10 Integrated Delivery Networks to Watch

IH Executive profiles organizations whose leadership and innovation are helping transform the U.S. healthcare system
Getting integrated healthcare right is an enormous—and ongoing—undertaking. At this moment, healthcare delivery networks across the U.S. are planning, launching, measuring and fine-tuning initiatives that will one day transform our healthcare system. In this special section, Integrated Healthcare Executive profiles 10 organizations that are helping to lead that transformation.

This curated selection highlights providers who are innovating across a variety of care types and settings. They’re partnering with their local communities, collaborating with other providers, creating new pathways of care and embracing new reimbursement structures. They’re each demonstrating leadership in a unique and exciting way that makes them worth watching.

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Symphony Post-Acute Network

Transitional Care Network, Chicago, IL

Symphony Post-Acute Network (PAN) has 30 member facilities in four states (IL, WI, IN and AZ) and provides care for 5,000 patients a day. Its focus is on transitional care, often for patients discharged from the hospital. “Patients come to us for some form of rehab or nursing services before returning home,” says Tim Fields, president of operations at Symphony PAN. “They’ll come for short stays to sometimes longer stays, depending on their age and diagnosis.”

Patients may be receiving care for orthopedic surgery, cardiac surgery, lung disease, congestive heart failure, wounds, infections or other issues. If the patient is to receive home health services after returning home, Symphony PAN stays involved through the transition. “We coordinate care from the time referral is made from us to home health,” says Fields. “If the patient needs to come back to us, for things like being noncompliant on their diet or meds, we’re able to stabilize that patient in our facility as opposed to the emergency room. That can save a readmission. And the patients like it better, because they’re not going into the emergency room; they return to people who are already used to treating them.”

In fact, Symphony PAN partners with several major hospitals and health systems in the Chicagoland area, to help them meet goals regarding length-of-stay and readmissions. One example is its Care Bridge Program. “We can take patients directly in from home care or from the emergency room, and provide interventions to keep that patient from being a 30-day readmission,” says Fields.

To ensure information transfers seamlessly along with patients, Symphony PAN is an active member of the Illinois health information exchange (ILHIE) and can upload and share information from its EMR system. Depending on the technology, Symphony PAN staff may also have direct access to partner organizations’ EMRs.

While a patient is at a Symphony PAN facility, staff focuses on their overall satisfaction, through a program called High-Note Hospitality. “We have dedicated directors of customer experience in each building who provide a hospitality model,” says Fields. “We make sure guests are happy with their food, with their nurses and therapists. We’ll also go out and get little surprise-and-delight things like puzzles and magazines, their favorite food or beverage. It’s like having a personal concierge who helps make sure they’re getting their needs met and that they are happy.” The network benchmarks itself against the hotel industry, using net-promoter scores. Companywide, Fields reports, Symphony PAN is performing “like a 4.5-star hotel brand. But a lot of our buildings that focus on the short-term population have been consistently in the five-star range.”

Symphony PAN benchmarks itself against the hotel industry. Here, Steve Owen, director of customer experience, ensures patients receive five-star hospitality at Symphony of Crown Point, IN.
Community Care Collaborative

Nonprofit Partnership, Austin, TX

The Community Care Collaborative (CCC) is a nonprofit corporation created by Central Health (the business name of the Travis County, TX, hospital district) and Seton Healthcare Family, part of Ascension Health. The organizations will share the financial risks of providing healthcare to the county’s poor and vulnerable. They will also establish a new integrated delivery system to improve the quality, cost-efficiency and outcomes of care for that population.

Plans for the integrated delivery system—which is about to begin operations—also call for development of a health information technology infrastructure and a framework for transitioning from fixed-rate to value-based reimbursement.

“At the same time we were [developing the CCC], Seton was involved with CMS on some of the early ACO development,” says Greg Hartman, Seton’s president for external affairs, academic medicine and research. “And we started brainstorming, ‘What if we could figure out a way to create an ACO that took care of the poor and vulnerable?’”

The need was clear. “Austin has been for the last 20 years arguably the fastest growing city in the country, and we as a state have the highest percentage of uninsured population,” says John Stephens, CCC’s executive director.

A third, although unofficial, participant in the partnership will be the new Dell Medical School at The University of Texas at Austin, which will enroll its first class in 2016. Stephens says he hopes the medical school will bring some new specialists into the delivery system. That would address the supply side of a specialty care shortage. On the demand side, says Stephens, “We’re going to put in a system where we allow the primary care doctors access to specialist consults that they don’t have right now, whether it’s a teleconsult or an email consult.” That will help ensure that only appropriate cases are referred to specialty care doctors.

Overall, the system will shift from a focus on treating illness to emphasizing prevention, wellness and chronic disease management. A key element will be conducting health risk assessments of enrollees. The CCC will also adopt a “no wrong door” approach. “We plan to station folks who are doing eligibility or enrollment work in all of the main sites where patients might try to access care,” says Stephens. “It doesn’t matter whether they go to the hospital first or one of the primary care clinics. If they’re seeking service, our objective is going to be to try to bring them into the system as early as possible, doing that health risk assessment, and determining what sort of course of treatment they might need.”

Watchable for: Integrating Care for the Uninsured/Underinsured
Carroll Hospital
Hospital, Westminster, MD

As one of 10 hospitals that piloted Maryland’s global reimbursement structure before it went statewide, Carroll Hospital, a Lifebridge Health Center, has been operating in a value-based purchasing environment for a few years now. But its population health efforts, through a partnership with its local health department called The Partnership for a Healthier Carroll County, date back to 1999.

The partnership regularly conducts community health needs assessments and invites a diverse group of community stakeholders to help analyze the data and prioritize needs. “We have the health department, school system, faith organizations. Everyone sits down in a big room and we prioritize the needs of our community,” says Dorothy Fox, executive director and CEO for the partnership. “We believe that when we gather people with diverse skills and the willingness to be innovative, as long as they have that same shared vision of a healthy community, we find that we can really see some progress and movement in some of our data that we’re tracking.”

Collectively, the participants identify Community Health Improvement Areas (CHIAs) in which to focus the partnership’s efforts. Current CHIAs include prevention and intervention, behavioral health, access to healthcare and elder health.

The partnership forms leadership teams on which community members can participate to drive health improvements in the target areas. Support is broad-based: “We have at last count 300 individuals and 140 organizations within our county that serve on some type of leadership team or action team,” said Fox.

The leadership teams track health indicators and report their progress as part of an extensive community health dashboard on the partnership’s website, www.healthycarroll.org.

Sharon Sanders, RN, BSN, MBA, vice president for clinical integration at Carroll Hospital, says Maryland’s unique hospital reimbursement structure not only makes this type of partnership easy, it promotes it. “Our global reimbursement encourages us to provide care in the right place, at the lowest cost, in the right setting,” she says. “And the best way to do it is to form these sorts of partnerships.”

Sanders acknowledges that, in an environment where healthcare providers have revenue at risk, trust is an important part of any community partnership. “When we put our population health efforts to the partnership we’re really trusting that our community

The Partnership for a Healthier Carroll County takes population health to the community with health-promotion events.

Watchable for:
Population Health in a Value-Based Environment
Regional Emergency Medical Services Authority (REMSA)

REMSA is a private nonprofit provider of emergency and nonemergency paramedic ambulance services in northern Nevada. Over the past several years it has begun offering area residents with urgent, low-acuity medical conditions three new options for receiving the safest, most appropriate levels of care at a lower overall cost.

First is the Nurse Health Line, staffed 24/7 with specially trained nurse navigators. Washoe County residents, regardless of insurance status, can call a dedicated line with their nonemergency medical questions and concerns. A nurse navigator assesses the patient and recommends the appropriate level of care. That can include sending an ambulance or recommending the patient visit an emergency room, visit an urgent care center, schedule an appointment with a primary care doctor or stay at home with self-care instructions. Nurses are co-located with the 9-1-1 emergency medical dispatch system and can perform a warm transfer if an ambulance is needed. An integrated directory of community services allows nurses to identify recommended care locations and help the patient access an array of medical and community services closest to their home.

Another option is Community Paramedicine. Patients referred by a healthcare provider can receive home visits from community health paramedics specially trained to evaluate patients and perform tasks such as IV procedures, nebulizer treatments, 12-lead EKGs and blood tests. Paramedics can also monitor vital signs, weight and medication usage. The visits are intended to provide follow-up after hospital discharge, episodic evaluation of patients for whom a trip to the emergency room may not be optimal, and interventions to help ED high-utilizers access the right types and levels of healthcare, behavioral health and other services. During in-home visits, community health paramedics reinforce the healthcare provider’s discharge instructions and treatment plans, perform medication reconciliation and provide education at the patient’s health literacy level. On the initial visit, paramedics also assess the in-home environment to identify any needs for—and provide referral to—in-home support services and community resources.

The third pathway is Ambulance Transport Alternatives. Following an advanced assessment in the field, paramedics provide alternative pathways of care for 9-1-1 patients, including transport of patients with low acuity medical conditions to urgent care centers and clinics, transport of inebriated patients directly to a detoxification center, and transport of psychiatric patients directly to a mental health hospital. To date, the service has 16 participating alternative care destinations.

Based on data from December 2012 to June 2015, preliminary results (which are subject to independent validation) show that these pathways have avoided 4,284 ED visits, 817 ambulance transports and 102 hospital readmissions—in the process saving $7.2 million in avoided payments.

Watchable for: Creating New Pathways for 9-1-1 Patients

REMSA Community Health Paramedic Dominic Polimeni answers a patient’s questions.
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Burcham Hills and Great Lakes Caring Home Health & Hospice

Burcham Hills is a nonprofit Continuing Care Retirement Community (CCRC) that offers independent living, assisted living and memory care residences; inpatient skilled nursing and sub-acute rehabilitation services; and an outpatient therapy clinic. To provide continuity of care between these settings, Burcham Hills has entered into a collaborative arrangement with Great Lakes Caring Home Health & Hospice. “We call it ‘Collaboratinuity™’,” says Great Lakes Caring CEO William Deary, whose company pioneered the model.

When a Burcham Hills resident is prescribed home healthcare and requires physical therapy, occupational therapy or speech therapy (and chooses Great Lakes Caring Home Health), Great Lakes Caring has contracted the services of Burcham Hills therapists to provide the care.

“We’re able to provide continuity of care by having our own team provide the therapy services,” says AnnaLee Alexander, director of rehabilitation and wellness at Burcham Hills. “Our residents feel comfortable with our staff, because they see them every day in the community.” If the patient needs outpatient rehab after home care, they can simply continue with the same therapist at the Burcham Hills outpatient facility.

Collaboratinuity™ can also mean better outcomes for the patient, says Deary. “At Burcham Hills, the patient sees the same therapist for their home health rehab and outpatient rehab. At other CCRCs, they may also see the same therapist for inpatient rehab. This is the most effective and efficient model of clinical care continuity. Additionally, Medicare has a cap on outpatient therapy; it may cover 14–15 visits. If the patient doesn’t have home healthcare after inpatient therapy, the therapist may not be able to get the patient where they need to be in 15 outpatient visits. The patient would be 100% responsible for outpatient visits over the cap.”

The collaboration has helped improve patient recovery and decrease unnecessary rehospitalizations. And the residents are happy with it. “The biggest feedback is about the continuity of care and having people they know come to see them when they’re not feeling the best,” says Alexander. “They really feel at ease.”
North Shore-LIJ Center for EMS – MIH

Health System EMS Service, Syosset, NY

North Shore-LIJ Health System launched its mobile-integrated health-community paramedicine (MIH-CP) pilot in October 2013 as a project of its Center for Emergency Medical Services (CEMS). The program is closely tied to North Shore-LIJ’s House Calls program, in which physicians make scheduled, in-home primary care visits to some 1,000 high-risk, high-utilizer Medicare and Medicaid patients. “The idea is to bring care home to the patients versus them going to the care,” says Jonathan Washko, MBA, NREMT-P, AEMD, assistant vice president, North Shore-LIJ’s Center for EMS.

If a patient has an exacerbation outside of scheduled visits, the patient and family are advised to call CEMS instead of 911. At CEMS’ 24/7/365 command center, nurses sit in the same room as dispatchers so they can offer advice to callers. “If there’s a more concerning clinical situation, the nurses will get the physician on the phone,” says Washko. “If the patient has an urgent change in clinical status that might be able to be managed at home, the physician will ask for a community paramedic response.”

A team consisting of CEMS’ most highly trained paramedics—critical care paramedics or supervisors—is dispatched to the home. A House Calls physician joins them remotely via videoconference. In terms of regulations, New York State doesn’t have an allowance for community paramedicine. But a paramedic can operate as a “physician extender,” provided the physician is a credentialed online medical control physician, says Washko. The House Calls physicians have all obtained that credential and can give the paramedics orders by videoconference or phone.

At the home, the team does a clinical assessment and can provide a range of care, including doing a 12-lead EKG, starting an IV, and giving fluids or medications. If the situation is more serious or if the patient doesn’t improve, the paramedics can transport the patient to the emergency room.

“We’re hovering around the 18% to 20% mark of patients that we respond to and transport, with the remaining group staying at home,” says Washko. That compares to a 90% transport rate for CEMS generally. Washko estimates the program has saved $1.8 million to $2.2 million over the pilot period, based on Medicare payments that were avoided. It has also enabled House Calls physicians to grow their capacity; the MIH-CP program now responds to unscheduled patient calls during regular practice hours in addition to off-hours. Both patient-satisfaction and provider-satisfaction scores are regularly above 90%.

“We think we’re on to something, as many other community paramedic programs are,” says Washko. “And now we’re looking to expand this out to other populations.”

System Controller Deborah Cardillo at the North Shore-LIJ Center for EMS Command and Control Center.
In 2011, CMS selected OSF HealthCare as one of the founding participants in its Pioneer ACO program. OSF remains a participating member of the Pioneer ACO program and also has several pay-for-performance, shared-savings, shared-risk, and capitated contracts with major commercial payers and large employers in its markets. As part of the Illinois Partnership for Health, it was recently selected by the Illinois Department of Healthcare and Family Services to develop a Medicaid Accountable Care Entity that requires transition from fee-for-service to full risk after three years.

How has OSF, an integrated health system owned and operated by The Sisters of the Third Order of St. Francis, embraced these changes in reimbursement structure so swiftly? Bob Sehring, central region CEO, OSF Healthcare System, attributes it in part to early awareness—and acceptance—that things had to change. “There was a growing belief within OSF that the way health care in America is being financed is just not sustainable,” he says. “We believed that change was going to happen. Then the question was, do we let change happen to us or do we try to help shape change as it unfolds?”

OSF’s leadership chose the latter. Sehring says the decision to apply for the Pioneer ACO became a flag to rally around, a point of focus for other, internal changes that were already underway and essential to making the shift to value-based payment. These include introducing the systemwide EMR that now provides the data used to manage the health of populations as well as individuals, expanding OSF’s physician practice from mostly primary care to a multispecialty group, and growing OSF’s home care services.

Alongside these structural changes have come operating changes designed to foster a more integrated delivery system and improve patient care. Examples include integrating care management into OSF’s physician practices as part of their patient-centered medical homes, establishing a practice of rounding in skilled nursing facili-

ties—even though OSF doesn’t own or operate them—and changing the way home health nurses’ appointments are routed to ensure continuity of care.

Fortunately, OSF’s culture was already aligned with the changes. Sister Diane Marie McGrew, OSF, president of OSF HealthCare, says the decision to move toward value-based payments was consistent with the history of her order. “Since our very beginning, we have always taken innovative steps that may have been looked at as aggressive or not the norm, to try new things to provide better care for our patients.”

Sehring is careful to point out, “We still have a foot in two canoes. We still have a considerable amount of the activity that happens at our facilities and with our physicians that is under the old fee-for-service model.” And he acknowledges that managing the transition can be a difficult balancing act, as changes affect fee-for-service revenues. McGrew says that’s where OSF leadership’s commitment to putting the patient at the center plays a key role. “That helps remind us,” she says, “if one canoe gets ahead of another, so to speak, the right decision really is about what’s best for the patient.”
Geisinger’s Mobile Paramedic Program provides an alternative clinical pathway for patients who are discharged from the emergency department but for whom skilled nursing, rehab or home health aren’t viable options. “We wanted to create a nimble, flexible clinical resource that we could deploy rapidly and provide a level of service to the patient,” says David Schoenwetter, DO, FACEP, director of Geisinger EMS and medical director of Geisinger Life Flight.

The program doesn’t focus on patients with specific diagnoses or ED “frequent flyers.” Says Schoenwetter, “We allow clinicians to make clinical decisions, to say, ‘This patient is appropriate for the service.’”

Its three specially trained paramedics are Geisinger employees, and the patients they treat are typically medically complex. “Our mobile integrated health program provides an additional clinical resource for the care management team coordinating outpatient medical management,” says Schoenwetter. “Our mobile health paramedics are highly integrated into our system and will comfortably take care of people who are complex and ill.”

Operating the program with employed paramedics averts regulatory, compliance and credentialing issues. It also means the paramedics can access the same EHR as the referring doctors. “When they’re out seeing a patient for a primary care doctor, the fact that the clinical record is right there is really important,” says Schoenwetter.

The paramedics also have real-time audiovisual teleconnectivity with doctors in Geisinger’s ED command center. “To have the patient able to see the clinician adds support and reassurance as the paramedics are reinforcing the treatment plan the patient needs to be following in the home,” says Kathleen Sharp, senior performance innovation consultant.

The pilot period, which began in March 2014, has yielded dramatic reductions in hospital admissions (from 292 to 133) and hospital days (from 1178 to 579). Sharp estimates more than $2.1 million in charges were avoided, based on patients’ prior utilization. And the program has perfect five-star patient satisfaction scores, with a 60% response rate.

Geisinger staff paramedic Veronica “Roni” Koval can connect with referring doctors via real-time audiovisual teleconnectivity and a common EHR system.

Watchable for:
Technologically Integrated Mobile Health (Rural)
Intermountain Healthcare looked at data from 2008 through 2012 and discovered that its top 5% of high-utilizing patients accounted for 51% of healthcare costs. The top 1% accounted for 24% of costs. One group of patients—about 100 of them—remained in the top 1% throughout the five-year period.

“We mapped out for these patients all the care they received over five years,” says Scott Pingree, Intermountain’s director of strategic planning and chair of hotspotting and high-cost patient care. “For each venue of care, we’d place a mark on the date of each visit to see all the care they were receiving. We reviewed that information with physicians to understand our opportunity to improve continuity of care.”

After carefully studying the data, Intermountain launched pilot projects to better coordinate care for high-utilizing patients. The first, called the Comprehensive Care Clinic (CCC), provides intensive, team-based care, with staff members spending as much time as needed with each patient. While an internist at a regular clinic may see 25–30 patients a day, a CCC internist may see only six patients. CCC staff members, including professionals from pharmacy, behavioral health and care management, address such issues as medication reconciliation and compliance, coordination of lab and imaging services, home care needs, transportation, and claims and payment.

Another pilot project is called Community Care Management. “We meet with the patient in their home, where possible,” says Pingree. “The team focuses on tapping into community resources, providing the patient with referrals and coordinating activity.”

If the inspiration for these programs was data-driven, so too will be their evaluation. Intermountain has put measurement processes in place and made adjustments based on what the data show. “When we were first inviting patients to participate, our process wasn’t as refined, so our participation rate wasn’t very good,” says Pingree. “But we’re getting better at how to contact patients, refining the way we explain what it is we’re doing and how it might benefit them.”

First-year data are still being evaluated, but so far the trends are positive. Pingree emphasizes that Intermountain is truly a learning organization. “We’re still very much in a mode of trying to figure out how to do this,” he says. “Our chief objectives are how can we improve people’s care, is that possible to do, and how can we potentially do it at the lowest appropriate cost?”