Suffolk Care Collaborative

Project 2.b.iv & 2.b.ix: TOC/OBS Program Committee Meeting

April 4th, 2017, 3:00pm – 5:00pm

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Suffolk Care Collaborative

AGENDA FOR 4/4/17

Time	Agenda	Presenter
3:00pm-3:10pm	**Welcome & Introductions**	Kelly Donnelly, Project Manager, Acute Care Transitions
3:10pm-4:55pm	**Hospital Presentations**	Kelly Donnelly Project Manager, Acute Care Transitions
3:10pm-3:25pm	**Stony Brook Medicine**	Mary Ann Lind, RN, BSN, CMAC Director of Case Management
3:25pm-3:40pm	**John T. Mather Memorial Hospital**	Lorraine Farrell, FNP, RPAC Assistant Vice President, Medical Affairs
3:40pm-3:55pm	**Northwell Health Hub Hospitals:** Huntington Hospital, Southside Hospital, PBMC	Hallie Bleau, ACNP-BC AVP, Transitions of Care
3:55pm-4:10pm	**Brookhaven Memorial Hospital Medical Center**	Karen Shaughness, LCSW, ACSW, BCD Senior Director, Ambulatory Services
4:10pm-4:25pm	**Southampton Hospital**	Janet Woo, RN, CNRN Director of Quality
4:25pm-4:40pm	**Eastern Long Island Hospital**	Tara Kraemer, MSN,RN AVP, Quality Management
4:40pm-4:55pm	**Catholic Health Services Hub Hospitals:** St. Charles Hospital, St. Catherine's of Siena Medical Center, Good Samaritan Hospital	Gloria Mooney DSRIP Project Manager
4:55pm-5:00pm	**Wrap Up**	Kelly Donnelly, Project Manager, Acute Care Transitions

TOC Model:

- Education regarding transition of care and the implementation has been provided to the Care Management and interdisciplinary team.
- The Care Management team has strengthened relationships with on-sites and community based partners to create seamless transition from hospital to community.
- SBM embraces embedded community partners:
  - The embedded SCC TOC Case Manager works with the interdisciplinary team for identified TOC patients who are followed post discharge for 30 days.
  - On-site Health First Case Manager follows all beneficiaries to ensure all needs are provided for post-acute needs are coordinated.
- A Social Needs Screen, Comprehensive Assessment, and Discharge Plan are all utilized to assist in the TOC plan for patients.
- SBM has made several upgrades to our Cerner Application (EMR) that includes a moderate to high risk for readmission flags for early identification and assessment.
- Patients are provided recommended post-acute care options and education with providers/facilities to choose from for all discharge needs.

Community Partnership:

- The Care Management Leadership met with 20 community based Skilled Nursing and Rehab facilities on an individual basis to improve communication and handoffs.
- The Care Management Leadership will continue these efforts by meeting with community Home Care Agencies individually throughout 2017.
- SBM has been referring patients to the embedded Case Mangers and Social Workers in both the Hospital and Clinicals for further follow up.

Post-Discharge Protocols:

- Together, the SCC TOC Care Manager and Stony Brook, identify patients located on units 12S and MRN and then offered Care Management enrollment:
  - Post enrollment, the SCC Care Manager will provide TOC services for at least 30 days post discharge. This includes assisting in the process connecting unassigned patients to PCPs and ensuring PCP follow up appointments are scheduled prior to discharge.
- All BOOST patients are followed post 30 days by our BOOST Team (Case Manager, Social Worker, and Pharmacist) to ensure post follow up appointment with PMD is made and attended, all medications are received and in use as prescribed, and any post psycho-social needs are resolved.

High-Risk and Chronic Disease Populations:

- All Heart Failure patients are followed by our BOOST Social Worker and Case Manager who are assessed in-house and followed post-discharge for 30 days.
- All Stroke patients are assessed for anticipated long term transitional care needs which includes caregiver readiness and education.

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Transition of Care
Department of Care Management

Dr. Steven Feldman
Mary Ann Lind, RN, BSN, CMAC, CCM
Susan McCarthy, LMSW, MS, CCM

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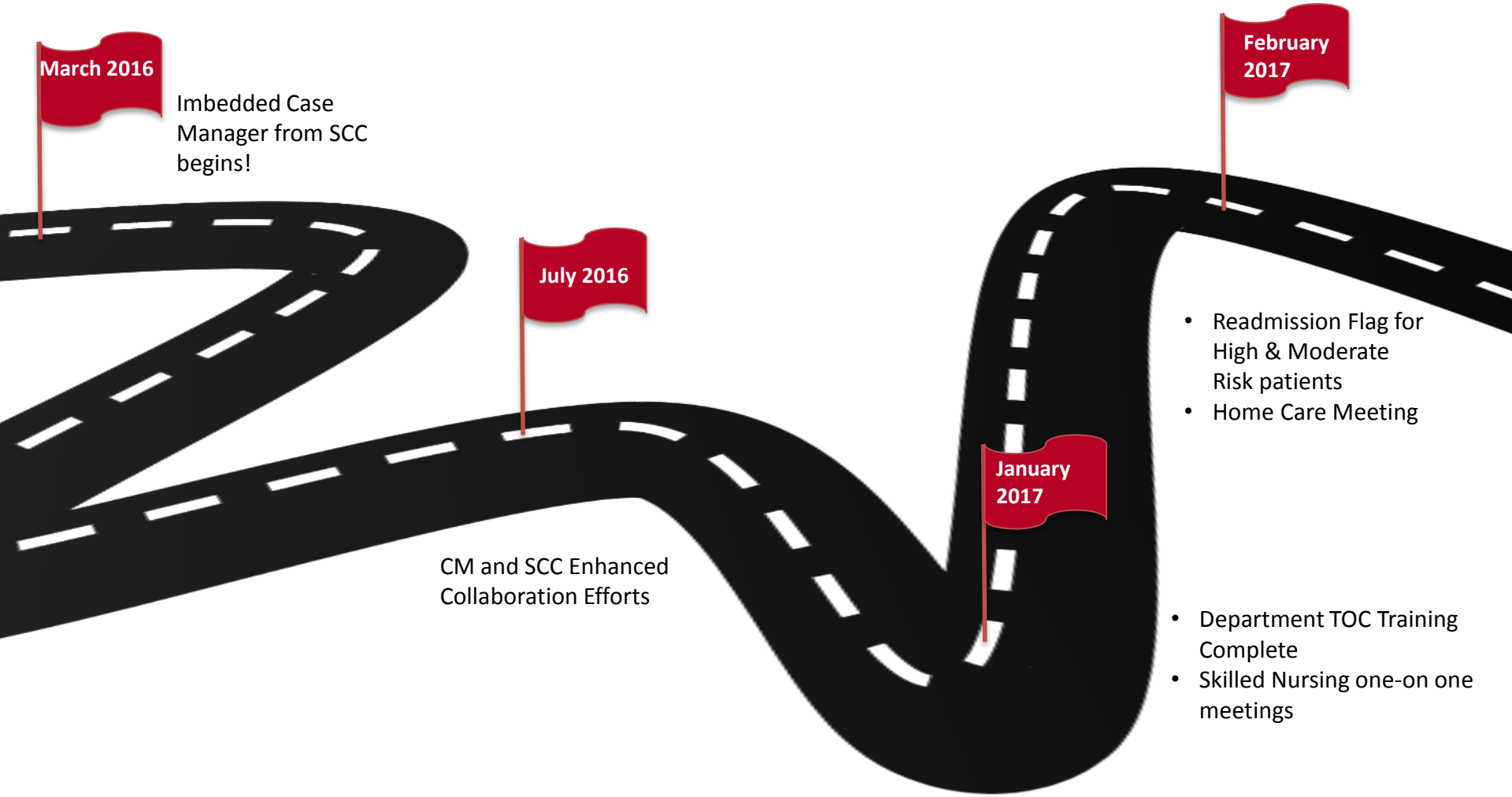
Care Management Transition of Care Roadmap



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Implementation Team Phase I

Care transition team to reduce 30-day readmissions:

Case Managers	Case Manager Director, RN Case Manager for SCC, Case Manager Supervisor, Case Manager Champions, BOOST Case Manager
Social Workers	Social Work Director, Social Work Supervisor, Social Work Champion, Social Work Educator, BOOST Social Worker
Nursing	Discharge Nurses, ED Medicine Nurse Champions, ADN Nurse Supervisor
Physicians	Hospitalist, Physician Fellow, Care Management Physician Advisors
IT	CMIO, Programmer/Analyst
Post-Acute Providers	Community SNF, Home Health Care Agency Partners, Health Homes

Implementation team of Observation Program:

Physicians	Hospitalist, ED Physician Team, Care Management Physician Advisor
Case Managers	Case Manager Director, RN Case Manager Supervisor, ED RN Case Managers
IT	CMIO

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Care Management's Long History with Transition of Care Programs

Transition of Care Program with DSRIP	• Internal Partnership with Care Management • Expansion of services • Further collaborative efforts • INTERACT Tool
BOOST Program	• 7 Year involvement in transition of care • High Risk Identification • Pharmacy Enhancement • Expansion of Services
Community Partnership	• 7 Year Partnership Enhancement (SNF, Homecare and DME) • One on One meetings • Readmission Prevention • EMR and Emergency Room • Clinical Case Review
Health First Medicaid Imbedded Case Manager	• Imbedded Nurse Case Manager on-site for the past 8 years • Identifies and oversees home health admissions • High Risk Oversight and Authorization Assistance

All the teams above collaborated with Stony Brook Case Managers and Social Workers

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In-house Transition of Care Programs

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Transitions of Care Program with DSRIP

Hospital imbedded Case Manager follows high risk patients in the Stony Brook Practices (Family, Internal, and Pediatrics)

What constitutes High Risk in the TOC Model:

- A Medicaid patient who meets any of all of the following criteria
  - Readmitted within 30-days of previous hospitalization
  - History of 3 or more hospitalizations (inpatient or OBS) within the past 12 months
  - Any behavioral health comorbidity
  - Diagnosis of Asthma, Hypertension or Diabetes

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Transitions of Care Program with DSRIP

Recent Expansion includes:
Referrals from medical units 12S and MRN
This includes patients in and out of the Stony Brook practices

Outcomes:
Prior to the program, there were 357 Emergency Department visits for this population of patients

Post Implementation, 241 Emergency Department visits recorded

32% Reduction

The imbedded TOC goal is to provide access to better healthcare

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BOOST Program

BOOST Team includes:
Nurse Case Manager
Social Worker
Pharmacist
Nursing Student Volunteers

BOOST Criteria: Patients 65 years and older with the eight (8) P's
Problem medications
Psychological
Principal diagnosis
Polypharmacy
Poor health literacy
Patient support
Prior Hospitalization
Palliative Care

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BOOST Program

BOOST Units are as follow:
Medicine Units:15N/S
Neurology/Medicine: MRN
Cardiology Unit: 5SD

BOOST Program recently expanded their services to include Heart Failure and Stroke specific diagnosis on the units mentioned above.

We also will be utilizing Nursing Students to assist with the follow-up phone calls during the 30 day transitional period.

History of SNF Meetings

- Care Management has hosted this forum over the past 7yrs
- Held on a Quarterly basis
- Invited all Suffolk County SNF's
  - Included: Directors, CNOs, and CMOs
- Reviewed Hospital Initiatives
- Reviewed Readmission Rates using a blind report
- Distributed individualized reports
- Feedback- How are we doing?

Example of 3rd Quarter 2016 Facility Data

SNF Code	Total Referrals	# Accepts	% Accepts	Total Bookings	30 Day Readmit	% Readmit
S6	396	154	39%	101	14	14%
S3	192	102	53%	98	5	5%
S14	346	194	56%	85	18	21%
S1	221	63	29%	59	9	15%
S2	313	81	26%	53	10	19%
S21	313	66	21%	51	4	8%
S8	311	66	21%	44	5	11%
S11	280	36	13%	43	8	19%
S4	310	91	29%	43	5	12%
S9	198	104	53%	29	12	41%
S13	254	59	23%	28	0	0%
S5	250	50	20%	26	5	19%
S10	190	51	27%	23	1	4%
S37	214	98	46%	22	4	18%
S12	245	12	5%	22	4	18%

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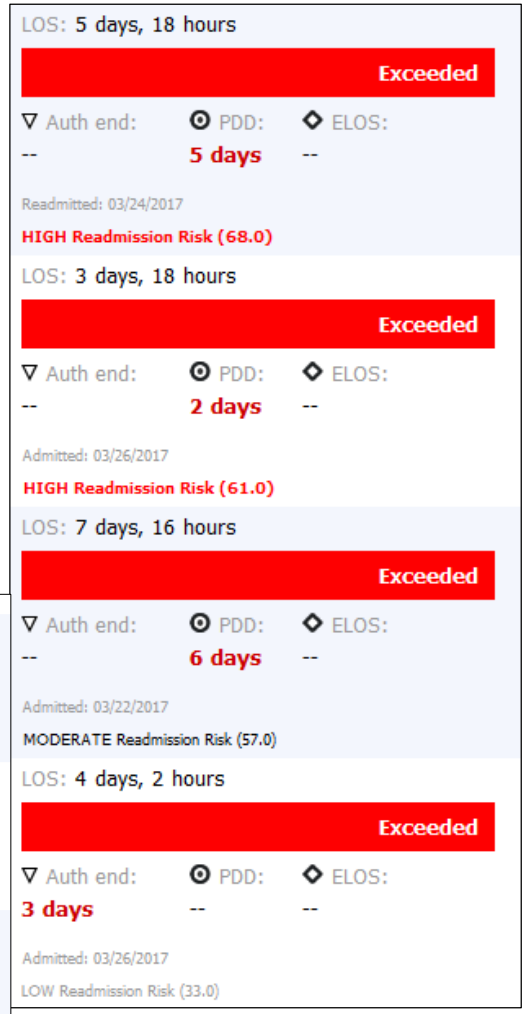
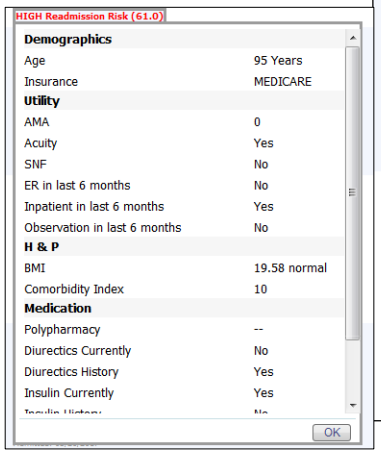
Community Partnership
Skilled Nursing Meetings

2016-2017 Refocus with Transition of Care Partnership

- Enhance our meetings by arranging one-on-one meeting forums
- Create clinical pathways for high risk patient population
- Enhance electronic communication between hospital and SNF
- Case review of High Utilizers of 2016
  - Medical Director, CNOs, CMOs, and Administrative Staff
- Gather feedback on "How are we doing?"





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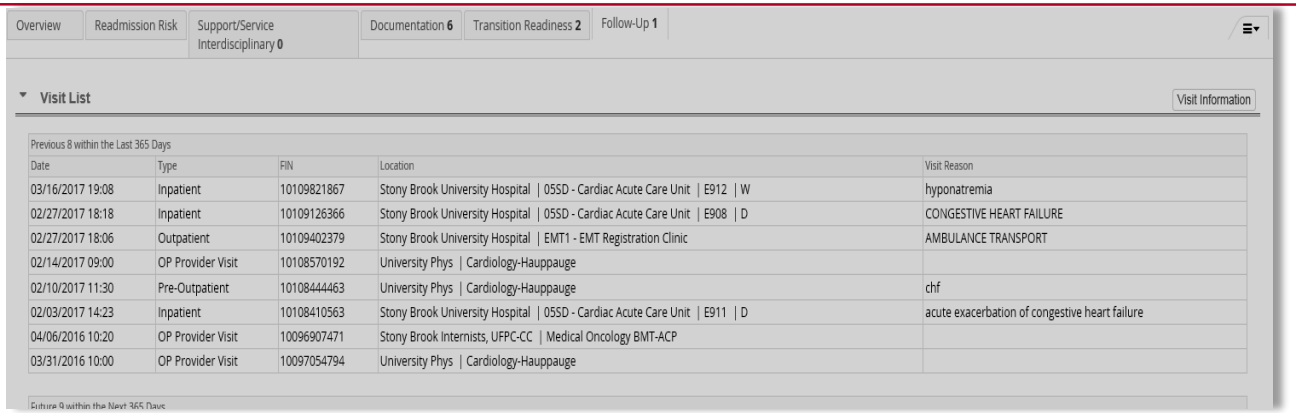
Care Management Risk Stratification

- Assessment of all patients within 48hrs of admission
- High Risk "flag" on every assessment
- All patients identified as high risk will receive comprehensive assessment and social needs screen
- Patient who meet qualifications for transitional care programs receives referral to imbedded Case Manager, BOOST team, or Health First Case Manager.



Stony Brook and SNF Meeting Highlights

- Create Plan of Care Documents for High Risk Population
  - Heart Failure first on the list
- Create a Transfer document more comprehensive than the Interact Tool "STOP" Form
  - Facilities will continue to call ED Central Line prior to Transfer
- Care Management to work with Department of Nursing for continued education in transitional care
  - Handoff Form, Transfer phone call, MD phone call
- Medication Reconciliation process needs some work
- Enhance Electronic Communication (RHIO, Community Physician Office)

What we gained…

- Face to face allowed us to have a better understanding of both hospital and skilled nursing barriers
- Facility and Hospital verbal communication is always needed
- Family dynamic plays an important role in care and readmission
- Full understanding of Skilled Nursing capabilities
  ie. Monitoring, medication management

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Updated Resources for Staff

Services Offered	Affinity Skilled Living and Rehab Center 305 Locust Ave Oakdale Admission office hours: 8am-6pm	Brookside Multicare 7 Route 25A Smithtown Admission office hours: 8am-5pm	Brookhaven Health Care 801 Gazzola Drive E. Patchogue Admission office hours: 8am-4pm	Gurwin Jewish Nursing 68 Happauge Road Commack Admission office hours: 8am - 6pm	The Hamptons Center for Rehab and Nursing 64 County Rd 39 Southampton Admissions office hours: 830am-6pm	Island Nursing and Rehab Center 5537 Expressway Drive N Holtsville Admissions office hours: 9am -5pm
Ability to place lines	YES	NO	YES	YES	YES	YES
BIPAP/CPAP	YES	YES	NO	YES	YES	YES
Cardiology	YES	NO	YES	YES	YES	YES
CHF Protocol	YES	NO	YES	NO	NO	YES
Dementia Unit	NO	YES	YES	YES	YES	NO
Family Transportation	NO	YES	NO	NO	YES	NO
Hemodialysis Available (ONSITE OR TRANSPORTS TO OFFSITE	NO	YES	NO	YES	YES	YES
Hospice/Comfort Care	YES	YES	YES	YES	YES	YES
Infectious Disease	YES	NO	NO	YES	YES	YES
Interact Tool	YES	YES	YES	YES	YES	YES
IV Antibiotics	YES	YES	YES	YES	YES	YES
Psychiatry	YES	YES	YES	YES	YES	YES
PT/OT	YES	YES	YES	YES	YES	YES
Pulmonology	YES	NO	YES	YES	YES	YES
Respiratory	YES	NO	YES	YES	YES	YES
Secured Unit	NO	YES	YES	YES	YES	NO
Stroke/ Neuro	NO	YES	NO	YES	YES	YES
Telemedicine	NO	NO	YES	NO	NO	NO
Trachs	YES	YES	YES	YES	YES	YES
Vents	YES		NO	YES	NO	NO
Weekend Admissions(With prior auth)	YES	YES	YES	YES	YES	YES
Wound Care	YES	YES	YES	YES	YES	YES

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Health First Medicaid Imbedded Case Manager

On-Site Imbedded Nurse Case Manager from Health First

Risk Stratification

- A HF Medicaid patient who meets any of all of the following criteria
  - Readmitted within 30-days of previous hospitalization
  - History of 3 or more hospitalizations (inpatient or OBS) within the past 12 months
  - Any behavioral health comorbidity
  - Diagnosis of COPD, Asthma, Hypertension, CHF, or Diabetes

- Follow through includes following patients into the community up to three months.
- Ensuring patients have PCP's and appointment post hospitalization
- Health Home referrals **(HARP)** are already identified and flagged for imbedded Case Manager
- Follows patients in the community past 30 days

healthfirst

Primary Health First patients account for approximately 33% of our monthly discharges

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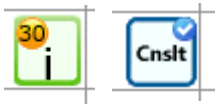
2017 Expectations for Transition of Care Programs

Transition of Care Program with DSRIP	• Data Elements supporting expansion of imbedded CM Role
Community Partnership	• Skilled Nursing Meetings • Home Care Meetings (Q1 2017) • DME Partnership • Create "STOP" form for transfer communication for Emergency
BOOST Program	• Focus on High Risk Diagnosis with BOOST P's. • Importance of Polypharmacy • Data improvement for outcomes
Health First Medicaid Imbedded Case Manager	• Enhancement of HARP program and Care Management collaboration (*included all Health Plans**)

Questions?

Transition of Care Model for John T. Mather Memorial Hospital – Utilized for all patient types; focus for Medicaid referrals identified as appropriate.
Patients eligible for TOC services will be defined as falling into 2 groups – Emergency Department Treat & Releases (includes patients assigned to Observation status who are discharged) and Admissions (includes patients assigned to Observation status who are Admitted).



ED Identifiers for patients eligible for TOC services (ED Tracking Board Badge Icons):
3 badge types are used to identify patients requiring specialized TOC services delivered by the Case Management Department:

- **Those who are Medicaid eligible/have active Medicaid AND have two or more qualifying chronic conditions OR have one single qualifying condition of HIV/AIDS or serious mental illness (SMI) are identified on the ED TB by use of a SW consult badge displaying a red outline (same as badge pictured in blue below, but outlined in red).**

This badge triggers the ED SW to notify Mather's Health Home at Northwell. Contact information:_____

- **Comprehensive Care Joint Replacement patients (CCJR) are identified by an "S" badge on the ED TB. This badge is triggered when these patients present to the ED within 90 days of the acute admission. ED Case Manager then investigates reason for ED presentation and confers with ED physician.**
- **Patients presenting to the ED within 30 days of discharge from the acute setting receive a SW consult badge on the ED TB. This flags a potential readmission requiring Case Management investigation of the reason for ED utilization.**

ED Treat & Release Patients:
The ED SW notifies the Heath Home for those patients falling into the Health Home eligible groups. (see above)
All ED patients receive Screening Brief Intervention Referral to Treatment (SBIRT) screening and referrals as appropriate.
Behavioral health (BH) patients are serviced by the ED BH SW. There is coordination between ED SW and ED BH SW. Care for certain Medicaid patients may also be provided by the SCC/DSRIP Case Manager and referrals are made as appropriate.

Admissions:
In-patient SW/RN (Case Management Dept) receives hand-off from ED SW for Health Home patients & follows patients throughout the hospital stay. A discharge plan is developed at admission with special attention to provision of individualized patient needs based on needs assessment. Those falling into a risk group as identified by the SW High Risk screening criteria receive referrals to Community Programs as appropriate (see SCC booklet for listings).

Case Management (CM) Department coordinates discharge plan with Health Home coordinator assigned to the patient for those that fall into above groups. Care coordination of Medicaid patients may also be provided by the SCC/DSRIP CM, who may meet the patient while hospitalized.

Admitted patients being discharged: The TOC period is defined as discharge day through 30 days post discharge.

- **Reports are generated for use by TOC staff that list currently admitted patients by number of readmissions in prior rolling year. This list contains the patient's insurance carrier to identify Medicaid patients. The list also contains the patient's diagnosis(es) to identify Behavioral Health comorbidities.**

SCC/DSRIP assigned RN Case Manager provides services as described above for Medicaid patients.
Hospitalist physicians serve as resources for clinical issues; SW department provides for other post-acute needs.

Transitions of Care Model

JOHN T. MATHER MEMORIAL HOSPITAL

APRIL 4, 2017

Tenets of Transition of Care

Patient self-education

Follow-up appointments

Discharge medication reconciliation

Communication with post acute providers

JTM TOC Scope of Practice

All patients receive same interventions regardless of insurance.

All ED patients receive Screening Brief Intervention & Referral to Treatment (SBIRT) screening and referrals as appropriate.

Staff providing specific interventions may vary depending on patient insurance. That is:

Health Home eligible?

Medicaid/managed Medicaid?

If “yes”, Northwell/Hudson River HH or SCC/DSRIP staff involved

JTM TOC Model

TOC Eligible Patients fall into two patient groups:

- Emergency Department Treat & Releases (includes patients assigned to Observation status who are discharged)
- Admissions (includes patients assigned to Observation status who are Admitted).

Case Management in the ED

- ED Case Manager (SW) staffs the ED from 8am through 10pm seven days/week
- Responsible to intervene with patient disposition driven by badge icon triggers on the ED tracking board
- Responsible to assess patient needs and provide education, after-care services, resource information (CBOs), support, and counselling

Behavioral Health in the ED

- Patients identified as BH cohorted in the Behavioral Health area within the ED.
- ED BH SW & NP perform same process as medical SW staff

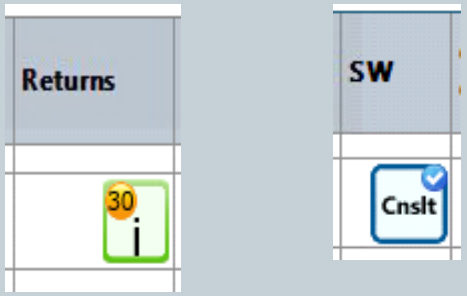
ED Arrivals: TOC Eligible Patient Identifiers

- Those who are Medicaid eligible/have active Medicaid AND have two or more qualifying chronic conditions OR have one single qualifying condition of HIV/AIDS or serious mental illness (SMI) are identified on the ED TB by use of a SW consult badge displaying a red outline.

- This badge triggers the ED SW to assess the patient and, if appropriate, notify Mather's Health Home at Northwell/Hudson River. Contact information:_____

30 Day Post-Acute Returns

- Patients presenting to the ED within 30 days of discharge from the acute setting receive a SW consult badge on the ED TB. This flags a potential readmission requiring Case Management investigation of the reason for ED utilization.



“Bundle” Patients

- Comprehensive Care Joint Replacement patients (CCJR) are identified by an “S” badge on the ED TB. This badge is triggered when these patients present to the ED within 90 days of the acute admission. ED Case Manager then investigates reason for ED presentation and confers with ED physician.

TOC Interventions from ED

- Notification of SCC counterpart for follow-up plan for eligible patients (Medicaid)
- Determine if patient is SNF or TCU eligible
- Educate ED clinicians re: clinical capabilities of area nursing homes
- Arrange for any needed services to prevent admissions related to need for these services

  Example: PICC line placement, dialysis

Admissions

- All admits screened for High Risk Criteria by Case Management Department within first day of stay with a full bio/psycho/social assessment
- Transition of care plan begun at admission to address patient's unique needs
- If patient is a 30 day return, there is investigation to determine if need to seek care was potentially preventable?

Admissions

- Reports utilized listing current in-patients by number of admissions within prior rolling year, diagnoses (including Behavioral Health Dx), insurance, PCP, & hospital location

- SCC RN visits referred Medicaid patients while hospitalized; follow-up plans made

Admissions

- Medicare patients identified as high readmission risk are referred to the CHF NP and/or the TOC NP. Both meet patient in hospital and discuss readmission prevention strategies.
- Also meet with care givers when possible and review same
- TOC plan tailored to needs of patient

Post Acute Care Services

- TOC SW & TOC NP are tasked with post-acute care phone calls. Calls performed within 24-48 hours post discharge.
- The TOC NP performs a warm hand-off to post-acute providers in the community.
- This includes community PCPs, Harbor View (Mather's Patient Centered Medical Home), SNFs, Home Care staff, Community Based Organizations, and Health Homes.

Discharge Summaries

- Discharge summaries are faxed to Harbor View and other community PCPs/specialists, whose patients are attended to by Hospitalists (75% of our in-patient census), within 24 hours of the discharge
- D/C summary includes Case Management assessment notes & HADS for CHF patients
- Community PCPs use a face sheet to track their own patients (25% of the census).

Additional TOC Activities

- Regular face to face meetings with local SNFs
- Individual SNF clinical capability lists compiled & advertised (physicians often unaware of services that can be provided in this setting)
- SNFs provided with extensive patient information beyond requirements (Labs, VS, physician notes, speech/swallow studies, CM assessment & notes)
- Local pharmacy bedside delivery of 1 month supply of meds

Lessons Learned

- Patients are in trouble within 24-48 hours post discharge
- Medication confusion most common reason for trouble
- Delays in DME, confusion regarding diet and other care instructions also contribute
- Clinician to clinician warm hand-off necessary to review care nuances often not mentioned in D/C summaries
- Follow-up after discharge from SNF

Huntington Hospital

- Transitions of Care Model focused on patient engagement, risk stratification, care coordination and care management services
- Patients are identified as high risk based on their LACE score which calculates readmission risk based on length of stay, acute admission through the emergency department, comorbidities and emergency department visits in the past six months
- The 8P Screen Tool from Project BOOST is also used to risk stratify patients which focuses on problems with medications, psychological issues, principal diagnosis, physical limitations, poor health literacy, patient support, prior hospitalization, and palliative care
- Once identified as high risk patients receive the following:
  - 24 hour discharge follow-up phone call
  - 72 hour discharge touch (call or visit based on risk)
  - Follow-up thereafter is based upon risk
- Assigned a Care Manager in the Emergency Department with the responsibility for SNF patients
- Northwell Health has partnered with God's Love We Deliver to provide medically tailored food services in care transitions
- Northwell Health hospitals are rolling out a pilot program with Patient Access Services to schedule follow up appointments prior to discharge
- Discharge summaries are sent via Allscripts or Sunrise electronically via the CCDA

Southside Hospital

- Transitions of Care Model focused on patient engagement, risk stratification, care coordination and care management services
- Patients are identified as high risk based on their LACE score which calculates readmission risk based on length of stay, acute admission through the emergency department, comorbidities and emergency department visits in the past six months
- The 8P Screen Tool from Project BOOST is also used to risk stratify patients which focuses on problems with medications, psychological issues, principal diagnosis, physical limitations, poor health literacy, patient support, prior hospitalization, and palliative care
- Once identified as high risk patients receive the following:
    - 24 hour discharge follow-up phone call
    - 72 hour discharge touch (call or visit based on risk)
    - Follow-up thereafter is based upon risk
- Assigned a Care Manager in the Emergency Department with the responsibility for SNF patients
- Collaborating with 1 Unit to implement an Accountable Care Unit (ACU Care Model) on 2 Gulden and possibly expanding to another unit
    - ACU Care Model includes: Unit-based physician teams, Structured Interdisciplinary Bedside Rounds (SIBR® rounds), Unit-level performance reporting, and Unit-level physician and nurse co-leadership
    - Assists in reducing 30-day re-admissions, length of stay, in-hospital mortality, complications of care, and nursing turnover
- Northwell Health has partnered with God's Love We Deliver to provide medically tailored food services in care transitions
- Northwell Health hospitals are rolling out a pilot program with Patient Access Services to schedule follow up appointments prior to discharge
- Discharge summaries are sent through Allscripts or Sunrise electronically via the CCDA

Brookhaven
Memorial Hospital Medical Center

Assembled a Multidisciplinary team including, ED, Inpatient, Nursing, PCP, respiratory, Behavioral Health, Care Mgmt, and Health Home staff:

- ❑ Team established early intervention with patients presenting in the ED and engaged Health Homes, Behavioral Health , PCP and residential providers in the discharge planning process
- ❑ Enhanced partnership with the Health Homes through onsite meetings and training sessions with staff ; established key contacts for improved communication process with Health Homes and other CBOs
- ❑ Established ongoing meet and greet with several SNFs and assisted living agencies
- ❑ Super Utilizer/High Risk pts (3 or more ED visits and 1 re-admission; COPD w/co-occurring disorders)
- ❑ Created a Flagging System w/ notification to Team for real time intervention
- ❑ Enhanced Social screen completed by Care Manager
- ❑ Retained detailed Patient profiles on shared drive for easy staff access
- ❑ Health home Care Managers are contacted at time of admission to visit patient and team and engage in D/C planning process
- ❑ TOC Providers: Health Homes, CBOs, Brookhaven's PCMH Social Worker , SCC Care Managers
- ❑ Provided Motivational interviewing training for Care Management, ED and Home Care staff
- ❑ TOC Process: Follow patients post D/C with at least 2-3 calls per week, and weekly thereafter for 30-45 days
- ❑ Link them to PCP, and Behavioral Health or other CBO
- ❑ Warm hand off given to them post successful transition in the community
- ❑ If not enrolled, application to Health Home and/or Home Care is made upon admission
- ❑ If admission is required, patients are co-horted on COPD unit for continuity of care
- ❑ Educated staff on TOC concepts and relevant DSRIP projects
- ❑ Established a Brookhaven Better Breathers Club for patients and the community
- ❑ Enrolled 75% of Pts into a Health Home, 46 % decrease in ED visits ; 32% decrease COPD re-admissions with original cohort of 62 pts
- ❑ In process of applying same protocol with other super utilizers and will utilize SCC Care Management program

Brookhaven Memorial Hospital

TOC Model Implementation Plan

Presented by: Karen Shaughness, LCSW

Date: **April 4, 2017**

Brookhaven
Memorial Hospital Medical Center

TOC Team Structure

Ambulatory Services

Behavioral Health

Care Management

Cardiovascular

Emergency Department

Home Care

Hospitalists

Information Services

Nursing Department and Professional Development

Performance Improvement

Pharmacy

Primary Care

Respiratory

Workflow

- High Risk pts are flagged upon arrival in ED
- Enhanced Social screen is completed
- Contact with CBO is made to involve in Treatment plan
- If not enrolled, application to Health Home and/or home Care is made
- If admission is required, patients are cohorted on same unit, and Team collaborates with CBO such as Health Homes, Home Care, behavioral health, or residential provider

Workflow Attributes

- Use of Super Utilizer List
- Created a Flagging System
- Patient profiles on shared drive
- Opened a COPD Unit
- Created a secured shared drive to document and communicate within the action team

Brookhaven
Memorial Hospital Medical Center

Team Strategy

Brookhaven Team Meeting Weekly

Case conferences with patients and community based organizations are held for challenging cases

Contact via email to Team members as needed

Training

- Educated staff on TOC and DSRIP projects
- Brought Health Homes onsite to train staff
- Provided Motivational interviewing training for care management and ED staff

Brookhaven
Memorial Hospital Medical Center

Partnerships

- Enhanced partnership with the Health Homes
- Improved communication process with Nursing Homes to ensure warm hand-off
- Established ongoing meet and greet with several SNFs and assisted living agencies
- Established a Brookhaven Better Breathers Club for patients and the community

Brookhaven
Memorial Hospital Medical Center

SOUTHAMPTON HOSPITAL

SHH model is focused on the high risk inpatient and observation patient for the Medicaid population.

- SHH provides a 30 day follow up, scheduling appointments, reconciling medications and providing self-education using teach back methodology.
- Our goal is to have the primary care provider to see the high risk patient within 48 hours.
- At SHH we partner with Dominican Sisters. We have just instituted a Community Palliative Care Program. If a patient is on the program, after going home the patient is followed up by a Palliative Care Physician.
- At SHH our high risk criteria are patients re-admitted within 7 days as well as 30 days.
- Reasons for re-admission are reviewed by the residents. Also, medication compliance, behavioral/ social issues as well are reviewed.
- Social risk screens are reviewed for appropriateness.
- SHH initiated a red, yellow, green, process for early recognition of a discharge. Unfortunately, non-compliance was experienced by the residents and hospitalist. The residents will notify the patient verbally that they may be going home the next day. The residents also coordinate care with social work and case management to provide a smooth transition.
- The TOC provider can work closely with case management by attending interdisciplinary rounds Monday thru Friday. This will provide the TOC provider with information/progress about the patient.
- Patients who don't have a PCP are assigned to a physician in the Meeting House Lane practice or the Hudson River Health Care Services.
- Post discharge protocols include calling patients, except transfers to a tertiary care facility or the Nursing Home or Rehab, within 24 hours. Medications are reviewed, wound care treatments and calling for follow-up appointments as well as the hospital experience.

Eastern Long Island Hospital, in collaboration with the Suffolk Care Collaborative, has developed and implemented a Transition of Care Model designed to reduce 30 day readmissions for high risk Medicaid patients.

Implementation of Transitions of Care Model- Eastern Long Island Hospital:

- Transition of Care education provided to all applicable staff.
- CCTM training completed by one RN.
- Social needs screen developed to assist in identifying high risk patients.
- The EHR is utilized to assist in identifying readmitted Medicaid patients and those requiring behavioral or substance abuse services.

A Transitions of Care guidance document was developed and approved by leadership. This document explains the consent process as well as the care manager's access to visit with the patient prior to discharge to establish a therapeutic relationship.

- Suffolk Care Collaborative social work care manager was embedded in the hospital.
- Medicaid patients are identified.
- Readmitted patients are identified and the social needs screen is completed.
- Consent is obtained from the patient for the Transition of Care program.

The interdisciplinary team develops individualized discharge plans (including the need for a health home) and an embedded SCC Transition of Care- care manager (social worker) collaborates with the interdisciplinary team to identify patients who will be enrolled in the TOC program for 30 days post discharge.

The care manager works collaboratively with the interdisciplinary team to identify patients who are expected to be discharged. A system was developed to provide the care manager with a census of all discharged patients. The care manager meets with the patients prior to discharge.

Social work referrals are generated for high risk emergency room patients who are discharged home. Case manager or social work follow-up is completed. The patient is connected with appropriate community based referrals based on the needs identified.

Post discharge follow-up phone calls are made for the medical/surgical population to assess for medication issues, understanding of discharge plan, follow-up Dr. appointments compliance, etc.

EASTERN LONG ISLAND HOSPITAL

TRANSITIONS OF CARE

TARA KRAEMER, MSN, RN
AVP QUALITY MANAGEMENT

IMPLEMENTATION TEAM

Implementation team members identified by Senior Leadership:

- According to the specific needs of our organization and goals of transitions of care
- Behavioral Health units- Large Medicaid population
- Medical/Surgical unit- Small Medicaid population
- Multidisciplinary team consists of: Senior Leaders/Clinical Dept. Heads, Medical Director, Quality Services/Facility Champion, Nursing, Social Work
- Embedded SCC TOC Care Manager

TRAINING AND AWARENESS

Raised awareness through:

- Board of Trustees meetings
- Medical Executive Committee meetings
- Management meetings
- Unit staff meetings
- Presence of embedded TOC provider on patient care units
- Utilized train-the-trainer method

SOCIAL DETERMINANTS

- Developed a *comprehensive* social needs screen to:
  - Identify non-healthcare related issues that may impact one's health
  - Identify high risk patients
  - Allows for a more comprehensive evaluation to assist the embedded TOC provider in understanding the patients needs
  - Assists in developing an appropriate and comprehensive discharge plan
  - Patient's on the Behavioral Health units are automatically flagged as high risk- social needs screen helps in identifying the specific needs of these patient's

TOC GUIDANCE DOCUMENT

- Developed and approved by leadership
- Explains the consent process
  - Large behavioral health/substance abuse patients—consent required for TOC CM to approach
- Outlines SCC embedded CM's access to visit the patient prior to D/C
  - CM given a daily census of all upcoming "high-risk patient" discharges

INFORMATION TECHNOLOGY

Use of IT to implement project goals:

- Nursing Informatics- integrate social needs screen into EHR assessments: Case Management, Nursing admission database and psycho-social screens
- IT: Build and run required TOC and OBS quarterly reports
- Ensure flags on Face Sheet are present at registration: previous admission/ER dates, Behavioral Health patient, insurer information ie: Medicaid or self pay

COMMUNITY RELATIONSHIPS

- Hospital staff work collaboratively with community based physician offices
  - Many of the PCP's follow patients in the hospital and interact directly with staff
- Work with community based organizations to secure necessary appointments are made
- Identify individuals who need to be linked to a health home
- TOC provider works directly with physicians practice manager and participates in their PCMH meetings

Catholic Health Services of Long Island
At the heart of health

St. Charles Hospital, St. Catherine's of Siena Medical Center, Good Samaritan Hospital

CHS's approach is a combination of collaborative in-patient care coordination and 'High-Touch' clinical outreach. The CHS Model embeds TOC Navigators who collaborate with traditional care management services within each CHS facility in executing the patient's discharge plan to its full potential within the 30-day post discharge period. Following the 30-day discharge period, if on-going clinical and social needs exist, the patient is transferred to an out-patient clinical team for maintaining the care plan within the community/home.

The TOC Navigator will also determine Health Home eligibility to facilitate enrollment and collaborate with Health Home TOC providers. MCO engagement is in progress and when committed, TOC Navigators will also collaborate with MCO TOC providers.

The outreach component of the CHS model strategically focuses clinical resources geographically located around CHS's hospitals and facilities. The end result is clinically integrating the inpatient, outpatient, and community needs of the DSRIP and under-served population. TOC Collaborative efforts between CHS entities, Health Homes and MCOs are expected to continue on an out-patient basis as well.

High risk criteria of focused patient population:

- CHS TOC Care Coordination focuses on high risk/high need complex patients with multiple chronic conditions, co-morbidities and/or complex social/economic issues. Care coordination services are targeted at developing individual action plans to support the needs of those patients with complex health care needs.
- Additionally, as a participant of the MAX Series, [payor agnostic] identification of the High Utilizer and processes for identifying and addressing drivers of utilization have been implemented. Any patient incurring a fourth admission or more generates a Social Worker referral with further deployment of a focused clinical team to specifically address and identify drivers of utilization.

Different cohorts of patients are assigned to specific TOC Care Coordination Providers such as non-joint vs. joint. Any patient identified as having any behavioral health co-morbidities fall into a registry specifically designed for Social Work to collaborate with TOC Care Coordinators.

TOC Providers identified for 30-day TOC services, highlighting early notification of planned discharges and early access to visit patients in hospital:

- CHS has a system-wide electronic process for the discharging physician to alert the hospital care management team of an anticipated discharge and date promoting early intervention, collaboration and creation of the discharge plan as well as advising the patient and/or the patient's family of the anticipated discharge timeframe. The hospital Care Manager will refer the high risk patient to the CHS TOC Care Coordinator for TOC enrollment in a 30-day transition plan.
- CHS employed TOC Care Coordinators are embedded within each CHS facility and will visit the patient (if they are still in the hospital) within 1-2 business days of the referral. Any external TOC provider will be permitted to collaborate on-site with the patient and the CHS Care Coordinator provided there is an established relationship with the patient (such as a Health Home Care Manager) or has a signed partnership agreement with CHS (such as a Managed Care Organization) and has been vetted through the CHS vendor policy.

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Description of establishment of 30-day transition of care period, highlighting post-discharge protocols

- Upon receipt of referral, hospitalized patients will be screened by the CHS TOC Care Coordinator within 1-2 business days of the referral and assigned to the appropriate TOC Care Coordinator (RN/LPN/SW) and confirm/determine risk level.

The interval of the follow-up will be based on acuity of interventions and will be no less than weekly or as status dictates for 30 days.

Interventions Post Discharge:

- If a patient meets high risk criteria, the TOC Care Coordinator will be followed by TOC Care Coordinator for 30 days and transferred to the OP Care Coordinator for continued management.
- Patients with moderate risk of readmission will be followed for up to 30 days post-discharge by the TOC Care Coordinator and will be transferred to the OP Care Coordinator as appropriate.
- Patients with low risk of readmission, will be assigned to an OP Care Coordinator for assessment and delegated to OP Care Coordinator as appropriate.
- At 30 days post discharge – if the patient has continued care coordination needs the TOC care coordinator will refer the patient to an outpatient care coordinator for continued care coordination services for up to 90 days post-discharge. .
- Either TOC Care Coordinator or Outpatient Care Coordinator will conduct follow-up activities, communicate with provider(s)/external TOC Care Managers, update risk stratification/priority as patient's condition/needs evolve, and schedule follow-up based on patient need and appropriate risk stratification.

Quantifiable Achievements:

- The implementation of the CHS Care Coordination/Transitions of Care Model throughout the Catholic Health Services System's 6 hospitals is an achievement in and of itself. As a participant in the MAX Series Good Samaritan will soon have documented quantifiable achievements to report as the program is further implemented.

Scaling of model to other high risk populations or chronic disease populations:

- CHS's TOC Care Coordination model is payor agnostic, spans multiple chronic disease conditions, joint replacements and the model will be implemented across all CHS facilities regardless of DSRIP participation.

Suffolk Care
Collaborative

FINAL THOUGHTS