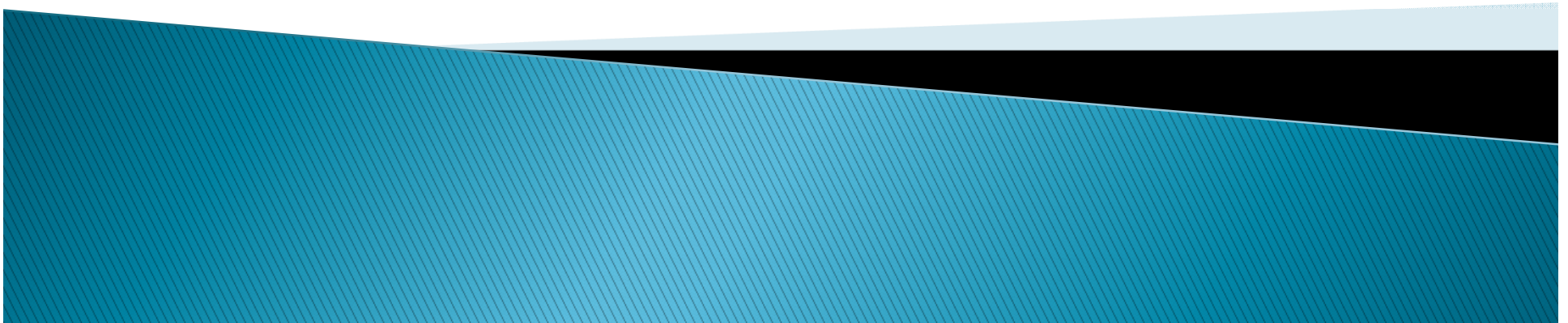


Our Lady of Lourdes Medical Center

Lourdes Medical Center Burlington
County

DSRIP Learning Collaborative

12/10/2015



Project: Care Transitions Intervention Model to Reduce 30 Day Readmissions for Chronic Cardiac Conditions

- ❖ Utilizing Coleman Model, attributed inpatients are identified for program placement.
- ❖ Expanding to include attributed patients discharged from any hospital by using the Camden HIE



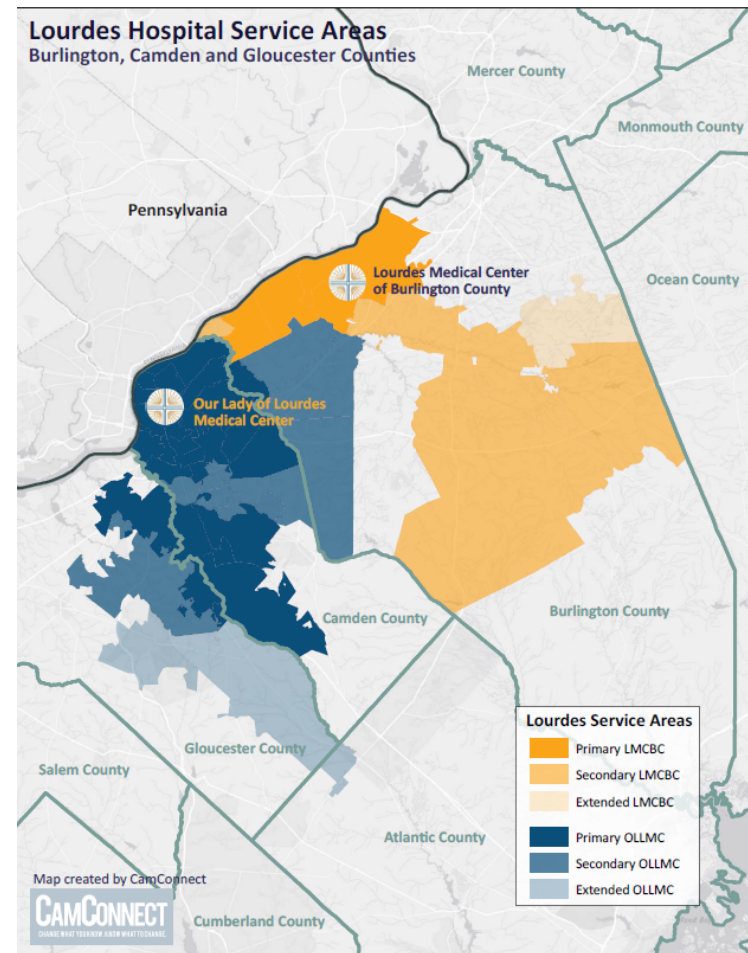
Partners

- ❖ Lourdes Medical Associates
(OLLMC) 6467 Attributed Lives
- ❖ Lourdes Cardiology Services
❖ (LMCBC) 1373 Attributed Lives

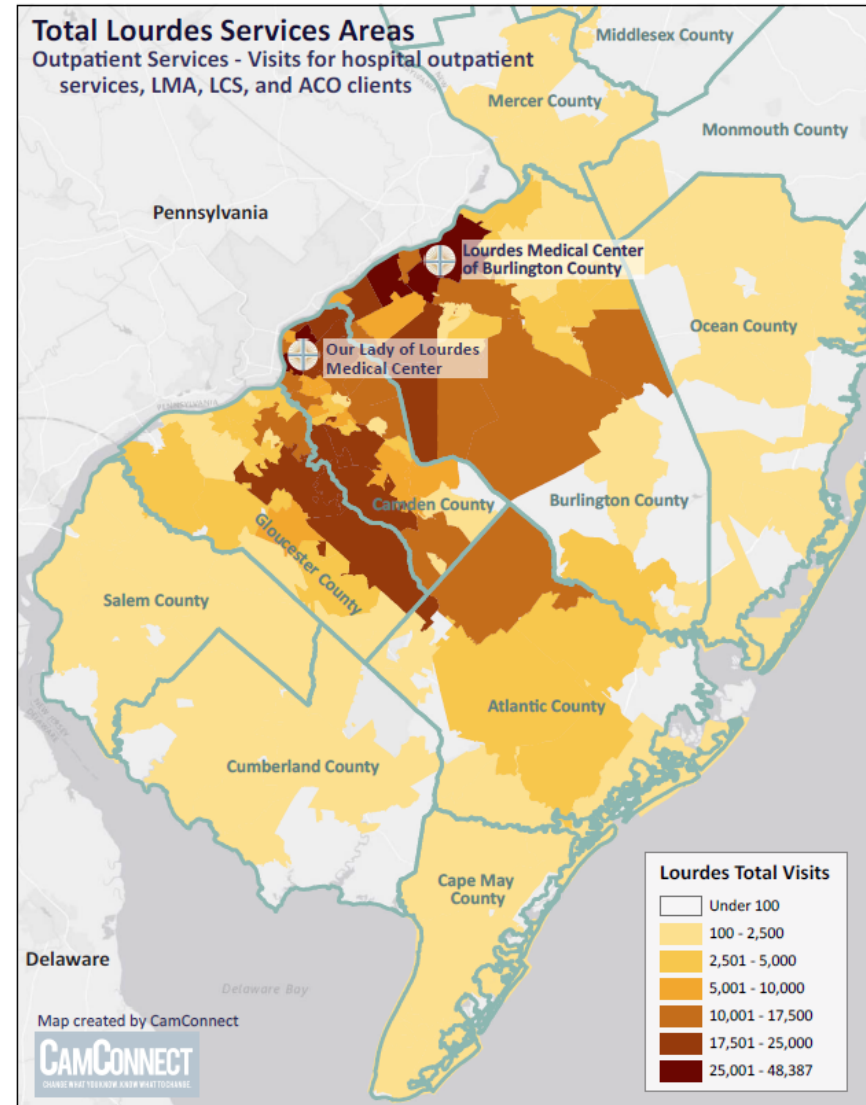


Traditional Hospital Service Areas

Defined as the zip codes that comprise top 80% of our hospital inpatient admissions)

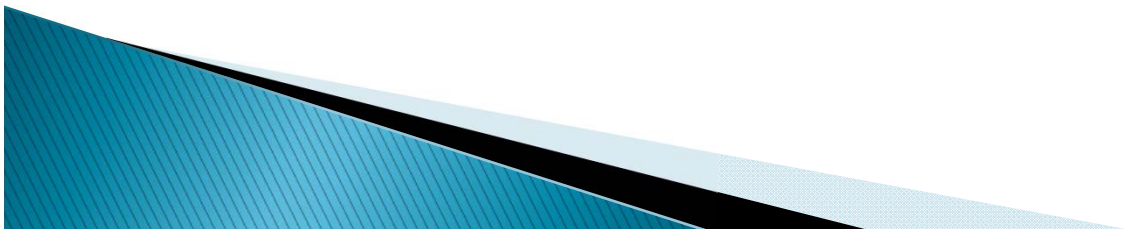


(defined as the zip codes that our outpatient visits come from – this includes hospital based outpatient services, visits to LMA and LCS practices and our ACO clients)



Lourdes Medical Associates (OLLMC)

- ❖ 33 Primary Care Physicians
- ❖ 90 Specialists
- ❖ Osborn Clinic
- ❖ 31 Office Locations



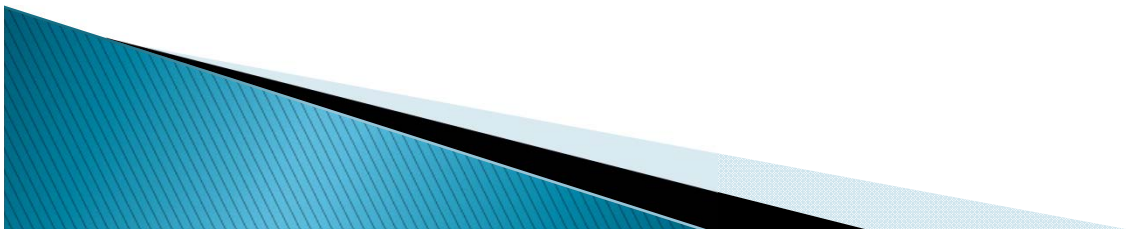
Lourdes Cardiology Services (LMCBC)

- ❖ 53 Physicians
- ❖ 18 Office Locations
- ❖ 4 Heart Failure centers
 - Willingboro
 - Cherry Hill
 - Woodbury
 - Sewell



Communication with Partners

- ❖ DSRIP Quarterly Meetings
- ❖ LCS Quarterly Meetings
- ❖ LMA Quarterly Meetings
- ❖ Integration with Lean Initiatives to treat the Heart Failure Population



Why Partners were selected?

- ❖ Relationship of partners to our health system
- ❖ Staff other nearby hospital health systems
- ❖ Use of Heart Failure Centers staffed by LCS
- ❖ Opportunity to improve communication and care transitions between hospital and outpatient areas for this population group
- ❖ Alignment of partners with other population health initiatives



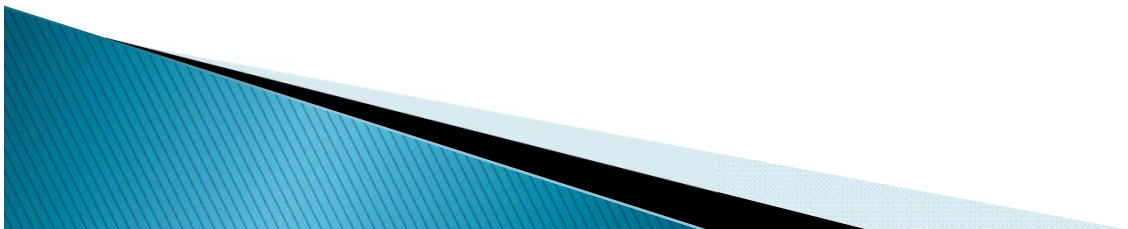
Benefits to Partners

- ❖ Development of relationships
- ❖ Internal process changes



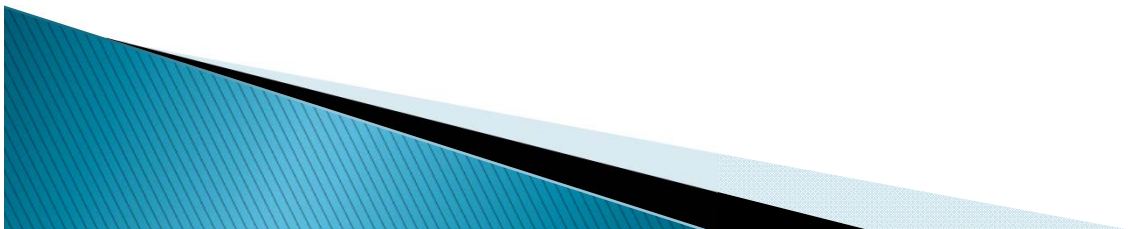
Successes

- ❖ Designated office space in practices for coaching.
- ❖ Priority post-discharge appointments.
- ❖ Follow-up in HF Clinics.
- ❖ Coordination of office visit and coach follow-up.
- ❖ Ability to touch attributed outpatients.
- ❖ Successful completion of metrics
- ❖ Beginning identification of recent LMA and LCS office visits with Cardiovascular diagnoses on attribution list to offer assistance



Challenges

- ❖ Different electronic medical records at LCS and LMS.
- ❖ Practices utilizing paper records
- ❖ Sample methodology was complex(multiple locations)
- ❖ Utilized outside vendor to develop programs and match attribution list.
- ❖ Practices involved in multiple Population Health initiatives that involve metric collection.
- ❖ Lack of HIE in Burlington County



Moving forward

- ❖ Expanding to include attributed patients discharged from any hospital utilizing the Camden HIE.
- ❖ Expanding to include attributed patients seen in the outpatient offices and admitted to any hospital using the Camden HIE.
- ❖ Coordinating care transition that includes timely follow up doctors appointments.

