



Report to the Community

Community Health 2020 Commission on System Performance

August 2010

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To the Community:

More than 100 stakeholders in the Rochester region are actively participating in the largest, most collaborative effort in local history to improve the performance of our health system. The Community Health 2020 Performance Commission is embarking on an ambitious effort to improve the health of our community and to save more than \$150 million in local health-care costs by 2014.

FLHSA established the 2020 Performance Commission as a follow-up to the original 2020 Commission, which helped our community save \$126 million in capital costs for new hospital beds, while enabling three local hospitals to modernize their facilities. The 2020 Performance Commission is working to create a high-performing health system through collaboration among major stakeholders. Three work groups are addressing key goals, decreasing preventable hospital admissions and avoidable emergency room visits, and developing strategies to sustain a regional health-care system.

We are honored to lead this effort, alongside leaders from health care, business, labor, government, education, faith-based and community organizations, and the community at large. The 2020 Performance Commission and work groups represent every aspect of our community, from those with the expertise to know what changes are needed, to those with the authority to make these changes happen. It also includes health consumers, including actively engaging people of color in the process of planning their health care.

Working together, we are taking a regional, collaborative, and multi-stakeholder approach to improve local health care. We have established clear goals with measurable outcomes. This report is the first in a series of community updates to keep stakeholders and the public apprised of our efforts. We will issue subsequent reports through the coming year with additional updates on the commission's progress.

Sincerely,

Leonard Redon, Chair
Vice President of Western Operations
Paychex Corp.

Susan Holliday, Vice Chair
President and Publisher
Rochester Business Journal

Introduction

In 2007, Rochester's health system faced a problem. In the aftermath of The Genesee Hospital's closure, Rochester's three remaining large hospitals were operating at or above capacity, with inpatient facilities that were at least 30 years old. In the span of a few months, Rochester General, Strong Memorial and Unity hospitals all filed separate Certificate of Need (CON) applications to add inpatient medical/surgical beds and to modernize facilities. Together, their proposals would add 278 new inpatient beds – more than a community study determined were needed.

To develop a community recommendation that would inform the New York State Department of Health's decisions on these CON requests, Finger Lakes Health Systems Agency (FLHSA) convened the 2020 Commission. This diverse, multi-stakeholder group reviewed data and worked directly with the hospitals, consumers, and rural communities to develop recommendations on needed bed capacity and modernizations plans. Following a transparent, community-driven process, the commission concluded that all hospitals had a reasonable basis for their expansion projections, but conflicting market share created redundancy.

The commission also suggested special actions to decrease the disproportion rate of hospitalizations among people of color and found several trends driving hospital admissions that were potentially avoidable:

- Patients being admitted to hospitals for conditions that might have been prevented with more timely primary care.
- Patients visiting emergency rooms for treatments that could be provided more efficiently or more cost-effectively in other settings.
- Patients in outlying counties coming to Monroe County for treatment that they could get in their own community hospitals.

Addressing these trends by making the system more efficient would reduce the community's future demand for hospital beds. Based on these findings, the 2020 Commission made a series of recommendations, which were approved by the state:

- To support plans for three Monroe County hospitals to modernize - each hospital benefits from updated facilities.
- To reduce the number of new hospital beds from 278 to 152.
- Future expansion could be approved on a fast-track basis, but only if the hospitals worked collaboratively to reduce avoidable admissions.



By reducing the total request for beds, the community saved \$126 million in capital costs and \$20 million in annual operating expenses.

Delivering on the Promise of a High-Performing Health System

Along with its CON recommendations, the 2020 Commission recommended a follow-up effort to carry out the additional community investment activities. The next phase, FLHSA's 2020 Performance Commission, was formed to drive the changes necessary to reform the regional health system and to control medical costs, with specific savings targets of more than \$150 million over three years.

The 2020 Performance Commission recognizes that hospitals are key components to creating a more efficient and effective health system, but that other stakeholders play a role as well. By being more engaged in their personal health, individual health consumers can reduce the need for treatment and live happier, more productive lives. Primary care providers and office-based specialists are critical to delivering care in the most cost-efficient settings, and in helping to educate patients. Health insurers and employers, who help pay health-care bills, have expertise in analyzing costs and identifying efficiencies.

Appreciation for various stakeholder roles in creating a high-performing health system is evident in the makeup of the 2020 Performance Commission. Not only is the commission composed of the right organizations, it also boasts the right people - from hospital CEOs, to physicians, to consumers. Commissioners are representatives of the hospital systems, insurers, physicians, consumers, human-service organizations, communities of color, business, public health and nursing. They are people with the day-to-day knowledge to create necessary changes and those with the authority to make change happen.

Community Impact

While the 2020 Performance Commission's work remains in the early stages, the benefits of its community-wide focus and collaborative approach are already becoming visible.

- All area hospitals have agreed, through their discharge planning departments, to collaborate on a common approach to discharging patients that will help reduce hospitalizations.
- Stakeholders from across the community are coming together to identify and address key inefficiencies in the health system that are helping drive costs.
- A pilot program to educate new parents is helping to keep children out of the hospital emergency room.
- For the first time, people of color in the Rochester community are actively engaged in the process of planning their own health care.

Cost Savings

By addressing system inefficiencies, the 2020 Performance Commission's work is expected to save at least \$150 million in local health care costs by the year 2014:

Priority Initiative	Current Number of Admissions/Visits (SPARCS Data, 2008)	Goal	Cost Savings / System Benefit
Reduce potentially preventable hospitalizations	Approx. 12,000	25% reduction by 2014	\$75.5 million (total compounded savings, 2011-2014)
Decrease avoidable ED visits	Approx. 120,000	15% decrease by 2014	\$83.2 million (\$20.8 million annually, 2011-2014)

Three work groups were created to guide plans to achieve these priority initiatives and to recommend ways to sustain a regional health system. The work groups – Preventable Hospitalizations, Avoidable ED Visits, and Regional Health System – have created standing subcommittees to drive long-term projects, along with task forces or focus groups to gather information or to address shorter-term needs.

Preventable Hospitalizations Work Group

Chaired by Kathy Parrinello, Chief Operating Officer of Strong Memorial Hospital, this work group's focus is helping patients take better care of themselves to reduce both hospital admissions and readmissions. Four chronic diseases have been identified that, with better care management, could have the most impact in preventing re-hospitalizations - Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), diabetes and Coronary Artery Disease (CAD).

The overall goal is to reduce preventable hospitalizations by 25 percent by the year 2014, through a two-staged process. First, the group aims to decrease avoidable readmissions. Eventually, it will look at addressing all preventable hospitalizations.

Prevention Quality Indicators (PQI) will measure progress. Developed by the Federal Agency for Healthcare Research and Quality (AHRQ), these measures assess the quality of outpatient care for ambulatory sensitive conditions – those conditions in which good outpatient care can prevent the need for hospitalizations or in which early intervention can prevent complications or more severe disease.

Following analysis of the issues related to hospital readmissions, this group created subcommittees to address key areas for improvement. Subcommittees are focusing on enhancing the discharge planning process, supplementing physician practices with care managers and employing coaches to help patients who are most at risk of being readmitted.

Discharge Planning Process Subcommittee

According to the AHRQ, nearly 20 percent of patients experience adverse events within three weeks of discharge that lead to re-hospitalization. Other communities have reduced this percentage by ensuring that patients get detailed discharge plans and understand how to avoid getting sick again.

Under the guidance of the Discharge Planning Process Subcommittee, hospitals in the six-county Finger Lakes region are collaborating to ensure that their discharge process incorporates four standard components:

- Patient needs / active participation. Discharge planning will be guided by each patient’s active participation and individual needs, in language they can understand rather than in medical terms.
- Medication reconciliation. Medications that patients are given in the hospital and prescribed when they go home will be screened against those they took before they were hospitalized, and updated with the patients and their PCPs.
- Information transfer. As much as 60 percent of medication errors happen between handoffs between providers (source: AHRQ). All hospital information about a patient will be sent to every provider involved in his or her care, from the primary care physician, to the residential day program or nursing home.
- Post-discharge support. Additional follow up with patients after they are discharged from the hospital.



Goals: Discharge Planning Subcommittee	Subcommittee Status
Hospitals will agree to four standards with essential components to be integrated by each hospital	All hospitals have agreed to common goals of a discharge planning process and will begin working on implementation
Each hospital will include a Coleman National Quality Forum (NQF)-endorsed patient discharge questionnaire for monitoring patients’ experience with the hospital discharge process	The subcommittee expects the questionnaire to be implemented in all area hospitals in 2011

Embedded Care Managers Subcommittee

Reducing hospital readmissions in patients with chronic diseases is the charge of the Embedded Care Managers Subcommittee. Its initial focus is preventing avoidable readmissions and subsequently preventing these hospitalizations from occurring in the first place.

FLHSA and subcommittee members are working to place care managers working alongside physicians in primary care practices. Care managers will help patients to better navigate the health-care system. They will work directly with patients after discharge from the hospital, serving as the point of contact to answer questions and ensure patients are following their

individual discharge plan. Because chronic diseases are disproportionately high in African American and Latino populations, cultural competency will be integrated as a key component of the program. The care managers program is modeled after successful programs at Kaiser Permanente and Geisinger Health Systems.

Subcommittee Status	Goals: ECM Subcommittee
Community representatives including hospitals, physicians, nurses and home care agencies developed a community standard that addresses essential elements of the program and of the care manager	<ul style="list-style-type: none"> • Develop a pilot program by December 2010, placing at least 3 ECMs in pilot physician practices • Determine large-scale viability by May 2011

Transition Coaches Subcommittee

While care managers will give patients the “fish” of direct care monitoring, transition coaches will teach patients “how to fish” by empowering them and teaching necessary skills to advocate for their own needs. Coaches will make one hospital visit, one early home visit and two follow-up visits.

Patients identified as being at high risk of readmission due to a chronic illness, age or social factors are coached to: 1) understand their medications; 2) have knowledge of, and maintain, their personal health record; 3) identify signs and symptoms that indicate a worsening condition; and 4) schedule and complete follow-up visits with their primary care physician or specialist.

Subcommittee Status	Goal: Transition Coaches Subcommittee
<ul style="list-style-type: none"> • Currently identifying a funding mechanism and funding sources to provide transition coaches in community agencies, such as Lifespan and The Community Place of Greater Rochester • Implementing the Care Transitions Program™ to train the coaches 	Train and integrate 12 coaches in hospitals and community agencies by March 2011

Avoidable ED Visits Work Group

Between 2005 and 2006, approximately 80 percent of residents in the Finger Lakes region who made visits to the ED were treated and released. Nearly 45 percent of these treated and released ED visits had the potential to be treated in a non-ED setting.



A recent study released by Excellus BlueCross Blue Shield revealed that approximately 163,000 ED visits involved such minor symptoms as sore throats, earaches, rashes and non-traumatic back pain.

Chaired by Robert Thompson, Vice President for Safety Net Programs at Excellus BCBS, this work group’s goal is to reduce potentially avoidable emergency department visits by 15 percent by the year 2014.

In examining the factors involved in ED use, the work group identified three key findings:

- Many patients do not have a strong connection to their primary care physician or to their PCP's practice.
- Patients’ self-management skills and their willingness to manage their health are low.
- Patient convenience drives ED use.

The ED Work Group is targeting ways to improve primary care so that patients begin to see their physician as the best source to manage their health, to promote self-management skills, and to address the need for convenient, readily accessible medical care.

- ED notification. A primary care physician would receive real-time and consistent information about their patient’s emergency department visit.
- Self-management. A small FLHSA pilot program involved giving new parents booklets with information about symptoms requiring an ED visit and others that could be attended to in an office visit. This pilot program among Medicaid patients shows tremendous promise, as it has resulted in no ED visits since it began in November 2009.
- Pursue telemedicine. Video conferencing has shown success in pediatric practices. This technology enables long-distance communication between doctors and children, providing diagnostic-quality images of areas affected by common childhood illnesses, such as the eardrum, throat and eyes.



Work Group Status	Goals: Avoidable ED Work Group
<ul style="list-style-type: none"> • Enrolled in the Institute for Healthcare Improvement’s (IHI) Reducing Avoidable ED Visits Collaborative 	<ul style="list-style-type: none"> • Self management: fewer avoidable ED visits categorized by diagnosis, socioeconomic status, and race • ED notification: establish and implement information exchange from ED to PCP • Telemedicine: expand use of telemedicine where it already exists; establish telemedicine in at least 2 new pediatric practices • Strengthen primary care • Partner with FLHSA’s Community Engagement initiatives to identify and implement programs targeting health disparities

Regional Health System Work Group

Community hospitals in regional counties offer many surgical and medical treatments with the same quality of outcome as Monroe County hospitals. The proportion of out-of-county residents choosing Monroe County hospitals for these treatments has steadily grown – inflating bed demand in Monroe County and threatening the sustainability of some regional hospitals.

Chaired by Stephen Ashley, Chairman and CEO of The Ashley Group, this work group is developing recommendations to sustain a regional health-care system and to improve access to care for residents in the five-county Finger Lakes region of Livingston, Ontario, Seneca, Wayne, and Yates counties.

Patients in these counties will be encouraged to obtain hospital care in their own communities, whenever appropriate. Challenges to this effort include: 1) ensuring the long-term viability of community hospitals; 2) improving access to services for area residents; and 3) encouraging partnerships between hospitals, community-based providers and other stakeholders.

Work Group Status	Goals: Regional Work Group
Reviewing data on health-care demand, provider supply, and the future financial viability of the regional health-care system	<ul style="list-style-type: none">• Better understand the challenges facing regional community hospitals• Develop specific initiatives and recommendations to sustain a regional health-care system and to improve access to care for residents in the five-county Finger Lakes region• Promote increased collaboration between the larger Rochester-based and smaller regional hospitals (FLHSA to report “community preferences” to NYS DOH for use in consideration of resource distribution in the region, e.g., hospital beds, public funding)

Conclusion

As the 2020 Performance Commission achieves its critical goals, Greater Rochester’s health-delivery system will save millions of dollars. More importantly, though, area residents will lead healthier lives.

No individual organization can accomplish the goal of a higher-performing health system by itself. It requires the resolve, dedication and active involvement of the entire community. Through a regional, collaborative and multi-stakeholder approach, we can – and we will – collectively improve local health care, reduce costs and enhance the care experience of patients. This first Report to the Community provides an update on the 2020 Performance Commission’s work to date; subsequent reports will keep the community apprised of its progress.