Suffolk Care Collaborative
Transitions of Care Project for Inpatients and Observation Units

2biv. Care transitions intervention model to reduce 30-day readmissions of chronic health conditions &
2bix. Implementation of Observation Programs in Hospitals

Project Charter

Through the Delivery System Reform Incentive Payment (DSRIP) Program, a grant waiver administered by the NYS DOH, $6.42 Billion Medicaid dollars were allocated to fundamentally restructure the health care delivery system to transition care delivery from a largely inpatient-focused system to a community-facing system that addresses both medical needs and social determinants of health. DSRIP is a 5-year, performance payment-based program with primary goal of reducing avoidable hospital use by 25% over 5 years. At the end of program life, the aim is for the newly-transformed system to be sustainable. Project efforts are focused on achieving improved overall health through integration of behavioral health and primary care, provision of appropriate levels of care management, and care delivery models designed to improve chronic disease prevention and outcomes.

Objective Statement:

To provide a 30-day supported transition period after a hospitalization to ensure discharge directions and plans are understood and implemented by and for e patients at risk of return to acute care, particularly patients with cardiac, renal, diabetes, respiratory and/or behavioral health disorders (2biv).

To establish appropriately sized observation units (either dedicated beds or scattered beds) in all hospitals in the county to reduce short stay admissions, thereby minimizing Potentially Preventable Readmissions (2bix).

High Level Deliverables:

- Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.
- 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.
- Ensure required social services participate in the project.
- Transition of care protocols may include early notification of planned discharges and the ability of a transition care manager to visit the patient while in the hospital to develop the transition of care services.
- Establish protocols that include care record transitions with timely updates provided to the member's providers, particularly to members' primary care provider.
- Use EHRs and other technical platforms to track all patients engaged in the project.

- Establish appropriately sized and staffed 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 be provided.
- Implement standard 30-day care coordination methodology for safe discharge with inpatient and observation patients (short stay) protocol
- Hospital EHR Meets Meaningful Use Stage 2
- Hospital EHR Meets connectivity to RHIO's HIE and SHINY-NY requirements

Benefits:

There were 30,678 "at risk" admissions within Suffolk County in 2012, which in turn triggered 1,580 Potentially Preventable Readmissions (PPR) chains. Implementation of an effective Transitions of Care (TOC) program could address this high level of PPRs.

Assumptions:

- Significant cause of avoidable readmissions is non-adherence with discharge regimens as a result of language issues, health literacy, and lack of engagement / access with the community health care system.

Constraints:

- Project budget, available workforce, and resources to contribute to implementation and the sustainability of the project
- Lack of electronic connectivity between providers, facilities, hospitals, and SNFs within the community
- Communications challenges and barriers as well as real time information

High-Level Risks:

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 due to increased difficulty of providing care management services to this population.

Patient Remedies: 1) Expansion of Suffolk County Accessible Transportation (SCAT) program; the PPS will work to streamline the process to make transportation services more accessible to the patient. 2) The PPS will forge collaborative relationships with all participating SNFs and ensure that the payment model creates alignment of the SNFs with the purpose of the PPS. 3) A Multi-disciplinary teaming process that includes a social worker/CHA/CHW may be engaged to address these potential issues. The social worker/CHA/CHW will work closely with PPS CBO's to reach patients in their communities in an effort to educate and engage them in their own health and monitor their progress towards adequate self-management of disease.

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. 3) Providers might be at different stages of readiness for meeting project requirements

Provider Remedies: 1) As relevant PPS providers move towards NCQA PCMH Level 3 status, additional appointments will be available as practices become more efficient. PCP recruiting efforts will occur and the collaboration with BH providers will improve access. 2) Protocols will be established to provide early notification of discharge and avoid duplication of effort. This will be accomplished in the following ways: a) Hospital alert to PCP office, Health Homes and CM b) Discharge summaries transmitted electronically within 24 hours c) The PCP – Hospitalist communication provides requisite information to support the TOC. 3) PPS will develop provider prioritization plan to provide the appropriate training to providers and develop plan for a staged roll-out project implementation

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. Training resources will be made available through the creation of a Provider Engagement team to engage the redeployed staff in appropriate training programs (e.g., online, in person, etc.). Additionally, the PPS may elect to is actively searching, through collaboration with a vendor or existing CMO's partner for enough CM's to be effective in providing CM services across Suffolk County. Overarching care management structure will ensure appropriate risk stratification and effective use of CM resources. 2) Effective implementation of the PPS's IDS IT strategy, and an emphasis on continual improvement, will enable the PPS to create this route for information sharing and communication.

Success Criteria:

- Successful completion of all Domain 1 requirements, including meeting patient engagement and project engagement commitments
- Improvement throughout DSRIP Measurement Years across all Domain 2-3 outcome measurers (achievement of 10-20% gap to goal)
- Overall achievement of project objective
- Sources that influenced the development of the program is accepted by public, community and key project stakeholders

Stakeholder Analysis:

The Transitions of Care Project will include PPS partners from across the continuum of care including hospitals, CBOs, SNFs, Health Homes, MCOs, home care agencies, and other social service agencies. Care management and coordination of care will be key to the success of the project and preventing avoidable readmissions to the hospitals. The Suffolk Care Collaborative's

Care Management program will add additional resources to existing agencies and resources within the county.

Closeout Criteria:

- Close out will be managed during the monitoring phase of the project lifecycle and is tentatively scheduled for period ending March of 2020
- Evaluate and ensure all Archive Data and final project records/documents are filed in a secure location and appropriate to demonstrate achievement of DSRIP metric/project commitments within Domain 1 - 4
- Archive all project data in a central repository. Include best practices, lessons learned, and any other relevant project documentation.
- Verifying acceptance of final project deliverables/ data sources by the NYS DOH
- Completion of the post-project assessment and lessons learned
- Completion of post-project review and evaluation

Project Strategy:

The Suffolk Care Collaborative is in the process of building a care management organization to support the TOC program goals. Under the direction of the SCC, transition care managers will provide support for a high risk patient post-discharge for 30 days. These care managers will link Health Home, primary care medical home, and community based behavioral health resources for patients post discharge. The model encompasses patient risk assessment, multi-disciplinary rounding, enhanced patient communication, and proactive care coordination, with patient centric information. In the outpatient setting, care management 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. The SCC will also create county-wide partnerships with existing social service, home care, care management, community based organizations and align with MCOs and Health Homes to ensure that post-discharge protocols are followed. The Transition of Care Plan that will be designed will be a collective effort of all parties described herein to create a valuable program for all Suffolk County hospitals.

In the acute care setting, the interdisciplinary team may include: Social Worker (SW), TOC/ primary nurse, physician, rehabilitation specialist, pharmacist and others. The multidisciplinary team will help to ensure ongoing sharing of information between acute care and community settings. Discharge planning will begin at admission. Follow up will ensure communication with community-based organizations to address potential barriers to care post discharge e.g. transportation, housing, linguistic barriers. The discharge process will focus on culturally and linguistically competent person-centered care including “teach-backs” and culturally and health literacy appropriate educational materials.

The TOC protocols will ensure patients more 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 as available. 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.