Health Home Linkages at John T. Mather Memorial Hospital

Kelly Donnelly, MHA, Project Manager Acute Care Transitions at Suffolk Care Collaborative
Richard Poveromo, LMSW, CCM, Director of Social Work at John T. Mather Memorial Hospital

Background

On February 15, 2017, the NYSDOH introduced new requirements of hospitals to ensure policies and procedures are in place for health home referrals from hospital emergency departments (ED). The Suffolk Care Collaborative (SCC) partnered with John T. Mather Memorial Hospital (Mather) and Hudson River HealthCare's (HRHCare) health home, CommunityHealth Care Collaborative to improve communication lines and implement a streamlined referral process to support the transition of care for hospital patients to health home services.

Objectives

To improve awareness of health homes (HH) and referral processes for hospital ED and inpatient staff, streamline health home referral workflows for ED and inpatient staff, and implement an electronic health home referral tool into hospital's electronic medical record (EMR).

Approach

1. SCC partnered with the CommunityHealth Care Collaborative team to do a hospital "roadshow" to assist facilities to meet requirements.
2. Together, we met with Mather's medical/surgical and behavioral health department leadership to discuss current state, areas for improvement and next steps.
3. From there, we were able to define referral workflows, finalize a staff training approach and identify the opportunity to embed HRHCare's new online referral tool within the EMR.

Workflow

ED Social Worker screens patients for Health Home eligibility & makes appropriate referral.

As a part of the TOC program, SCC embedded care manager follows high-risk patient for 30-days post discharge and will act as a bridge between hospital and HH activation.

CommunityHealth Care Collaborative enrolls and follows patient through long-term care management services.
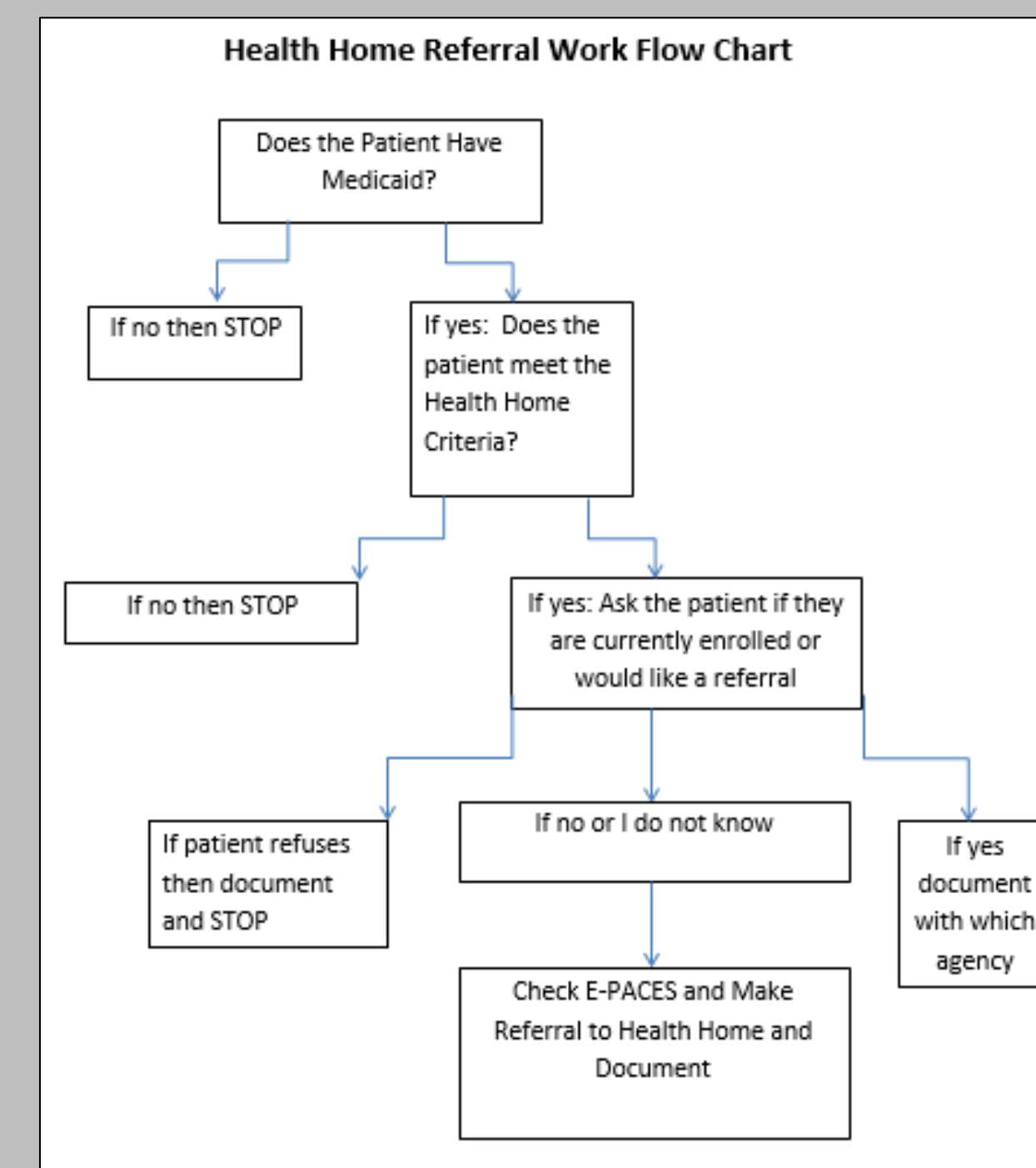
Policy, Referral Process & Education

Step 1: Health Home Policy Creation
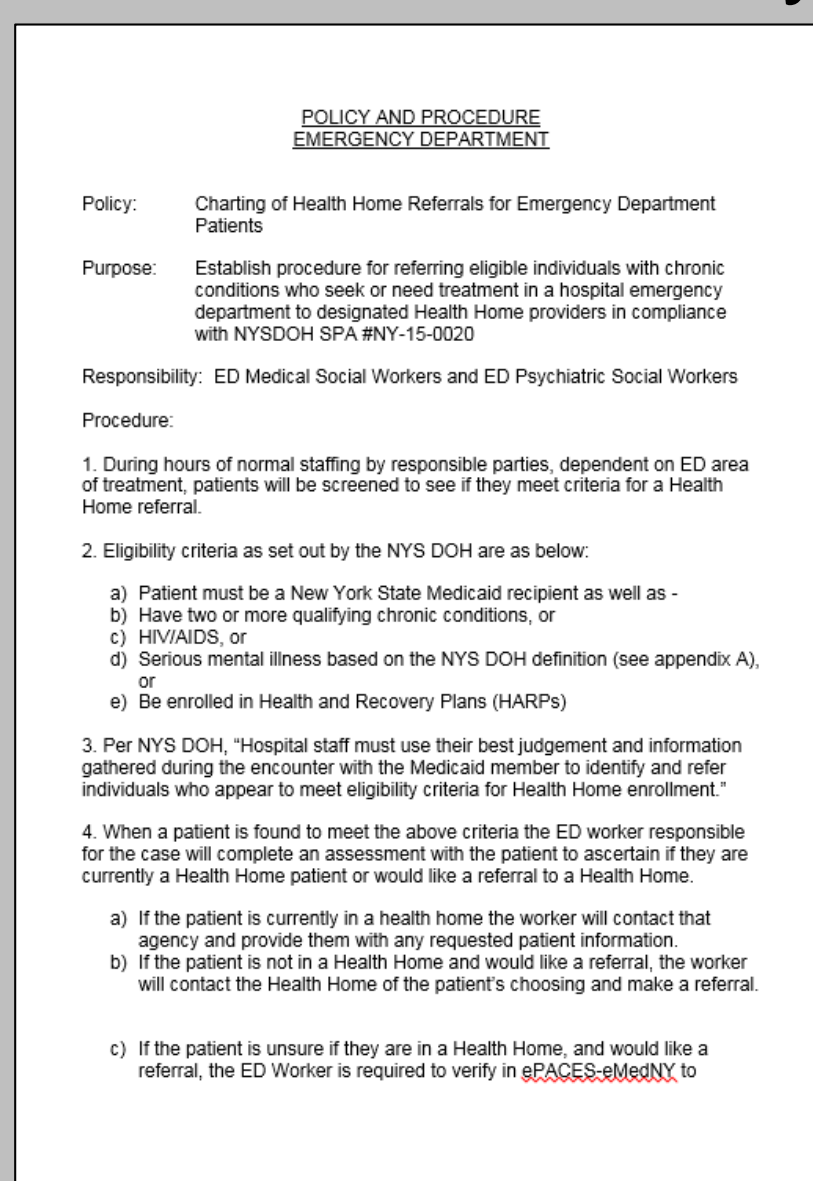
Mather created a comprehensive health home referral policy for emergency department patients.

Step 2: Streamline Health Home Referral Process

### Step 3: Staff Education

Staff members in the medical/surgical and behavioral health departments were in-serviced on the policies, workflows and Health Home 101.

IT Integration

Step 4: Integrate HRHCare Referral Form into EMR

HRHCare's online referral form simplifies the referral process for eligible patients to the health home. At Mather, the IT department was able to build the referral tool into the hospital's EMR. Any staff member can refer a patient to HRHCare's health home via the "HRHCare button" in the medical record, during the patient's screening. By embedding this online referral form within the hospital's EMR, it streamlines the workflow and allows for increased utilization of the referral form.

Health Home Referral Screening within EMR
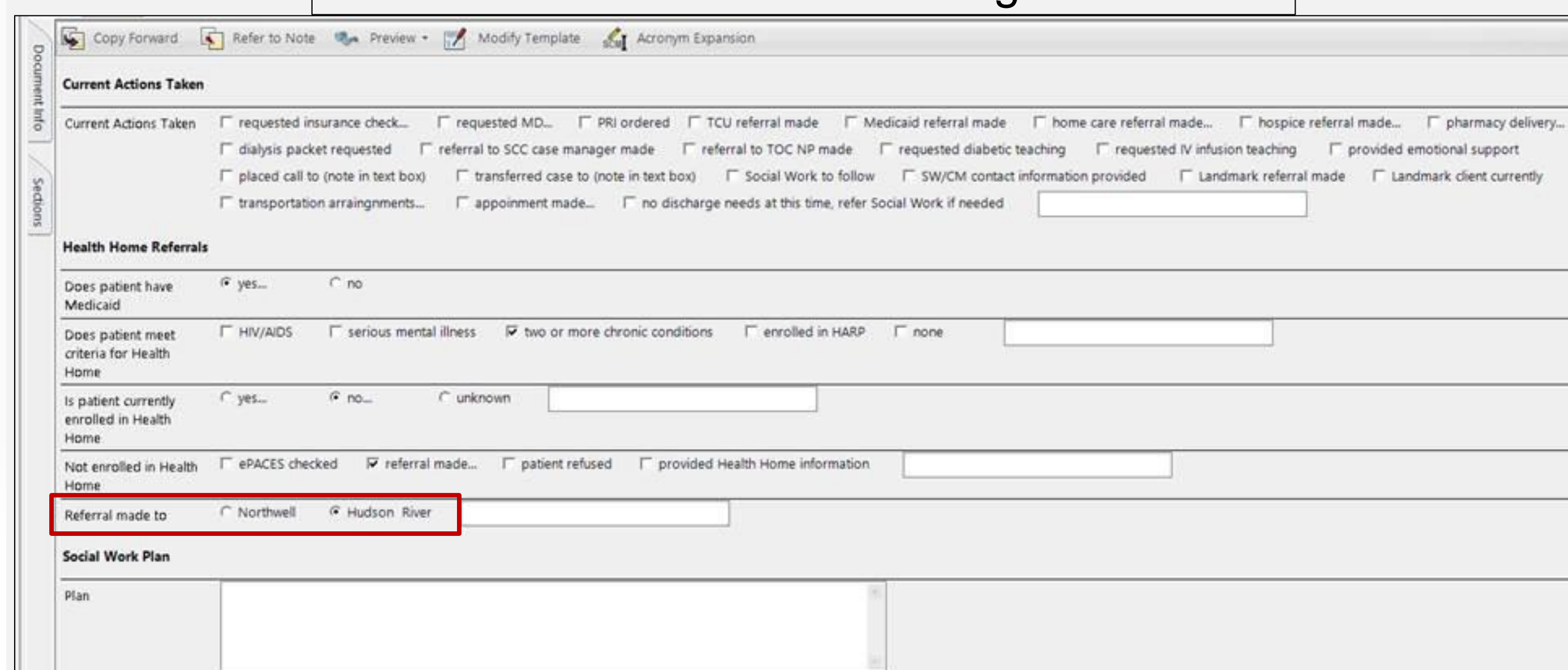
Staff will see this screen within the EMR prompting them to make an appropriate health home referral.
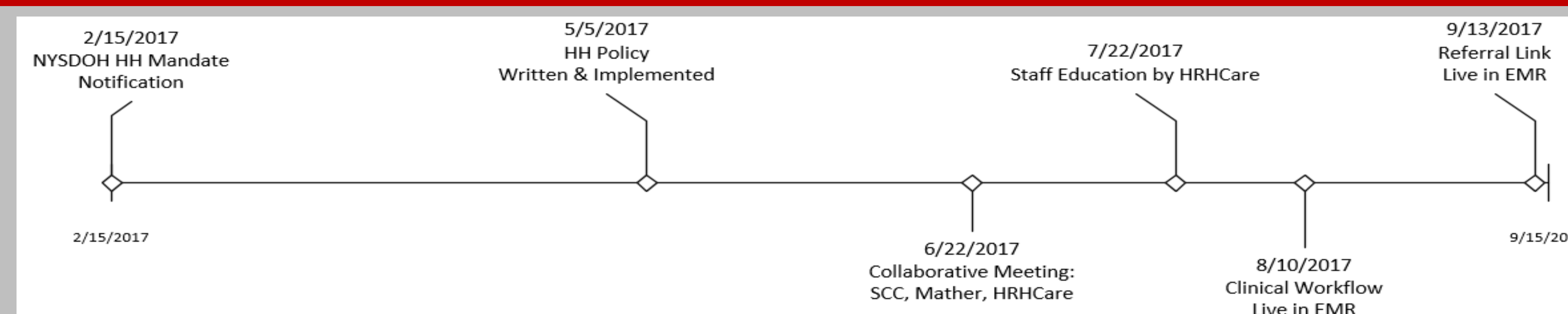
If a staff member would like to make an HRHCare health home referral, they indicate "Hudson River" within the EMR and they are redirected to HRHCare's online referral form.

HRHCare's Health Home Referral

https://www.cognitoforms.com/CCCHealthHome/CCCCommunityReferral

Timeline

| 2/15/2017 NYSDOH HH Mandate Notification | 5/5/2017 HH Policy Written & Implemented | 7/22/2017 Staff Education by HRHCare | 9/13/2017 Referral Link Live in EMR |

| 2/15/2017 | 6/22/2017 Collaborative Meeting: SCC, Mather, HRHCare | 8/10/2017 Clinical Workflow Live in EMR | 9/15/2017 |

As a part of next steps, we will monitor the rate of referrals to health home services from both the ED and inpatient units at Mather.

Acknowledgements
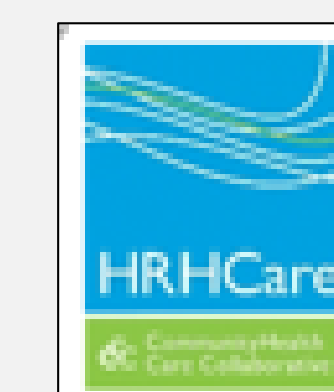
Contact Information

For more information, please contact: Kelly Donnelly, Project Manager, Acute Care Transitions @ Kelly.Donnelly@stonybrookmedicine.edu