

Meadville Medical Center

Meadville, Pennsylvania

Care Coordination for Adults and Children



The Meadville area is nestled in the rolling hills of the lake lands in northwestern Pennsylvania. Meadville, the seat of Crawford County, is 90 miles north of Pittsburgh. The population of Meadville and the surrounding area is approximately 35,000, with the hospital's service area covering about 75,000 residents. Meadville Medical Center (MMC) has 178 inpatient acute care beds and 32 skilled nursing beds.

MMC reports annual inpatient admissions of approximately 7,624 and more than 242,387 outpatient visits. The Emergency Department alone reports 35,157 visits yearly, and approximately 650 babies are born at MMC each year. MMC has a medical staff of more than 100 physicians across of 37 medical and surgical specialties, with an extensive primary care foundation.

Why Coordinated Care?



MMC views care coordination as an important aspect of fulfilling its mission as an independent community health system. Care coordination adds tremendous value to the community by assisting some of its most vulnerable residents, many of which have complex healthcare and socioeconomic needs, which go far beyond the traditional scope of acute care services. In addition to advancing its mission, MMC believes the program established an important framework for the future of healthcare delivery in the community as MMC evolve services to better align with overall wellbeing of the population.

Care Coordination

The Community Care Network (CCN) is an interdisciplinary team of dedicated clinicians who work with physicians, health care providers and other agencies to help manage chronic disease conditions, with a focus on meeting patient's health and wellness goals. The coordination of services offered in the CCN are provided at no charge and aim to assist in the following areas:

- Appointment Adherence
- Nutritional Support
- Medication Reconciliation
- Prevention & Risk
- Emotional Support
- Accessing Community Resources
- Challenges of Daily Living
- Education on Health & Well-being

The top 4 diagnosis are:

- Hypertension
- Diabetes
- Hyperlipidemia
- Depression

Parenting classes also are part of the CCN. Programming is very diverse and may be offered in schools, homes and physician offices.

Staffing the Networks

The CCN has eight core members comprising registered nurses, dietitians, social workers and counselors who are augmented in the field by trained health coaches. The team is led by a medical director and works closely with physicians in the community.

The CCN offer internships for graduate students, typically from University of Pittsburgh; Gannon University, Erie, Pennsylvania; or Edinboro (Penn.) University. Students that are hired as interns typically are studying counseling, social services or a related health science and they augment the care team by providing home visits.



Similarly, the CCN recruit students from Allegheny College who are preparing for careers in health and human services and train them as health coaches. Presently there are 40 active coaches visiting over 80 patients in the CCN including children and their parents.

To become a health coach, students participate in a one-semester seminar that provides instruction on chronic disease management, population health management, health law and more. Upon successful completion of the seminar, students receive 2-credit hours and can then participate as health coaches and receive an additional 2-credit hours per semester for making weekly home visits, supporting caregivers and patients, and reporting outcomes and findings to the Networks' team. The CCN director supervises the health coaches and reviews and modifies their curriculum as needed.

Patient Referrals

Patients are referred to the Networks in several ways including a hospital emergency visit, direct hospital admission or community referral. Likely participants for the Networks are screened for medications, level of education, psych/social conditions and support at home, among other indicators and stratified by risk to determine their suitability for the program.



After screening, the team provides patients an initial home visit to determine the appropriateness of care coordination. Those who can benefit from – and who wish to participate in – care coordination will work with the CCN team to establish goals. In this model, it is the patient's goal that drives care planning and progress. The clinical team visits on a weekly, biweekly or monthly basis as necessary as long as the patient is enrolled and has care coordination needs.

The multidisciplinary CCN team meets weekly with the medical director to review progress and utilization. Members report on their patients and make determinations about the plan of care and continued service. Interns and health coaches meet with the clinical team weekly to report and discuss their findings as well. Currently the CCN serves about 350 patients including 60 children.

Care Coordination Outcomes

Because the Networks are cost centers, their effectiveness is scrutinized carefully. Based upon a review of the most recent utilization for patients in the Networks, readmissions declined by 45 percent and emergency department visits declined by almost 25 percent for CCN patients. On average, spending for CCN patients declined about 28 percent per patient ranging from \$3,731 to \$6,112 per patient on average depending upon payer type. While readmissions were reduced, outpatient business increased.

Keeping the patient engaged in their plan of care and to do it as efficiently as possible is the goal. This requires coordinating services not only within the hospital, but across the community as well. The CCN collaborates with the designated area agency on aging or Active Aging, Inc., Meadville, Crawford County Human Services Department, visiting nursing, hospice and others. The County augments the program with support primarily for mental health, early childhood intervention and children and youth services. The Networks also work with multiple area agencies to address local transportation, food and housing needs.

Conclusion

The goal is to engage patients and help them take ownership of their plan of care and stay out of the hospital. By reducing readmissions and emergency department visits and by keeping patients focused on wellness and health promotion, the CCN improve the overall health of the population while conserving scarce resources and reducing costs.

This approach also provides an opportunity to educate and develop career professionals in health and human services by engaging students in the delivery of care. It cannot be done alone and the collaboration between the hospitals, colleges and universities and community services is exceptional as are the outcomes of their combined efforts.