2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions

Project Objective: To provide a 30-day supported transition period after a hospitalization to ensure discharge directions are understood and implemented by the patients at high risk of readmission, particularly patients with cardiac, renal, diabetes, respiratory and/or behavioral health disorders.

Project Description: A significant cause of avoidable readmissions is non-compliance with discharge regiments. Non-compliance is a result of many factors including health literacy, language issues, and lack of engagement with the community health care system. Many of these can be addressed by a transition case manager or other qualified team member working one-on-one with the patient to identify the relevant factors and find solutions. The following components to meet the three main objectives of this project, 1) pre-discharge patient education, 2) care record transition to receiving practitioner, and 3) community-based support for the patient for a 30-day transition period post-hospitalization.
Additional resources for these projects can be found at www.caretransitions.org and http://innovation.cms.gov/initiatives/CCTP/.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.
2. Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.
3. Ensure required social services participate in the project.
4. Transition of care protocols will include early notification of planned discharges and the ability of the transition case manager to visit the patient while in the hospital to develop the transition of care services.
5. Establish protocols that include care record transitions with timely updates provided to the members' providers, particularly delivered to members' primary care provider.
6. Ensure that a 30-day transition of care period is established.
7. Use EHRs and other technical platforms to track all patients engaged in the project.

Project Response & Evaluation (Total Possible Points – 100):

1. Project Justification, Assets, Challenges, and Needed Resources (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For

example, identify how the project will develop new resources or programs to fulfill the needs of the community.

There were 30,678 "at-risk" admissions within Suffolk County in 2012, which in-turn triggered 1,580 Potentially Preventable Readmission (PPR) chains. Implementation of an effective Transitions of Care (TOC) program could address this high level of PPRs. In addition, access to a primary care provider (PCP) would greatly reduce issues with TOC, however, the ratio of PCPs per 100,000 in Suffolk County (84.9) is below the statewide number (109.6). Sixty six percent of the Medicaid population report difficulty/delay in obtaining healthcare services in the past year (versus 43.8% of the County population). The Medicaid population also experienced significantly more barriers than the County population due to inconvenient PCP office hours or a lack of transportation. Interviews were conducted with 249 key informants from community-based organizations as well as multiple in-person interviews with key PPS Providers and helped determine the following baseline care gaps. No PPS provider is currently providing comprehensive 30 day TOC services for their discharged patients. Inpatient Case Manager (CM) patient risk assessment tools vary in the degree of rigor in their application/adoption. Composition of the multi-disciplinary rounding team/frequency of the use of the team is variable. No dedicated, measured processes to ensure that patients consistently make follow-up appointments and receive medication reconciliation. Few warm handoffs between inpatient and outpatient CM resources within the community. To address these gaps we propose to combine current CM resources with redeployed and newly hired CMs to implement TOC protocols that cross the inpatient/outpatient settings, tightly link with the Health Home (HH), primary care medical home, and community-based behavioral health resources. The model for inpatients encompasses patient risk assessment, multi-disciplinary rounding, enhanced patient communication, and proactive care coordination, with patient-centric information. In the outpatient setting, CM outreach will occur to ensure post discharge follow-up; medication reconciliation and a PCP visit post discharge, all facilitated through EHR communication links and a care management tool/registry. We will develop connections with Medicaid Managed Care Organizations (MCOs) and Health Homes (HH) so that post-discharge protocols are followed.
ADDRESSING IDENTIFIED GAPS. INTER-DISCIPLINARY ROUNDING: will include: Social Worker (SW), TOC nurse, physician, rehabilitation specialist, pharmacist and others. The multidisciplinary team will help to ensure ongoing sharing of information between inpatient and outpatient settings. Discharge planning will begin at admission. The SW will ensure communication with community-based organizations to address potential barriers to care post discharge e.g. transportation, housing, linguistic barriers.
COMMUNICATING WITH TARGET POPULATION: The discharge process will focus on culturally and linguistically competent person-centered care including "teach-backs" and culturally appropriate educational materials at 5th grade reading levels.
FACILITATING WARM HANDOFFS: The TOC protocols will ensure patients consistently keep follow-up appointments, receive medication reconciliation and care coordination. This includes protocols that engage the HH CM, home health agencies and Medicaid MCOs at time of discharge, and may include a CM visit to the hospital, home-visits, follow-up calls and urgent care services while awaiting a post-discharge appointment. If there is no existing outpatient (OP) CM, patients will have a case manager assigned to his/her case.

b. Please define the patient population expected to be engaged through the implementation of

this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

The target population for this project is: 1) Suffolk County Residents 2) Medicaid patients, and 3) Inpatient admissions (excluding normal newborn) in 11 County hospitals. Patients will be identified as being at high risk of readmission through a patient risk assessment tool. Patients at high risk include: the elderly; patients entering from/returning to a Skilled Nursing Facility (SNF); patients with surgery/procedural complications, infections, cardiovascular, gastro-intestinal, pulmonary, behavioral health conditions; and patients who already have a 30-day readmission. The TOC approach will be rolled-out initially to higher volume inpatient facilities that have the highest Medicaid/Uninsured volume, highest readmission and avoidable admission rates. Then it will be spread to include all PPS hospitals.
PILOT PROJECTS TO ADDRESS CARE TRANSITIONS: Creation of an ambulatory care/urgent care center (UCC) for people in immediate crisis while connecting them to ongoing care. The UCC, located near the ED at Stony Brook UH, will serve patients in need of immediate follow-up post discharge as a bridge to outpatient care. This UCC is planned to provide a "fail safe" process for patients to be able to see a provider to address urgent/unplanned events. Mental Health issues are higher among the Medicaid population vs. Suffolk County as a whole. 40.2% of adults/Medicaid population (versus 18.7% of total population) has been diagnosed with a depressive disorder. 54.7% of the Medicaid population has experienced symptoms of chronic depression (27.3% of the County population). We will serve this population with a high degree of behavioral health (BH) comorbidities through the implementation of a community collaborative where a fast-track/warm hand-off relationship is created between the hospital and the community BH provider that can serve these patients' needs. Previously piloted at Southside hospital, this model will be further developed at all PPS hospitals.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

Inpatient CM support is currently available at all hospitals and will be leveraged to support this project. Additional staff for Outpatient 30 day TOC will come from: redeployment of staff from IP units or UM departments, strong relationships with Health Homes who can expand CM capacity, PPS home health agencies who will deploy staff for home visits, and then newly hired/trained CM staff to meet the needs of the project. Three Health Homes currently exist to serve the complex health needs of this population and will be leveraged to continue their foundational support for the highest risk population as well as to learn from their current knowledge of the community and community based resources. Hudson River HealthCare (HRHCare), is an award winning Federally Qualified Health Center (FQHC) network with 25 sites, serving 100,000+ patients in 10 NY counties regardless of their ability to pay. In Suffolk County, HRHCare currently operates 7 practice sites, projected to grow to 9 by 2015. Over the past 2 years, HRHCare has been assuming the licensure and operation of the previous Suffolk County Health Center network, and transforming the sites to reflect HRHCare's existing model which includes PCMH Level 3 designation, JCAHO accreditation, a system wide EHR with comprehensive data analytics, an integrated model of behavioral health and primary care

services, specialty services and comprehensive community based supports. HRHCare is also one of the 3 HH's in the region, actively engaged with over 5,000 Medicaid recipients in the county through contracts with local community based providers. Patient screening, education and engagement are key factors for success of this TOC project. Many IP facilities have experience with patient risk assessment tools such as LACE as well as with various patient education and discharge planning forms and tools. The PPS will use these core approaches as a foundation for the creation of a standardized risk assessment tool and the further development of patient education materials/tools especially to make them more culturally and linguistically appropriate additionally, patient education materials will be sensitive to the diverse health literacy levels of the patients. In addition there are numerous examples of other key resources, current assets and practices that will continue and will serve as a "learning lab" to help the PPS identify and implement new best practices in the TOC process that will further improve outcomes: Southside Hospital and Brentwood Family Health Center have CM for PCP follow-up and home visits for high risk patients and a relationship with Family Service League for patients in their ED with behavioral health concerns. Mather has interdisciplinary rounding each morning where the question is asked, "Why is this patient still here?" Discharge rounding like this would be useful, we will use it as a model for other sites. StonyBrook University Hospital (SBUH) has a "BOOST" program that includes a nursing/social worker team that provides discharge transition care and at least one post-discharge home visit. SBUH's IT platform ensures communication from the inpatient setting to the outpatient setting, regardless of the PCP's affiliation.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

PATIENT CHALLENGES 1)Lack of transportation results in missed follow-up appointments post hospital discharge. 2)Many patients need to be discharged to a SNF, however a number of long-term care facilities are reluctant to take Medicaid patients which delays the patient's disposition. 3)Homelessness places patients at risk of readmission. PATIENT REMEDIES: 1)Expansion of Suffolk County Accessible Transportation (SCAT) program; work to streamline the process to make transportation services more accessible to the patient. 2)Forge relationships with all PPS SNFs. Ensure that the payment model creates alignment of the SNFs with the purpose of the PPS. 3)Multi-disciplinary teaming that includes a SW from the time of admission will be built to address these potential issues.
PROVIDER CHALLENGES: 1)Lack of available PCP or BH appointments for post-discharge visits. 2)Coordination of handoffs between multiple entities can be difficult and the patient may receive conflicting messages. PROVIDER REMEDIES: 1)Additional appointments will be available as practices become more efficient through PCMH implementation. PCP recruiting efforts will occur and the collaborative with BH providers will ensure improved access. 2)Protocols will be established to ensure early notification and avoid duplication of effort: a)Hospital must alert PCP office, Health Homes and CM b)Discharge summaries transmitted electronically within 24 hours c)The PCP – Hospitalist communication exceeds simply the discharge summary.
INFRASTRUCTURE CHALLENGES: 1)Difficulty redeploying or hiring the CMs required for the program 2)Lack of interconnectivity and use between existing EHRs and the RHIO.

INFRASTRUCTURE REMEDIES: 1)The PPS will leverage existing Health Homes capability/capacity and then work together as a PPS to identify sources of CM's to redeploy and to hire. Overarching management structure will ensure appropriate risk stratification and effective use of CM resources. 2)Effective implementation of the PPS's IDS IT strategy to create this route for information sharing and communication.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

3. <u>Speed of Implementation/Patient Engagement</u> (Total Possible Points - 40): DSRIP projects w

funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

4. <u>Project Resource Needs and Other Initiatives</u> (Not Scored) a. Will this proje

Yes	No
☒	☐

If yes: Please describe why capital funding is necessary for the Project to be successful.

Technology: Upgrades to EMR platforms that are needed to track all patients engaged in the project and enable integration with care plans. Population Analytics Tools – Investments in risk stratification tools such as LACE for identifying cohorts of patients at the highest risk of readmissions. Physical UCC facilities: Creation of an ambulatory care/urgent care center (UCC) for people in immediate crisis while connecting them to ongoing care.

Care Management – The major capital resources for care management (tele-health, space, technology, equipment etc.) are included in the IDS project but will be allocated to this project on a proportional basis.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☒	☐

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
PROHEALTH Care Associates, LLP	Medicare Shared Savings			In addition to Medicare Shared Savings program, PROHEALTH also has several value-based incentive programs that focus on their Managed Medicaid population
St. James Rehabilitation and Healthcare Center	NY RAH Project	September 23, 2012	September 22nd, 2016	Reducing Avoidable Hospitalizations

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Central Nassau Guidance & Counseling Service	Beloved Incentive Program Funding		Funding until 8/2015	Home and Community based care transition to SMI
Dominican Sisters Family Health Service				Designated Community Based Organization for CMS:CCTP (Community Based Care Transitions Program for high risk Medicare beneficiaries being discharged from Stony Brook University Hospital and Southampton hospital. High Risk patients receive the Care Transistions Intervention. Care Transitions Coach makes a hospital visit initiating the CTI, one home visit and weekly follow-up calls

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Long Island Association for AIDS Care	Health Homes			Case management/ care coordination
Sayville Project -Stony Brook University	NYS Medicaid Health Home Initiative			Care management to persons w/ chronic health and behavioral health population
Sayville Project -Stony Brook University	Suffolk County Discharge Planning - Care Coordination Initiative			Assist to improve outcomes for persons discharged from inpatient psych hospital units to Care management in the community
Sagamore Childrens Center	Reinvestment $ from Sagamore building mobile integration teams	began 10/14		Mobile team to prevent hospitalizations, ensure aftercare follow-up, parent teaching/coaching to respite
Outreach Development Corp.				Care Coordination Program with FEGs Health Home

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Central Island healthcare & Daleview Care Center				NuHealth DSRIP

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

The programs listed above provide support to this PPS project through various means that primarily include the sharing of important information about their efforts. This includes such items as the sharing of comparative information about expected gaps in care, the type of community resources that have been found to be available, and sharing of information about individual patients that they may have been touched. However, in no case do these programs specifically duplicate what the PPS intends to accomplish with this project to be able to meet the specific project requirements. All staffing and resources that need to be applied to make this project successful do not duplicate the resources used by these existing community programs, they are complimentary. In particular all PPS efforts will be highly aligned with the local Medicaid Health Homes, which are taken into account as an existing form of care support that will not be duplicated in this project.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be

assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.