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Project goal

Immediate: Implement the SCC TOC Model, demonstrated by real time identification of patients at high risk of readmissions, early notification of patient and partners of planned discharge, provision of written TOC plan, timely completion of the discharge summary, and initiation of a 30-day transition of care period with PCP updates post hospitalization. Hospitals will also establish appropriately sized observation units (either dedicated or scattered beds) to reduce short stay admissions, thereby minimizing potentially preventable readmissions (3M).

Long-term: Reduce potentially preventable emergency room visits (3M) and potentially preventable readmissions (3M).

Interventions

The TOC Model was developed to improve the identification of patients at higher risk for readmissions and improve the discharge and post-hospital process to reduce future readmissions in collaboration with PPS partners across the continuum of care. TOC providers will provide a 30-day support transition period to identified high risk patients to reduce potentially preventable readmissions and emergency room visits. Each hospital will have the opportunity to partner with SCC CMO or utilize their own TOC services and personnel to meet patient and project requirements. Hospitals will establish relationships and partnerships with home care and social service providers, such as medically tailored home food services, to ensure appropriate social service and home care agencies are included in discharge planning and transitional care services. The hospitals will also identify community based TOC providers, including health homes, as partners in providing transitional care to high risk patients. Medicaid patients will be considered high risk and receive the 30-day support transition period if they meet any or all of the high-risk criteria, readmitted within 30-days of a previous hospitalization; history of 3 or more hospitalizations (inpatient or observation) in the past 12 months; any behavioral health comorbidity; unmet social needs identified via a social needs screen within 24 hours of admission. Early notification of planned discharge is established and maintained in hospital protocols emphasizing early identification/response to high risk patients to avoid adverse events that lead to acute care visits. This protocol also outlines that patients and TOC providers will be notified of planned discharge no later than 24 hours in advance. Patients that do not have a PCP will be assigned one by a member of the care team prior to discharge. Upon approval by the hospital, the TOC provider will visit the patient prior to discharge to provide care transition services as approved and properly credentialed/on-boarded by the hospital. It is required that the patient receives a written TOC plan prior to discharge that includes patient self-education written at an appropriate health literacy level, reconciled medication list, and a follow up appointment. Discharge summaries will be completed within 48 hours of discharge and will be transmitted or otherwise made available to the PCP as described in the TOC Model. Hospitals will establish the 30 day TOC period on the day of discharge and it will be measured for 30 calendar days following discharge. The TOC provider will provide the PCP with updates throughout the 30 day period. Hospitals may establish and create a dedicated unit or scatter-bed approach observation units if there are none currently in existence within their facility. Identified high risk Medicaid patients in observation units will follow the TOC Model policies and procedures. State and Federal guidelines to define observation level of care will be followed within hospitals. Each hospital will determine the clinical and financial model to support the need for the observation program, as well as benchmarking progress towards meeting clinical and financial goals annually.

Patient Engagement Metric

2.b.iv- The number of participating patients who receive discharge instructions that include patient self-education, medication reconciliation, and follow-up appointments, prior to discharge.

2.b.ix- The number of participating patients who are utilizing the OBS services that meet project requirements.

Clinical Metrics

Potentially Preventable Emergency Room Visits- The number of preventable emergency visits as defined by revenue and CPT codes.

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Potentially Preventable Readmissions- The number of readmission chains (at risk admissions followed by one or more clinically related readmission within 30 days).

PQI 90- Composite of all measures- The number of people, age 18 and older, with an admission meeting one of the adult prevention quality indicators.

PDI 90- Composite of all measures- The number of people, age 6 to 17, meeting one of the pediatric prevention quality indicators.

Percent of total Medicaid provider reimbursement received through sub-capitation or other forms of non-FFS reimbursement- The dollars paid by Managed Care Organizations under value based arrangements.

Meaningful Use Certified Providers, who have a participating agreements- The number of eligible providers meeting meaningful use criteria, who have at least one participating agreement with a qualified entity (QE).

Meaningful Use Certified Providers, who conduct bidirectional exchange- The number of eligible providers meeting meaningful use criteria, who both 1) make data available and 2) access data using SHIN-NY with a QE.

Percent of PCP meeting PCMH (NCQA) or Advanced Primary Care (SHIP) standards- The number of PCP providers meeting PCMH or Advanced Primary Care Standards.

Primary Care- Usual Source of Care- (CG-CAHPS Survey-Q2)- The number of respondents who answered "Yes" that this is the provider they usually see if they need a check-up, want advice about a health problem, or get sick or hurt.

Primary Care- Length of Relationship- (CG-CAHPS Survey-Q3)- The number of respondents who answered they have been going to this provider for at least one year or longer.

Adult Access to Preventive or Ambulatory Care- 20 to 44 years- The number of people, age 20 to 44, who had an ambulatory or preventive care visit during the measurement year.

Adult Access to Preventive or Ambulatory Care- 45 to 64 years- The number of people, age 45 to 64, who had an ambulatory or preventive care visit during the measurement year.

Adult Access to Preventive or Ambulatory Care- 65 and older- The number of people, age 65 and older, who had an ambulatory or preventive care visit during the measurement year.

Children's Access to Primary Care- 12 to 24 months- The number of children, age 12 to 24 months, who had a visit with a primary care provider during the measurement year.

Children's Access to Primary Care- 25 months to 6 years- The number of children, age 25 months to 6, who had a visit with a primary care provider during the measurement year.

Children's Access to Primary Care- 7 to 11 years- The number of children, age 7 to 11, who had a visit with a primary care provider during the measurement year or year prior.

Children's Access to Primary Care- 12 to 19 years- The number of children, age 12 to 19, who had a visit with a primary care provider during the measurement year or year prior.

Getting Timely Appointments, Care and Information- (CG-CAHPS Survey-Q6, 8 and 10)- The number of respondents who answered they called for an appointment or called for information and "Usually" or "Always" got an appointment for urgent care or routine care as soon as needed and got an answer the same day if called during the day.

Medicaid Spending on ER and Inpatient Services- The total spending on ER and IP services.

Medicaid Spending on Primary Care and community based behavioral health care- The total spending on Primary Care and Community Behavioral Health care as defined by MMCOR categories.

H-CAHPS- Care Transition (Q23, 24 and 25)- The average of hospital specific results for the Care Transition composite.

Care Coordination (CG-CAHPS Survey-Q13, 17 and 20)- The number Of respondents who answered "Usually" or "Always" that provider seemed to know important history, follow-up to give results from tests, and talked about all prescription medicines.

Tools to be employed: PA Clinical Risk Stratification tool in the EHR to identify and notify providers and hospital staff when high risk criteria meet: readmission within 30 days, 3 or more visits within 12 months (ER & IP units), any BH ICD-9 or ICD-10 behavioral health diagnosis. Each hospital will utilize a social needs screen to identify needs not readily identifiable in administrative data, such as social support, transportation, food, affordability of medications or other health-related items.

References/Guidelines

Hospital Guide to Reducing Medicaid Readmissions: https://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html