff embraced the vision and goals. As they shared the vision across the system, those who would be most affected by change not only accepted the change, but are now driving the new care model.

Future direction/sustainability

Since completing the pilot program, HealthEast has expanded its age criteria to 50+ and has implemented the program at a second hospital. As the program continues, program leaders are redefining roles and functions within the system's hospitals and clinics. These actions support and fully align with the concepts of the medical home. HealthEast will continue the work of creating a truly integrated continuum of care, building on successes and expanding its focus to other areas across the continuum. Its goal is to be the benchmark for quality in the Twin Cities by 2010.

On the financial side, the system's next steps are to work with state government and local health plans to address needed changes in their reimbursement mechanisms. Minnesota is undergoing major healthcare reform and is starting to examine how to reallocate dollars to pay for care management and other programs shown to improve health outcomes.

Advice to others

Not every program fits the needs of every health care system. Your approach should be tailored to your organization and patient population, for example, inner city vs. suburbia. Review your clinical data (readmit rates, ER usage) and talk to your providers and patients. Through this upfront work, you will find your champions for the initiative, and the answers will become apparent. Start small and show the impact. Bring the payers in early, so that you can be involved in shaping reimbursement reform.

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