2.b.ix Implementation of Observational Programs in Hospitals

Project Objective: This project will reduce inpatient admissions vis-à-vis the creation of dedicated observation (OBS) units for patients presenting to emergency departments (EDs) whose need for inpatient services is not clearly defined or who need limited extended services for stabilization and discharge.

Project Description: While observation beds are not new to hospitals, the goal of this project is to bring care coordination services to the unit in order to ensure continuity of care with community services. Short stay hospitalizations are often related to ambulatory-sensitive diagnoses. These admissions can be avoided with improved access to primary care and behavioral health services, as well as with compliance to evidence-based clinical guidelines by the practitioner and patient. Health literacy, community values, and language may be barriers to connectivity of the patient with necessary health care services. Appropriate communication may assist with removing these barriers.

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. Establish appropriately sized and staffed observation (OBS) units in close proximity to ED services, unless the services required are better provided in another unit. When the latter occurs, care coordination must still be provided.
2. Create clinical and financial model to support the need for the unit.
3. Utilize care coordination services to ensure safe discharge either to the community or a step down level of service, such as behavioral health or assisted living/SNF.
4. Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.
5. Use EHRs and other technical platforms to track all patients engaged in the project.

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

1. <u>Project Justification, Assets, Challenges, and Needed Resources</u> (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.

CNA data indicates the need for additional medical observation units because: 1)27% of

Medicaid admissions are short-stay 2)Top drivers of short-hospital stays for Medicaid patients are non-specific chest pain, epilepsy, asthma, and behavioral health where a 72 hour stay is considered short. Key Informant Interviews conducted with community-based organizations and with PPS PAC meeting participants provided the following information regarding gaps in care: 1)The current process for observation status commonly caused situations in which: "the patient got lost up on the floor" or "stayed longer than they needed to", highlighting the need for a dedicated approach. 2)Case management (CM) and social work (SW) support are not targeted toward the OBS population, nor are there direct links back to the primary care physicians (PCP), behavioral health (BH) provider or skilled nursing facility (SNF) CNA data indicates the need for additional psychiatric observation units: 1)15%-20% of patients admitted to psychiatric units across the PPS had a short stay. 2)At South Oaks Hospital, 21% of all adults and 18% of adolescents had a stay < 4 days (Extended Observation Beds (EOB) is categorized by OMH as 72 hours). Key Informant Interviews provided information that additional EOBs are needed, because there is: 1)A trend in Behavioral Health (BH) toward reduced length-of-stay, making EOBs an effective option. 2)Unnecessary transports of patients from Comprehensive Psychiatric Emergency Programs (CPEP) to other hospitals due to the lack of an EOB option. 3)A reduction of BH beds across the County, resulting in a need to reserve inpatient unit capacity for only those who need a longer stay. 4)A need for EOB capacity to observe patients with co-occurring psychiatric and substance use disorders to connect people to resources and help prevent suicides.
OVERVIEW OF PROJECT: Develop effective observation unit processes that enhance care coordination and implement standard protocols to address patient needs, thereby reducing unnecessary admissions. Identify patients who need observation services and provide a team-based process either in a dedicated or virtual observation unit. There will be 2 components: 1) implementation of best practices in observation care and CM services; 2) interventions in several targeted hospitals to create dedicated observation units.
ADDRESSING IDENTIFIED GAPS: To promote best practices, standardized processes will be established including: screening tools, risk assessments, and standard workflows. 1)Centralized bed admission process with level of care screening criteria (including education for ED and admitting physicians). 2)Direct admission to observation unit from PCPs and SNFs. 3)Patient risk stratification tool to identify need to escalate to higher level of intervention. 4)Standards for CM and SW interventions. 5)In-hospital processes for rapid testing, short turnaround times for diagnostic studies. 6)Multi-disciplinary rounds 2x/day with multidisciplinary team. 7)Discharge process which includes enhanced communication: hospital to PCP/BH provider, SNF or Health Home. 8)24/7 discharge capability to address all discharge barriers such as transportation, Home Health and Durable Medical Equipment (DME). 9)Advanced arrangements established with SNFs for timely acceptance of patients.

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 first component of the project is to implement best practices in observation care in virtual

or dedicated units. This will include a focus on Suffolk County residents who are: 1)Medicaid beneficiaries 2)Admissions designated as observation status in all PPS participating hospitals 3)Cases that would be avoidable IP short stays, particularly those due to ambulatory sensitive conditions.
We will develop a methodology of identifying ED patients who need further care but whose anticipated stay makes the patient a candidate for observation. This methodology will include an electronic tool to identify these patients based upon validated criteria such as the Emory Model and Milliman criteria. The second component of the project to create dedicated medical observation units or EOBs will target patients at the following facilities due to identified need in those locations: 1)StonyBrook University Hospital (SBUH) and Southside Hospital (SSH) will develop specific units for medical observation. These hospitals have a large number of short stay admissions amongst the Medicaid population. 2)Southside Hospital (SH) will develop an approximate 12-bed unit for medical observation. 3)Stony Brook University Hospital (SBUH) will expand from a 10 to 30-bed unit.
SBUH, SSH and Sagamore will develop or expand EOBs. 1)EOBs at SBUH will be expanded from 6 to 12 beds. SBUH will ask for a waiver to locate the beds in a discrete unit where care coordination will be a primary focus. 2)SSH will establish 6 EOBs and 3)Sagamore will establish 3 EOB's. Since Southside and Sagamore do not have a CPEP, both will request a waiver of the requirement that EOBs be located in/adjacent to CPEP. SSH has an established relationship with Family Service League in Bayshore to take warm handoffs from the ED. This relationship would extend to these EOBs.

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.

Existing Inpatient CM and Social Work (SW) support is currently available at all hospitals and will be leveraged to support this project. The care management team for a dedicated/virtual observation unit will be composed of a CM, SW, pharmacist and hospitalist/ED physician with linkage to a BH resource. Assigned CM and social support staff will be hospital-based, employed by the hospital – but linked tightly to PPS care management governance that ties them to CM staff involved in TOC and in the Outpatient/PCP office CM processes. The presence of the SW on the team will allow hospitals to address issues of housing, transportation, etc. which impacts success. Additional staff for the development of specific Medical OBs units and EOBs will come from: redeployment of staff from IP units or UM departments. A reduction in admissions over time will allow some of these staff to be re-deployed to the team that focuses on observation admits. Newly hired/trained physicians, nurses, support staff and CM and SW staff will then be additionally needed to meet the needs of the project. Three Health Homes currently exist to serve the complex health needs of this population. Their CMs will be leveraged to provide input on discharge planning and necessary follow-up as an outpatient. This will include visits to the inpatient setting to see the patient prior to their discharge. They will also be a source to learn from with their current knowledge of the community and community-based resources that may help to meet the patient's needs after discharge. For the new or expanded EOBs, existing hospital space will also be leveraged with modifications as needed. Existing staff, supplemented with new staff, in Stony Brook and Southside with psychiatric expertise will be deployed/redeployed to support the program. The existing relationship between Southside

Hospital's ED and Family Service League will be leveraged and expanded to ensure appropriate OP follow-up is in place for the patient after the EOB admission. Hudson River HealthCare, an organization managing Federally Qualified Heath Centers (FQHCs) across multiple NY counties, is a key asset in this observation care process with its current plans to assume management of all six former Suffolk County DOH clinics. With the high volume of Medicaid and Uninsured patients they serve in the primary care setting, they will be leveraged to create strong connections from the Observation care team back to the primary care medical home.

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.

INFRASTRUCTURE CHALLENGES: 1)Ability to implement best practices across the PPS. 2)Limited communication across diverse providers. INFRASTRUCTURE REMEDIES: 1)Focus on staff/physician training to ensure best practices, a performance management process within the Quality Assurance program will be developed. 2)Optimization of EHR and the RHIO to provide for better communication between hospital and PCP or SNF or Intermediate Care Facility will create better communication linkages across the PPS.
PROVIDER CHALLENGES: 1)Significant variation between hospitals for definition of OBS status 2)Facilities where even a "virtual" OBS unit can create issues with staffing and economies of scale due to their low volume of admissions. 3)Limited access to primary care visits, particularly in underserved areas. 4)The need for effective communication with a population with limited health literacy. 5) Overall provider participation. PROVIDER REMEDIES: 1)Establish protocols for identifying patients who qualify as OBS utilizing an IT system for decision-making for OBS status admission. 2)Share best practices in the effective use of existing resources, including redeployed staff from other functions. 3)Increase primary care capacity through support by safety net PPS PCPs such as Hudson River Health. Additional PCP access will be available as practices become more efficient through implementation of PCMH/Advanced Medical Home. 4)Staff training on cultural competency, translate patient education materials and ensure 5th grade reading level. 5) Align providers through pay for performance incentive
PATIENT CHALLENGES: 1)Challenging socio-economic barriers and disparities in care. 2)Potential patient "no-shows" for post discharge appointments. 3) Issues with transportation that may delay an effective discharge. PATIENT REMEDIES: 1)Multidisciplinary teaming that includes a SW from the time of admission can address these issues. 2)Link into an effective PPS 30-day TOC process. Leverage the relationship with Health Homes and with FQHCs who care for a significant volume of these patients. 3)Expansion of Suffolk County Accessible Transportation, help streamline the process to arrange transportation assistance to make it more accessible to the patients.

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. Scale of Implementation (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. Speed of Implementation/Patient Engagement (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more 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. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

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

The current observation unit infrastructure in Suffolk County needs an overhaul. This extends to the extended observation needed for psychiatric patients. We anticipate capital costs as listed below:
Facility Costs - For Stony Brook Hospital will require finding for the development of a dedicated 20 bed medical observation unit. Southside Hospital will require funding to develop their 12 bed medical observation unit.
EOB Facility Costs – EOBs will be expanded at Stony Brook (approx. 6 beds) and created at Southside Hospital and at Sagamore Hospital (if CPEP waivers are received). For Stony Brook's expansion of psychiatric Extended Observation Beds (EOBs), capital is required for the renovation of an existing unit where space will be made available for the relocation of 6 current EOBs and for the add-on of 6 more, totaling 12 EOBs. The unit will have to be reestablished as in inpatient-like unit to meet required codes, including the elimination of all loopable hazards and appropriate program and clinical space. For Southside's expansion, the capital is also

requried all of the reasons stated above. At Sagamore funding is needed in order to make minor alterations to the facility.
Technology: Capital equipment/ modalities (e.g., telemetry instrumentation) needed to equip an observation unit adequately will be needed for equipment such as telemetry monitoring for all beds.
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
Long Island Association for AIDS Care	Health Homes			Case management/ care coordination

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives

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. <u>Domain 1 DSRIP Project Requirements Milestones & Metrics:</u>

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.