What happens in Vegas…

…..Could land you in the hospital!

MGM

IEHP Fracture Care Pilot Program

- Agreement with Arrowhead Orthopedics ***and*** Orthopedic Medical Group (OMG)
- Member must be seen in local Emergency Department (ED) for acute fracture
- The treating ED Physician must determine the appropriate level of care

Fracture Care Pilot Program Cont.

- Three levels of care:
  1. If immediate care needed, refer Member directly to Trauma/Ortho Paneled doctor on call at facility for same day service.
  2. Refer directly to orthopedic group at time of ED visit, or within 24 hours. This can be done by calling and scheduling the Member, or giving Member a RX or referral with group's contact info.
  3. Refer Member to their PCP with recommendation for referral to orthopedist within 24-48 hours.

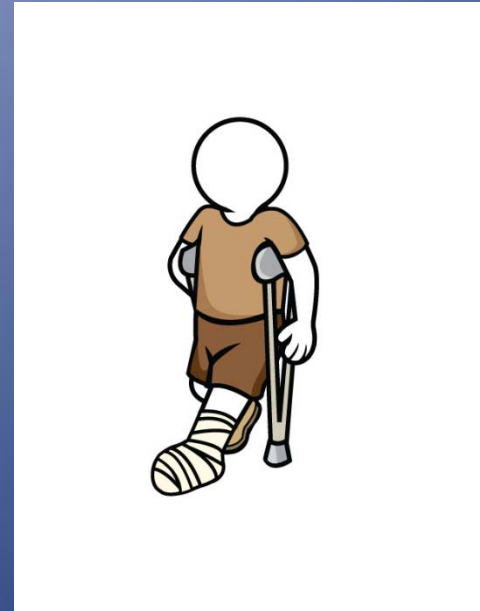
Fracture Care Pilot Program Cont.

- Hospital ED
  - Determine level of care required
  - Assist Member with contact info and/or schedule appointment with OMG or Arrowhead Orthopedics

- Orthopedic Provider
  - During first visit – verify eligibility and identify payer - IEHP/IPA
  - Treat and request authorization from IPA or IEHP
  - Communicate diagnosis and plan of care with PCP

Fracture Care Pilot Program Cont.

- IPA/Medical Group
  - Authorize the treatment and payment for global fracture care, *including* casting materials, x-rays and surgery when necessary
  - Timely claims processing



GOAL

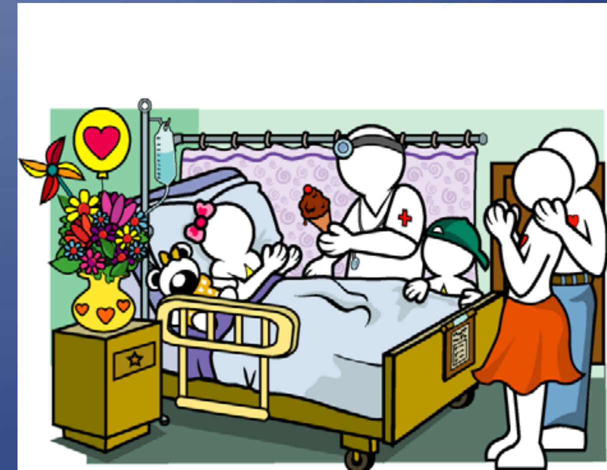
Access to timely
acute fracture care

P
A
R
T
Y

P
A
R
T
Y

Care Transition Pilot Program

- Partnership with Partners at Home (PAH) to provide a care transition program through the Post Acute Support System (PASS)
- Adapted from the Eric Coleman Care Transition Intervention (CTI) program
- Only two facilities – ARMC *and* St. Bernardine's
- Limited to specific Membership: DualChoice *and* Seniors & Persons with Disabilities (SPD)



Care Transition Pilot Program Cont.

- The PASS program focuses on 3 key areas:
  1. Reducing avoidable hospital re-admissions
  2. Providing patient tools and coaching for self-management
  3. Improving overall communication and coordination during the discharge process

Care Transition Pilot Program Cont.

- PASS Coach's interaction with Member:
  - Face-to-face during inpatient admission
  - Face-to-face at home post discharge (48-72 hours)
  - Telephonic follow up – days: 2, 7, 14 & 30 post discharge from facility
  - Medication reconciliation
  - Personal Health Record
  - Connect Members to Community Based Organizations
  - Liaison with providers (i.e. PCP, Specialist, IPA, DME & Home Health Providers)

GOAL

Effective Care Transition Back to the Home & Community

QUESTIONS???

Question #1

What 2 Orthopedic Groups are a part of the pilot program?

Orthopedic Medical Group (OMG)

And

Arrowhead Orthopedic

Question #2

Who determines the level of care a fracture patient needs?

Local ED Physicians

Question #3

What are the 3 Levels of Fracture Care?

1. Immediate Care – Trauma/Surgery
2. Refer directly to one of two Ortho Groups for care within 24 hrs
3. Refer to PCP for referral to Ortho

Question #4

What two specific Memberships are seen by the PASS Coaches?

DualChoice and SPDs

Question #5

What 2 hospitals is the PASS Program at?

Arrowhead Regional Medical Center (ARMC)

And

St. Bernardine’s Medical Center

Question #6

Name one of the 3 key areas the PASS Program focuses on?

1. Reducing re-admissions
2. Provide tools for self-management
3. Improve communication & coordination at time of discharge

GAME TIME!