Improving Care for our SCD Patients

Ruth Krystopolski
SVP, Population Health
The Goal:

To Be The First and Best in Care

Headquartered in Charlotte, NC

$9.9B in Net Operating Revenue in 2017

$5.56M per Day in Uncompensated Care

Network of 46 Hospitals across 3 states

27 Urgent Care Locations

25+ Cancer Care Locations

~3,000 physicians and 65,000+ teammates

Clinically Integrated Network and Accountable Care Organization
Problems to be Solved
High Admissions/Readmissions for Adults 18-35 with Sickle Cell Disease

30 Day Readmission Rate 36.2% (2012-2013)
Average 6 Inpatient/6 ED Visits per Year
• Early Discharge
• Secondary Infections
• Opioid Withdrawals
• Unrecognized or Untreated Comorbid Conditions

Solution Concerns
• Early Outpatient Follow Up average wait of 30 Days
Top 20 Patients

$20M in Charges

$1.2M for Highest Cost Patient
Creating Plans and Setting Goals

• Co-Management Program for Hospitalists and Sickle Cell Team

• Decrease days to Follow Up Appointment

• Follow Patient for 45 Days to address any emotional concerns or Social Determinants of Health

• Reduce 14/30 Day Readmissions by 20%

• Reduce Acute Visits by 20%
Implementation (OCT 2017)

• Establishment of the Transition Clinic
  o Follow up within 72 hours of discharge
• Creation of a Clinical Pathway
• Establishment of Collaborative Patient Care Team
• Integration with CBO
Improving Outcomes

• 39 Patients successfully followed through program

• Reduction of Readmissions for SCD from 23.7-15.27%

• Reduction in 30-Day Readmission Rates of 35.5%
Learning from Our Work

• MAT and ED Care Plans developed for highest need patients
  • Focus resources on High ED/Admits

• Real time alerts for ADT of SCD patients

• Introduction of Community Paramedicine and TeleHealth access

• Addressing SDOH using community and care management resources
Supportive Payment Models

• Development of Hub and Spoke models to support patients and clinicians

• Care Management fees paid for coordination of services

• Targeted Patient Engagement Incentives

• Potential for shared savings/Total cost of care models

• Improvement of payment for innovative delivery of services including use of technology and alternative caregivers