GREENVILLE HEALTH SYSTEM

Care Management Case Study

Greenville Health System Care Coordination Program

Greenville Health System is the largest multi-hospital health system in South Carolina. It is a nonprofit, patient-centered, teaching and research institution. The system has 1,268 licensed beds, 1,271 affiliated and employed medical staff, and 10,925 employees dispersed throughout five medical campuses and a variety of outpatient and specialty facilities. Its seven residency and seven fellowship programs provide training for physicians, and nursing and allied health students.

In December 2014 Greenville Health System (GHS) launched a nine-county, physician-led health care provider collaboration called My Health First Network. The affiliation of 1,850 providers from GHS, Baptist Easley, Self Regional Healthcare, Abbeville Regional, Newberry, and independent physicians enable optimal collaboration on best practices and consistency in health care delivery.

With Medicare, Medicaid, and commercial contracts, Greenville Health System (GHS) and My Health First Network (MyHFN) focus their efforts to help control escalating health care costs and improve quality of care for patients in the upstate region of South Carolina.

Background

Greenville Health System's Care Coordination Program is based on a population health model of care that provides care coordination across the continuum of care. The goal of the program is to optimize the triple aim by improving the health and quality of care for populations, engaging patients to improve their quality of life and health care experience, and coordinating care to provide the right care at the right time in the right place, therefore reducing costs and avoidable utilization. The program has multiple levels and points of entry from complex care management, including transitions in care to disease and lifestyle management concentrating on the individual patient wherever they may be on the care continuum.

Program Description

Greenville Health System uses an integrated and proactive approach to population health using a value based model that improves health and quality of care while managing costs. Care coordination and care management supported by integrated information technology enables seamless care throughout the continuum of health care from catastrophic and complex acute care management and disease management to lifestyle and wellness management. The overall goal of GHS care management is to foster health improvement in a patient-centered and clinically responsive environment.

The complex care management component utilizes predictive risk analysis tools to identify complex patients that have multiple chronic diseases and high utilization that require extensive care management and care coordination interventions. This risk analysis also allows GHS to identify those patients that are predicted to incur high costs and increasing utilization in the future to allow early intervention and care coordination to avoid unnecessary cost and health burden.

The transitional care component targets patients that are in acute care and are a high risk of readmission, poor outcomes, and increased utilization. Face-to-face contact with the acute patient and family/caregiver while hospitalized sets the stage for seamless hand-offs and continuity. These patients are managed across a thirty to ninety day intensive course to avoid re-hospitalization, improve outcomes, and coordinate care to the appropriate sub-acute, out-patient or community resource. Interventions targeted at the patients specific needs allow patients to transition through levels of care seamlessly and without complication.

The disease management component uses condition management registries to manage patients with at least one chronic disease. The program's goals are to educate patients about their condition, guide the patient through the health care system, and create a self-care plan that is patient centered and supported by the family, caregiver and physicians.

GHS utilizes key stakeholders and physicians in the development of best practice guidelines and clinical pathways for quality driven care. Seamless referral from one level of care to the next is a key element to guiding the patient through the complex health care environment.

Care Management Strategies

The care coordination team approach comprised of various skill levels including Registered Nurses, social workers, health coaches, and community health workers is key to GHS's care management success. The care managers are located in physician practices and are strategically placed geographically with a team comprised of RNs, social workers, and disease managers / coaches to enable timely interventions and collaboration with the physicians and help promote point of care strategies. Using an innovative care management tool, the care managers are able to comprehensively assess and create a longitudinal plan of care that follows the patient throughout the health care continuum. This tool also promotes culturally appropriate assessments to maximize patient values, preferences and life situation. The care management platform allows the care manager to create a care team that includes multi-disciplinary roles such as family and caregivers, pharmacists, diabetic educators, disease specific navigators, social and behavioral services, and nutritionists allowing a whole patient approach for input, management, and continuity while avoiding duplication of care.

Patient engagement is managed through face-to-face visits at the physician office or in the home when appropriate and telephonically for follow-up. The care managers and disease management coaches use motivational interviewing techniques and teach-back methods for optimal engagement. The patient care plan is created with the patient, the family and caregiver, the physician, and care team to provide a holistic and patient-centered path to optimal health. Patients are encouraged to use the system-wide patient portal for shared input and decision making.
This value-based model of care and the patient engagement strategies are shared throughout My Health First Network to promote integration of technology, best practices, critical pathways, and processes. This is accomplished through the network governance structure with regional steering committees and care management work groups reporting up through the network quality and care model committee and board. This enables key physician involvement and support for the care coordination program.

Other important care management program strategies and components at GHS include:

- Specialized training in palliative care, hospice needs and timely referrals
- Diabetes self-management programs
- Tele-monitoring programs for diabetes and heart failure
- Partnerships and close relationships with many community-based programs and services
- Care giver support through a Reach grant and TCARE initiatives
- Accountable community programs including paramedic outreach to under-served populations and the GHS mobile health clinic serving these neighborhoods
- Nurse triage services for after-hour calls to divert unnecessary emergency department visits and costs
- Collaborative pharmacy programs for medication reconciliation and “Med to Bed” program

Findings

The value-based population programs at GHS continue to evolve with Medicare Shared Savings Program (MSSP) and commercial contracts. Data collection is on-going.

The longest running shared savings arrangement with a Medicaid Managed Care Program has shown significant improvements:

Results comparing the year prior to program implementation (2012-2014) include:

- Inpatient utilization/1000 decreased 25%
- Emergency department utilization/1000 decreased 33%
- 30-day all-cause readmissions decreased 20%
- Wellness/preventative visits per member increased 300%
- Prescriptions/member decreased 14%
- Percent generic utilization increased 8%
- Significant shared savings realized at 2013 and 2014 years end
- Discharge satisfaction increased from 83.9% to 93.9%
- Transitions of Care satisfaction increased from 52.2% to 62.3%