2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions

Project Objective: To provide a 30-day supported transition period after a hospitalization to ensure discharge directions are understood and implemented by the patients at high risk of readmission, particularly patients with cardiac, renal, diabetes, respiratory and/or behavioral health disorders.

Project Description: A significant cause of avoidable readmissions is non-compliance with discharge regiments. Non-compliance is a result of many factors including health literacy, language issues, and lack of engagement with the community health care system. Many of these can be addressed by a transition case manager or other qualified team member working one-on-one with the patient to identify the relevant factors and find solutions. The following components to meet the three main objectives of this project, 1) pre-discharge patient education, 2) care record transition to receiving practitioner, and 3) community-based support for the patient for a 30-day transition period post-hospitalization.
Additional resources for these projects can be found at www.caretransitions.org and http://innovation.cms.gov/initiatives/CCTP/.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.
2. 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.
3. Ensure required social services participate in the project.
4. Transition of care protocols will include early notification of planned discharges and the ability of the transition case manager to visit the patient while in the hospital to develop the transition of care services.
5. Establish protocols that include care record transitions with timely updates provided to the members' providers, particularly delivered to members' primary care provider.
6. Ensure that a 30-day transition of care period is established.
7. Use EHRs and other technical platforms to track all patients engaged in the project.

Project Response & Evaluation (Total Possible Points – 100):

1. Project Justification, Assets, Challenges, and Needed Resources (Total Possible Points – 20)

a. Utilizing data obtained from the Community Needs Assessment (CNA), please address the identified gaps this project will fill in order to meet the needs of the community. Please link the findings from the Community Needs Assessment with the project design and sites included. For

example, identify how the project will develop new resources or programs to fulfill the needs of the community.

According to the Community Needs Assessment (CNA) Community Conversations, one of the most common negative experiences in healthcare is the lack of continuity in care. Providers interviewed also echoed the sentiment of lack of continuity and technology infrastructure across health care settings. Enhancement and expansion of the current SOCH/Catholic Health System Care Transition program for the Medicaid population will provide coordination of care between providers and amongst transition settings. The CNA provides insight to areas of impact by expansion of the existing Care Transition program: The current Potentially Avoidable readmissions rate is 5.8/100. A 25 % reduction would amount to 511 fewer readmissions or a goal rate of 1,238.4. Wyoming, Niagara, and Orleans counties are currently 80% above the goal rate (as high as 2289/100,000); WNY has a higher rate of hospitalizations for both adolescent and adult diabetes complications than NYS with Erie, Niagara, Cattaraugus, and Orleans performing worse than NYS. Erie County also showed higher rates of admission for congestive heart failure. Each of our counties have higher cardiovascular disease (CVD) mortality rates than New York State, with Niagara and Chautauqua reaching rates of over 300 per 100,000. Care Transition programs are about engagement of the patient /care giver in disease management programs to prevent complications which can affect hospitalization rates; WNY has a disproportionately large at-risk (health care needs, health vulnerability) population for five demographic groups: households without a vehicle, individuals Age 65+, single parent households, individuals in poverty, and African Americans who traditionally experience barriers to quality schools, good paying jobs and safe housing. Evidence supporting the success of Catholic Health's existing Care Transition program includes a comparison of patients enrolled in the program compared to eligible patients who declined enrollment. Data from 2010-2012 indicates a lower 30 day re-hospitalization rate for patients enrolled in the program. 2010 indicated a 6.60% re-admission rate compared to 9.04% readmission rate for those patients eligible but not enrolled; 2011-7.01% vs. 9.91% , 2012 results were 5.67% for vs. 13.96 and 2013 were 5.7% vs. 10.7%. Our partners and Medicaid patients will benefit from the enhanced Care Transition Program.

b. Please define the patient population expected to be engaged through the implementation of this project. The definition of patient population be specific and could be based on geography, disease type, demographics, social need or other criteria. This patient population that the PPS expects to actively engage over the course of the project will be a subset of the total attributed population.

The target population is Medicaid patients admitted to the hospital with a high risk for re-admission to the hospital who meet two or more of the 8 BOOST criteria. Medicaid patients will be identified while in the hospital through the use of a TARGET assessment 8P scale developed by Project BOOST (Society of Hospital Medicine). The "P" items on the assessment tool include: Problem Medications; Punk/Depression-presence of depression either in screening or in history; Principal diagnosis and/or co-morbidities of congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, cancer and stroke; Polypharmacy-number of medications as well as medications that increase the likelihood of adverse events post hospital discharge (66% of patients have at least 2 prescriptions); Poor health literacy-inability to teach back; Patient support-absence of caregiver or limited/lack of social supports; Prior hospitalization in the past six months; Palliative care-patients who have chronic disease management/symptom control needs. The program will begin where the highest concentration of Medicaid members visit, Mercy

Hospital of Buffalo in Erie County, while setting up programs in Niagara, Chautauqua and Orleans. A large proportion of Medicaid members reside in zip code areas 14218 and 14220 and those areas are nearest to Mercy Hospital. Our Community Needs Assessment indicated a high proportion of individuals at risk for re-hospitalization due to the prevalence of diabetes, CHF, cancer, stroke, COPD with co-morbid conditions, as well as behavioral health needs and lack of social supports. Individuals with low socio-economic status often have poor health literacy and therefore do not understand the instructions provided upon hospital discharge. Understanding of their disease state and compliance improves for this population when there is a visit in their own home with review by a Care Transitions Nurse/Coach trained to work in a culturally competent manner in the patient's own environment.

c. Please provide a succinct summary of the current assets and resources that can be mobilized and employed to help achieve this DSRIP Project. In addition, identify any needed community resources to be developed or repurposed.

This project will expand on the current program's success. Community Partners of WNY will utilize current assets and resources to help achieve the goals of this DSRIP project. CPWNY will engage partner hospitals and home care agencies and expand the number of Care Transitions Nurses/Coaches as well as provide augmented training for healthcare providers and new Care Transitions Nurses/Coaches. Addition of social workers and patient navigators will enhance our ability to reach out to complex patients. Catholic Health Home Care's Health Home, has been recognized as one of the most successful Health Homes in New York State. It is anticipated that many patients eligible for Care Transitions will benefit from a linkage to the Health Home for ongoing Care Coordination to prevent unnecessary readmissions. Care Transitions patients will also be connected with Care Coordinators in primary care offices to continue to provide telephonic follow up and monitor compliance with primary care visits and disease management. Standardized protocols and tools will be utilized and are assets to the program. Standard protocols include but are not limited to: engagement by a Care Transitions Nurse/Coach with the patient upon admission to the hospital (gain trust and assess specific needs such as language, cultural needs as well as access /transport issues); completion of pre-discharge patient medication reconciliation and review of patient education tools to effectively prepare patients and caregivers for hospital discharge; scheduling follow up patient appointments within five to seven days of discharge from hospital; home visit by Care Transition Nurse/Coach within 48-72 hours of patient discharge from hospital to reinforce and expand on the information provided in the hospital pre-discharge and provide continuity for the transition to the patient's community based setting; medication reconciliation by pharmacist with communication to providers; patient education materials and self-management tools/motivational interviewing; personal health record; series of structured telephone calls with a Care Transitions Nurse for 30 days post hospital discharge ideally at 2, 7 and 14 days post discharge to reinforce results at prior visit and determine changes, progress in meeting patient goals and to answer patient questions and concerns; modeling behavior for how to handle common problems and/or next encounter or visit; community-based support for Health Home enrollees by Health Home Care Coordinators; ongoing PCP office Disease Management Nurse coaching; referrals to managed care plan Health Coaches where available; Collaboration with Health Care Plans and their services where applicable as well as social services departments in partner counties. While the Care Transitions Program will be structured with workflows and standardized tools, the specific content and format may vary by

patient and visit to meet the patient, caregiver and situations specific needs. Resources would need to be enhanced for the Community Partners of WNY and community resources embraced such as home care, patient navigators (to be developed), use of Catholic Charities for social issues, to name a few.--- Medical Director (existing resource): 0.5 FTE; Health Information Technology Specialist (added): 1.0; Director/Manager of Program (existing resource): 1.0; Clinical Pharmacist (added): 2.0; RN Care Transition Nurse/case management: (added to existing for all counties): 4.0; Social Worker (added to existing positions for all counties): 3.5; Patient Navigator/Community outreach worker (new positions): 3.0.

d. Describe anticipated project challenges or anticipated issues the PPS will encounter while implementing this project and describe how these challenges will be addressed. Examples include issues with patient barriers to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.

Challenges anticipated with this program are: changing care processes at transition touch points that will be addressed with informational meetings and key successes of existing program; Provider buy in to order or speak to patient about the program -The approach is to use our local physicians to work with other physicians in their area regarding the program; Lack of standardization of electronic medical records that inhibits the transfer of information - Need to purchase a communication tool /or integrate EMRs so that coordination of care can occur without added burden.; Lack of financial support from all managed care plans to pay for these services- The DSRIP grant will financially enable the expansion of this program. Poverty was described in provider interviews as a pervasive overriding issue driving health care need. Nearly a half million individuals in the region live in or near poverty, and are concentrated in Erie and Niagara counties. Poverty status impacts financial capacity to access health-promoting resources such as vehicles, computers, healthy foods, preventive care copays and more. -Community outreach or patient navigators can meet patients where the patient wants, such as at the church, library or call the patient. Refusal from patients to accept the program. The refusal rate for Care Transitions Programs averages at approximately 38%. -The use of Patient Navigators/Community Outreach Workers should increase the acceptance rate.

e. Please outline how the PPS plans to coordinate on the DSRIP project with other PPSs that serve an overlapping service area. If there are no other PPS within the same service area, then no response is required.

Community Partners of WNY will work with the other PPS that has overlapping service areas through periodic collaborative meetings to discuss issues and share solutions.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the overall scale and broadness in scope, in terms of expected impact the project will have on the Medicaid program and patient population. Those projects larger in scale and impact will receive more funding than those smaller in scale/impact. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess scale, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

3. Speed of Implementation/Patient Engagement (Total Possible Points - 40):

DSRIP projects will be evaluated based upon the proposed speed of implementation and timeline for patient engagement. The projects with accelerated achievement of project requirements and active engagement of patients will receive more funding than those taking longer to meet goals. Progress towards and achievement of PPS commitments to these scale measures as provided in the application will be included in achievement milestones for future PPS funding. In order to assess speed and patient engagement, please complete the following information.

Please use the accompanying Speed & Scale Excel document to complete this section.

4. Project Resource Needs and Other Initiatives (Not Scored)

a. Will this project require Capital Budget funding? ***(Please mark the appropriate box below)***

Yes	No
☒	☐

If yes: Please describe why capital funding is necessary for the Project to be successful.

Support the integration of electronic medical records and communication tools.

b. Are any of the providers within the PPS and included in the Project Plan currently involved in any Medicaid or other relevant delivery system reform initiative or are expected to be involved in during the life of the DSRIP program related to this project's objective?

Yes	No
☒	☐

If yes: Please identify the current or expected initiatives in which the provider is (or may be) participating within the table below, which are funded by the U.S. Department of Health and Human Services, as well as other relevant delivery system reform initiative(s) currently in place.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Brooks Memorial Hospital	Medicaid / Interact Program	2015 Q1		Collaboration with Chautauqua County Health Network (CCHN) to reduce readmissions using Interact Program

c. Please describe how this proposed DSRIP project either differs from, or significantly expands upon, the current Medicaid initiative(s) identified above. A PPS may pursue a DSRIP project that exists as part of another effort if the PPS can demonstrate a significant enhancement to the existing project.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of project requirements, scale of project implementation, and patient engagement progress in the project.

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well

as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.