Suffolk Care Collaborative

Consolidated Project Information

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

Contents

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

2.b.iv Project Objective & Requirements

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.

The project must clearly demonstrate the following 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.

2.b.iv Requirements Matrix by Provider Type

	Primary Care Physicians	Non-PCP Practitioners	Hospitals	Health Home/Care Management	Community Based Organization	All Other	PPS Project Level
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.							X
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.							X
3) Ensure required social services participate in the project.							X
4) Transition of care protocols will include early notification of planned discharges and the ability of the transition case manager to visit the patient in the hospital to develop the transition of care services.	X	X	X				X
5) Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.							X
6) Ensure that a 30-day transition of care period is established.							X
7) Use EHRs and other technical platforms to track all patients engaged in the project.							X

2.b.iv Milestones & Metrics

Color Legend
Project System Changes
Project Requirements with Specific Time Periods
Project Requirements tied to PPS Speed and Scale Commitments

Project Requirement		Metric/Deliverable	Data Source(s)	Unit Level (subject to change per DOH)
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.	Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.	Documentation of process and workflow including responsible resources at each stage of the workflow; written training materials; completion of training documentation as necessary	Project
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.	A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.	Payment Agreements or MOUs with Managed Care Plans	Project
		Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.	Documentation of methodology and strategies including identification of responsible resources at each stage of the workflow; Periodic self-audit reports and recommendations; Written attestation or evidence of coordination of care transition strategies with Health Homes and the supportive housing site	Project
		PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.	Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained	Project
3	Ensure required social services participate in the project.	Required network social services, including medically tailored home food services, are provided in care transitions.	Support Services Lists; Documentation of process and workflow including responsible resources at each stage of the workflow; Written attestation or evidence of agreement; Periodic self-audit reports and recommendations	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 in the hospital to develop the transition of care services.	Policies and procedures are in place for early notification of planned discharges.	Documentation of early notification of planned discharge process and workflow including responsible resources at each stage; Written training materials; List of training dates; Number of staff trained	Provider
		PPS has program in place that allows case managers access to visit patients in the hospital and provide care transition services and advisement.	Contract; Vendor System Documentation, if applicable; Other Sources demonstrating case manager access to the system	Project
5	Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.	Documentation of care record transition process and workflow including responsible resources at each stage; Written training materials; List of training dates; Number of staff trained; Periodic self-audit reports and recommendations	Project
6	Ensure that a 30-day transition of care period is established.	Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.	Policies and Procedures	Project
7	Use EHRs and other technical platforms to track all patients engaged in the project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

2.b.iv Active Engagement Definition

The active engagement definition for project 2.b.iv is defined as the number of participating patients with a care transition plan developed prior to discharge who are not readmitted within that 30-day period.

Project	# of Actively Engaged	Attributed Population	% of Attributed	Definition of Actively Engaged	Counting Method
2.b.iv	25,326	148,118	17%	Care Transition plan developed	2

The purpose of counting methods is to estimate the number of patients that will be impacted by a particular project. This feeds the patient scale portion of the application.

Each counting method should be used in conjunction with the definition of "actively engaged" patients for that project.

Summary of counting method 2:

- Counted within a DSRIP year; resets each year
- Each encounter is counted
- Patients counted more than once if multiple encounters occur

e.g., if a patient receives TOC care plans on 5 discharges in a year, we count it 5 times in that year

2.b.iv Speed and Scale Submission

Scale is a measure of the magnitude of providers in the project and the volume of patients affected. Speed is a measure of how quickly project requirements are executed and how quickly patient impact occur. Speed and Scale represent 80% of the points for each project application – and therefore, most significantly impact initial valuation.

Project Implementation Speed for Project 2.b.iv

Project	**DY 0 (2014)**		**DY 1 (2015)**		**DY 2 (2016)**		**DY 3 (2017)**		**DY 4 (2018)**	
	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4	Q1-2	Q3-4
2.b.iv – TOC						**X**				

Patient Engagement Speed for Project 2.b.iv

Patient Engagement Speed	**DY0 (Baseline)**		**DY1**		**DY2**		**DY3**		**DY 4**	
	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4	Q1/Q2	Q3/Q4
Number of *Actively Engaged* Patients	0	0	6354	15255	10170	25326	12713	25326	12713	25326
Expected # of Actively Engaged Patients	25326	25326	25326	25326	25326	25326	25326	25326	25326	25326

Rationale for Project 2.b.iv

The rationale related to project 2.b.iv implementation speed is as follows:

- Project Implementation occurs at hospitals and most hospitals are currently doing some form of Care Transition plans. This allows for more rapid implementation.
- The Largest barrier to rapid project implementation is constructing a IT platform to document all Care Transition plans

The rationale related to project 2.b.iv patient engagement speed is as follows:

- For this project, Actively Engaged is defined as the number of participating patients with a care transition plan developed prior to discharge.
- Patients are counted over a 1 Year measurement period. Duplicate counts of patients are allowed, provided that they meet the criteria more than once. The count is not additive across DSRIP years.

The patient scale rationale is calculated as detailed below.

Total Medicaid Discharges (Including Article 31 Hospitals) less CHS Discharges	=	30,052 Discharges
Less Newborns (3,700)	=	26,352 Discharges
Less expected conversions to OBS (996)	=	25,356 Discharges
Expected # of Actively Engaged Patients	=	**25,356 Patients**

References

Please see pages 15-23 in the Suffolk Care Collaborative DOH Application for additional project related information.

http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/stony_brook_university_hospital/stony_brook_project_plan.pdf