Memorial Healthcare System

LIP Tier 2 Project

Readmission Reduction

MEMORIAL HEALTHCARE SYSTEM

- 4 Hospitals
  - Memorial Regional Hospital (includes Memorial Regional Hospital South and Joe DiMaggio Children's Hospital)
  - Memorial Hospital West
  - Memorial Hospital Pembroke
  - Memorial Hospital Miramar
- All 4 are subject to Tier 2 requirement
- Also Memorial Home Health Agency, Memorial Manor, and South Broward Community Health Services primary care centers

MEDICAID AND UNINSURED

- Market area is principally southern 1/3 of Broward County (South Broward Hospital District)
- Over 650,000 residents
  - 33% White, Non-Hispanic
  - 33% Hispanic
  - 28% Black, Non-Hispanic
  - 6% Other
- 30% Uninsured & underinsured
- 11% Medicaid

Readmission Statistics

Facility	AMI	HF	PNEU	Total (+5%)
MRH	114 (14%)	110 (18%)	215 (11%)	461 (14%)
MHW	85 (2%)	90 (29%)	66 (11%)	253 (15%)
MHP	3 (0%)	33 (9%)	70 (17%)	111 (14%)
MHM	4 (25%)	15 (33%)	63 (10%)	86 (15%)
Total	206 (9%)	248 (22%)	414 (12%)	911 (14%)

- # Target population; % of historical readmissions
- 30-day all-cause readmissions of target population in selected conditions
- Not risk-adjusted
- Medicare readmissions range from 20% to 27%
  - Medicaid better because of some case management at SBCHS

Readmission Reduction Program

- Objectives:
  - 5% reduction in all-cause 30-day readmissions for target population that is enrolled
  - 60% enrollment rate
- Program structure:
  - Care coordinators identify/recruit target patients
  - Transition coaches provide home and telephonic support services
  - 24/7 call center

TRANSITION COACHING

CORE COMPONENTS	
Medication Self Management	Patient is knowledgeable about medications and has a medication management system. During the home visit, the Transition Coach will conduct a face-to-face medication reconciliation.
Personal Health Record (PHR)	Patient understands and utilizes a PHR to facilitate communication and ensure continuity of the care plan across providers and settings. During a home visit, the Transition Coach will conduct a reconciliation of the PHR data and provide education.
Primary Care Physician (PCP) and Specialist Physician Follow-Up	Patient schedules and completes follow-up visits with PCP and Specialists and is empowered to be an active participant in these interactions. During the home visit, the Transition Coach will schedule and coordinate PCP and Specialty Physician follow up visits with the Specialty Care Coordination Program offered by MHS's Community Health Center.

TRANSITION COACHING

CORE COMPONENTS (CONT)	
Red Flags/Signs and Symptoms	Patient is knowledgeable about indicators that suggest his or her condition is worsening and how to respond. During the home visit, the Transition Coach will provide education and coordination of interventions.
Home and Community Based Services	During the home visit, the Transition Coach will identify and coordinate home and community based services to assist in the care transition and maintain patient independence. The transition Coach will provide referrals to community and faith-based agencies for needed resources.
Nutrition Management	Patient is knowledgeable about nutrition status, meal planning and diet as it relates to health conditions. During a home visit, the Transition Coach will complete a kitchen and environment evaluation. The Transition Coach will also complete a nutrition needs assessment to determine if there is an immediate need for post-discharge meals. The post-discharge meal intervention will provide 10 nutritious meals to the patient's home, as needed.

Project Timeline

- July 1, 2012 – September 30, 2012
  - Infrastructure development
  - Staff recruitment and training
  - Creation of support documents and tools
- October 1, 2012 – June 30, 2014
  - Patient recruitment
  - Service provision
  - Quarterly reporting

Project Budget

- MRH $314,222
- MHW $182,222
- MHP $91,326
- MHM $73,268
- Total $661,038