Evolving MediSys: Community-Based Care and Population Health Management

Angelo R. Canedo, PhD
Vice President
MediSys Health Network
So what is MediSys Health Network?

Our network is comprised of:

- Jamaica Hospital Medical Center
- Flushing Hospital Medical Center
- Trump Pavilion for Nursing and Rehabilitation
- A network of 13 Neighborhood-based Ambulatory Health Centers
- TJH Medical Services, PC
- A number of other supporting entities i.e. a DME, staffing and billing entities, etc.
Who we are: MediSys Health Network

- Jamaica Hospital Medical Center
- Flushing Hospital Medical Center
- Trump Pavilion for Nursing and Rehabilitation
- A network of 13 Neighborhood-based Ambulatory Health Centers

- 5,000 employees
- 700 Acute Care beds
- 78 Psychiatric beds
- 30 Chemical Dependency Unit beds
- 2 Transitional Care Units (13 beds)
- 38 Physical Rehabilitation beds
- 224 Long Term Care beds
- Level 1 Trauma Center
- 800,000 Ambulatory Care visits/year
- 200,000 Emergency Department visits/year
- 7 Ambulances serving in the New York City 911 system
- 8th largest physician group in New York City
The MediSys Network: Communities Served
Our Goal

- To use the Medical Home as the engine to move from a hospital centric model to a patient and community centric model
Patient-Centered Medical Home

- Initiated August 2010
- 10 sites at Jamaica Hospital
- Implementation of Electronic Medical Records – August 1, 2011
- Achieved Level 3 status for all 9 sites in December 2012
Working toward Population Health by redefining our services

- Retooling MediSys to become a *Life Care System* by integrating medical care with interventions that also address the social determinants of health
Health Concerns for Our Patients

- **Focus on Jamaica Queens**
  - Take Care NY
  - 2006 Neighborhood Profile
TCNY 8
Get the Immunizations You Need

- Older adults in Jamaica are less likely to get flu shots
- The flu immunization rates among older adults in Jamaica fall short of the 80% TCNY target by more than 30%
TCNY 10
Have a Healthy Baby

The birth rate to teenage mothers (15-19 years) is higher in Jamaica than in Queens overall.

Infant mortality rate (IMR)
The IMR in Jamaica is still higher than the TCNY target.

TCNY Target: <5.0 per 1,000 by 2008
About 1 in 5 adults in Jamaica are obese

11% of Jamaica adults have diabetes

44% of Jamaica adults report not exercising at all
The Big Picture: Heart Health and Death Rates

Heart disease hospitalizations have increased in Jamaica during the past decade.

Heart disease causes the most years of potential life lost in Jamaica:
- Other*: 39% (7,259 years lost)
- Heart Disease: 20% (3,694 years lost)
- Cancer: 19% (3,636 years lost)
- Homicide: 7% (1,283 years lost)
- HIV-related: 7% (1,304 years lost)
- Certain Perinatal Conditions: 8% (1,425 years lost)
Neighborhood Health Highlight: Diabetes

The death rate due to diabetes is higher in Jamaica than in Queens and NYC overall.

Hospitalizations for long-term diabetes complications and lower extremity amputations are more common in Jamaica.
In 2010, senior leadership began to consider the larger picture in terms of patients served by the MediSys Network. Readmissions was the initial driver. It became clear that to truly impact on readmissions, we had to look at community health and population health. The next step is to consider the factors that impact the health of our communities:

- Poverty
- Access to practitioners and medications
- Transportation
- Nutrition
- Medical Home – proper health management once care is accessed

“Life Care” – helping people address their life issues, in order to better manage their health needs.
The MediSys Life Care System: Key Initiatives
Goal: Patient Navigators support the Team based approach by:

- Providing culturally and linguistically appropriate services
- Supporting patient self care
- Referral tracking and follow-up
- Population management i.e. contact patients due for various services

* Funded by a NYS DOH Grant to improve Residency training and improve quality of care for Medicaid recipients
PCMH: Using Technology to communicate with and monitor patients

- MediSys “MyChart”
  - Enables patients to connect with their medical home via the MediSys patient portal
  - Messaging, appointments, requests and maintaining connection with the PCMH

- Technology will also help us develop our “Front Desk” function to track and monitor patients as they move between and among program elements
## Empowering our Patients

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<thead>
<tr>
<th>Seniors Coaching Seniors</th>
<th>Call for Advice Center</th>
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<tr>
<td>A volunteer program of pairs of seniors who call and visit other seniors to provide health coaching and liaison services to the MediSys Life Care System</td>
<td>This program will provide volunteers trained in Coleman coaching model and supervised by RN’s to take patient calls, to answer health questions and refer for more information and follow-up by MediSys</td>
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## Care Transitions and Care Management

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<th>Community Based Care (CBC)</th>
<th>Intensive Multidisciplinary Primary Care Team (IMPACT)</th>
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<tr>
<td>- Nurse Practitioner, Care Coordinator, and Community Care Assistant team that works closely with the patient’s MediSys primary care physician to ensure coordination of health care needs for thirty days after discharge from the hospital.</td>
<td>- Assists patients who need long term care management intervention to manage their health.</td>
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<td>- Interventions are provided in the home and the community to best suit the needs of the individual patient.</td>
<td>- Generally patients living with multiple chronic conditions.</td>
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<td>- Primary Dx served – CHF, Pneumonia, AMI, COPD, DM.</td>
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<td>- Care plan is developed for each patient.</td>
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<td>- Mean length of stay in program is 9–12 months.</td>
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## Activity thus far

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<th>Community Based Care</th>
<th>IMPACT Program</th>
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<td>- Tracking outcomes for first 15 patients transitioned post discharge into community based care model</td>
<td>- Serviced 62 high risk patients thus far</td>
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<td>- Tracking utilization and medical costs pre and post program</td>
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<td>- Also tracking measures for improved management of chronic conditions and patient satisfaction</td>
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<td>- 3 patients readmitted within 30 days</td>
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Additional Programs and Initiatives

- Neighborhood Medical Home (in development)
- Inpatient Care Transitions Team
- Care Transitions (CCTP – CMS) Demo Project
- CHF Readmissions Program
- Telemedicine /Telemonitoring
- TJH Medical House Calls Program
- QCCP Health Home
- CMS/GNYHA Foundation SNF Grant Participant
- Care Managing through EMS
Contact Information

Angelo R. Canedo, PhD, LNHA
Vice President
MediSys Health Network
Tel: 718–206–6595
acanedo@jhmc.org