Applying a Transitional Care Management Model with Proven Outcomes in Medicare Populations to the Medicaid Population at Staten Island University Hospital

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Purpose Statement

DSRIP Project 2.b.iv was designed to support safe care transitions from the hospital to the community in an effort to reduce the 30-day readmission rate for Medicaid beneficiaries. This program allowed Northwell to recruit, hire, and train the team needed to engage and support patients through their transitional period.

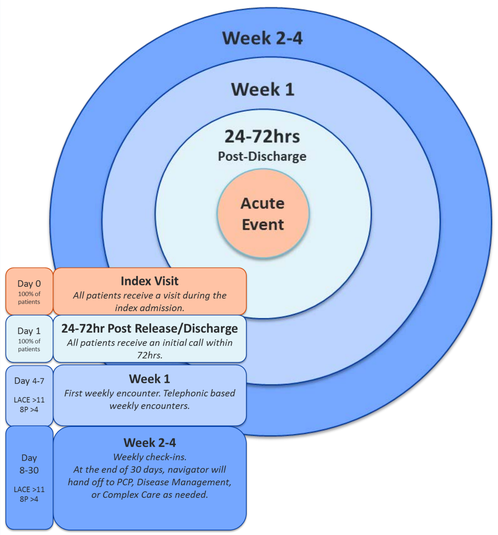
Through this evaluation and presentation, our goal was to evaluate if a transitional care management model that has been successful for Medicare populations would be successful for the Medicaid population in reducing readmissions, thereby improving patient outcomes and reducing cost.

Care Management Model

Medicaid patients who visit Staten Island University Hospital and have an inpatient admission are assessed for Care Management services. These services include:

- Creation of Care Plan
- Coordinating Primary and Specialist appointments
- Medication Reconciliation
- Connection to Community Programs and Social Benefits

Figure 1. Care Management Timeline.



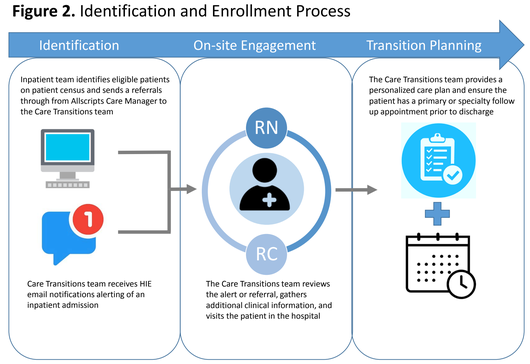
Background and Objectives

Northwell Health Solutions created a Transitional Care Management model in 2014 to address the needs of the BPCI/CJR programs for Medicare fee-for-service patients. The model included Registered Nurses (RNs) and Resource Coordinators (RCs)—non-clinical professionals with a Bachelor's degree and at least two years of professional experience.

The RNs and RCs form care management teams, who engage the patient population during their index admission and provide coordinated follow up after each visit. Each patient receives a 24 hours phone call after discharge, a 72 hour call after discharge, medication reconciliation, and home visits as needed. This model consistently demonstrated reductions in readmission rates and cost. The team has replicated this model for Staten Island University Hospital Medicaid patients and has been charged with enrolling at least 700 patients per demonstration year. As the program approaches maturity, we will become increasingly sophisticated in using data to evaluate and monitor our outcomes and overall impact.

Patient Engagement & Example

Figure 2. Identification and Enrollment Process



Finding the root cause of admissions – Patient Example:

- Patient is a 43 year old male who appeared adherent with medications and was engaged with a PCP and Pulmonologist
- After multiple readmissions, the care team learned the patient was experiencing shortness of breath/asthma attacks while waiting for the bus in community and would call 911
- The patient has limited health literacy, lives with his mother in public housing without air conditioning
- Patient relied on public transportation and was uncomfortable traveling to new providers if he was unfamiliar with the route.
- Care team referred patient to cooling centers, reviewed bus routes, and re-educated on use of inhaler and nebulizer
- Patient was referred to Home Care services for additional assistance in medication adherence, taking it in a timely manner and with the proper dosage
- Patient referred to the Health Home for ongoing services and has had a significant decrease in hospital utilization

Outcomes

The readmission rate over the 5 months for the sample of patients we followed was 16% compared to the 2017 baseline of 37%*. Patients in the sample population received an average of 3.3 telephone encounters throughout the course of their enrollment and an average of 2.4 in person visits. 100% of patients had a follow up appointment scheduled prior to discharge and 88% of patients had a medication reconciliation completed within 72 hours. Improvement in overall experience has been continuously noted in feedback received from the population.

- **16%** Readmission Rate compared to 2017 baseline of 37%*
- **3.3** Average telephonic contacts during 30 day enrollment
- **2.4** Average face-to-face contacts during 30 day enrollment
- **88%** Med. Reconciliations completed within 72 hours

*Patients in the 2017 baseline period received, at minimum, a follow up appointment prior to discharge. We began supporting 100% of cases with the 30-day care management model in October 2017.

Lessons Learned

1) In-person patient interaction

Face to face interaction with the patient has proven to be more effective than post-discharge telephonic interaction. This requires efficient, real time communication between the hospital based team and care management staff.

2) Differences by Population

Because this program is available to all Medicaid beneficiaries, there is a wide age range and patient needs vary greatly. Certain trends are distinguishable by group:

- *Medicaid Only:* younger patients more in need of access to care and navigation through follow up; often without established providers
- *Dual Eligible <62 years of age:* Typically have long term disabilities which may or may not mean they have established providers; transportation is often a barrier
- *Dual Eligible >62 years of age:* Often face socioeconomic barriers and have unreliable support systems. Following up with multiple providers and keeping up with medications can be overwhelming

Next Steps

1) **Improve readmission rate to the national benchmarks for all cause readmissions**
   As the program matures, we seek to achieve a readmission rate of 15.3% or lower

2) **Use data to support relationships and conversations with Managed Care partners**
   The more we understand the needs of our shared patients, the more we will be able to collaborate to improve their health outcomes

3) **Create seamless integration with the new Northwell Health Home on Staten Island**
   This care management program on the Staten Island will improve continuity of care for Medicaid patients seeking care at SIUH and expand capacity for services in the community

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Acknowledgements

A special thanks to the teams that make this work possible, from the Care Management team, to the SIUH Social Work and Inpatient Case Management teams.