Hudson Valley DSRIP

Clinical & Program Planning Sub-Committee Meeting

Focus on Cancer, Cardiology, and Care Transitions DSRIP Projects

Breakout Sessions

August 13, 2014
# Table of Contents

<table>
<thead>
<tr>
<th>I</th>
<th>Hospital-Home Care Transitions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Project Goals and Key Components</td>
</tr>
<tr>
<td></td>
<td>• Example Intervention</td>
</tr>
<tr>
<td></td>
<td>• Draft Driver Diagram</td>
</tr>
<tr>
<td></td>
<td><strong>Page</strong> 3-6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II</th>
<th>Primary and Secondary Chronic Disease Prevention Strategies (Cardio)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Project Goals and Key Components</td>
</tr>
<tr>
<td></td>
<td>• Example Intervention</td>
</tr>
<tr>
<td></td>
<td>• Draft Driver Diagram</td>
</tr>
<tr>
<td></td>
<td><strong>Page</strong> 8-11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III</th>
<th>Access to Chronic Disease Preventive Care &amp; Management (Cancer)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Project Goals and Key Components</td>
</tr>
<tr>
<td></td>
<td>• Example Intervention</td>
</tr>
<tr>
<td></td>
<td>• Draft Driver Diagram</td>
</tr>
<tr>
<td></td>
<td><strong>Page</strong> 13-16</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IV</th>
<th>The Medical Neighborhood – Primary to Specialty Care Transitions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Building the Medical Neighborhood</td>
</tr>
<tr>
<td></td>
<td>• Expanding the Medical Neighborhood</td>
</tr>
<tr>
<td></td>
<td>• Draft Driver Diagram</td>
</tr>
<tr>
<td></td>
<td><strong>Page</strong> 18-22</td>
</tr>
</tbody>
</table>
Hospital-Home Care Transitions – Project Goals and Key Components

2.b.viii Hospital-Home Care Collaboration Solutions

NYS Toolkit defines project goal as:

“Implementation of INTERACT-like program in the home care setting to reduce risk of re-hospitalizations for high-risk patients”

Toolkit specifies that the project must include the following key components:

• Rapid Response Teams (hospital/home care) to facilitate patients’ discharges
• Home care staff trained to identify and prevent patient risks for readmission and to support evidence-based medicine chronic care management
• Care pathways and other clinical tools for monitoring chronically ill patients
• Education of all staff on care pathways and INTERACT principles
• Advance Care Planning tools for residents and families
• Patient and family/caregiver education and engagement around care planning, including support of family/caretakers and potential for respite services
• Integration of primary care, behavioral health, pharmacy and other services within model
• Utilization of telehealth and interoperable EHRs
• Demonstration of cultural competence

What are additional goals for our PPS?
Are there other services that may enhance the project?
Example Intervention: INTERACT (Interventions to Reduce Acute Care Transfers)*

A quality improvement project adopted by many nursing homes in US, Canada, Singapore, and UK to reduce transfers from long term care facilities to acute hospitals.

5 Main Strategies

1. Quality improvement team facilitated by strong leadership; measurement, tracking, benchmarking clearly defined outcomes; continuous learning;
2. Early identification/evaluation of changes in patient condition;
3. Management of common changes without transfer when safe/feasible;
4. Improved advance care planning and use of palliative/hospice care;
5. Improved communication/documentation within facility, b/w facilities and families, b/w facilities and hospital.

3 Tools for Staff

1. Communication tools
2. Care Paths or Clinical tools
3. Advance Care Planning tools

* [http://interact2.net/index.aspx](http://interact2.net/index.aspx)
### Evidence Base

- 2009 Pilot implementation in 3 nursing homes with high hospitalization rates was associated with a 50% reduction in hospitalization rates and 36% reduction in proportion of avoidable hospitalizations.
- After 6 months of implementation, 25 nursing homes in FL, NY, and MA saw a 17% reduction in hospitalization rates compared to the 6 months pre-implementation.

### Implementation in New York

- In 2012, the Greater New York Hospital Association Foundation, Inc. began implementing an intervention in 30 nursing facilities in the NYC metropolitan region after being selected as an awardee from CMS in 2012. RNs have been deployed in the partnering nursing facilities to train the nursing facility staff on INTERACT tools and the American Medical Director Association Clinical Practice Guidelines on Acute Change in Condition. The project will also implement the use of an eINTERACT system to eliminate the need for the paper-based format and provide real-time access to beneficiary information to all providers across the continuum of care.
- Results from the GNYHA Foundation are not yet available. CMS has contracted with RTI International to conduct an evaluation.
• Stratify discharged patients by readmission risk; develop risk stratified protocols for post-discharge tracking
• Create a risk appropriate discharge care plan; identify “warning” items to alert of a change in condition and action plan steps to take
• Engage patients and families in culturally appropriate discussion of care plan, warning signs and action steps; assist with advanced care planning and incorporate palliative care into treatment plans as appropriate
• Assist patient/family with scheduling post-discharge follow up care; prepare patient/family with questions/items to address at follow-up visit
• Send reminders to patient and track compliance with post discharge care plan as indicated by risk

• Adapt INTERACT project to Home Care setting; adapt INTERACT tools and care plans; train staff
• Work across the delivery system in local hubs to develop “Rapid Response Team” capacity to safely manage some changes in condition without re-admission
• Employ health coaches to connect with patients pre-discharge and provide in-home assistance with questions and scheduling follow up care
• Build IT capacity to allow physicians caring for patient to access transitional care records and care plans across provider organizations
• Reconcile hospital medications with outpatient providers
• Obtain consent from patients for record sharing

• Review readmissions to better understand what is needed to keep patients safely at home after discharge.
• Continually assess community resources and build capacity to better meet patient’s needs
• Incorporate new technology (e.g. telehealth) and new services (e.g. patient navigators/community health workers; pharmacist led medication reconciliation.)

*New York State has set a goal of a 25% reduction in avoidable hospital use over 5 years.
# Table of Contents

## I  Hospital-Home Care Transitions
- Project Goals and Key Components
- Example Intervention
- Draft Driver Diagram

## II  Primary and Secondary Chronic Disease Prevention Strategies (Cardio)
- Project Goals and Key Components
- Example Intervention
- Draft Driver Diagram

## III  Access to Chronic Disease Preventive Care & Management (Cancer)
- Project Goals and Key Components
- Example Intervention
- Draft Driver Diagram

## IV  The Medical Neighborhood – Primary to Specialty Care Transitions
- Building the Medical Neighborhood
- Expanding the Medical Neighborhood
- Draft Driver Diagram
### Primary and Secondary Chronic Disease Prevention Strategies (Cardio)

#### Project Goals and Key Components

3.b.ii Implementation of evidence based strategies in the community to address chronic disease – primary and secondary strategies (adult only)

#### NYS Toolkit defines project goal as:

“Improving patient self-efficacy and confidence in self-management, and engagement of the at-risk population in primary and secondary disease prevention strategies related to cardiovascular health”

#### Toolkit specifies that the project must include the following key components:

- Development of, or partnership with, community resources to expand availability of evidence-based self-management programs (e.g., Stanford Chronic Disease Self-Management Program)
- Development and administration of protocols for screening and referral
- Collaboration with self-management programs to monitor patient progress
- Adoption of comprehensive nutrition standards for PPS facilities
- Use of quality committee to monitor outcomes and implement improvements

What are additional goals for our PPS? Are there other services that may enhance the project?
Example Intervention: Strategies from Million Hearts Campaign

• National initiative co-led by CDC, CMS and HHS that aims to prevent 1 million heart attacks and strokes between 2012-2017\(^1\)

• Focuses, coordinates and enhances cardiovascular disease prevention activities across public private sector

• Clinical interventions include:\(^2\)
  • Improving access to effective care
  • Improve quality of care of ABCs
  • Focus clinical attention on prevention of heart attack/stroke

• Community interventions include:
  • Activate public to lead a heart-healthy lifestyle
  • Encourage reduced smoking, improved nutrition
  • Improve prescription and medication adherence for the ABCS

• Sample activities include:
  • Educational campaigns
  • HIT and quality improvement initiatives to standardize and improve relevant care delivery
  • Community efforts to promote smoke-free policies and reduce sodium in food
  • Reducing/eliminating copays for medications, team-based care approaches, stepwise care mgmt

NOTES:
1) [http://millionhearts.hhs.gov/index.html](http://millionhearts.hhs.gov/index.html)
2) Drop in NEJM link
Example Intervention: Stanford Chronic Disease Self-Management Program (CDSMP)

- One of several evidence-based self-management programs for people with chronic health problems developed by Stanford
  - In addition to CDSMP, other programs include diabetes, chronic pain, HIV/AIDS, arthritis

- Workshop for people with different chronic diseases to learn skills needed in day-to-day management of treatment and maintaining or increasing life activities
  - Courses run for 6 weeks, meeting once a week for 2.5 hours
  - Meetings are held in community settings (e.g., senior centers, churches, libraries and hospitals)

- Subjects covered include:
  - Techniques to deal with problems (e.g., frustration, pain, fatigue)
  - Appropriate exercise
  - Appropriate use of medications
  - Effective communication techniques
  - Nutrition
  - Decision making
  - Evaluating new treatments

- Stanford offers training on model for healthcare organizations

EVIDENCE/RESULTS:
- Patients who received intervention had fewer days in hospital, less outpatient visits; reported improved symptom management, communication with physician and improved general health
- National study showed potential net savings of $364/participant, and national savings of $3.3B if 5% of adults with 1+ chronic conditions were reached

ADOPTION:
- Adopted by numerous groups including: the NHS of England, Diabetes Society of British Columbia in Canada, Kaiser Permanente, and Group Health Cooperative of Puget Sound
- In Hudson Valley area, Hudson River Healthcare is licensed to offer these classes; “Healthy Choices NY” classes are offered for free

NOTES:
1) http://patienteducation.stanford.edu/programs/cdsmp.html
3) http://patienteducation.stanford.edu/organ/cdsitenewyork.html
4) http://www.hrhcare.org/events/healthy-choices-ny-chronic-disease-self-management/
Primary and Secondary Chronic Disease Prevention Strategies (Cardio)

Driver Diagram

**Global Aim**

Reduction in avoidable hospitalization and ER utilization

**Primary Drivers**

- Expand availability of evidence-based self-management programs
- Develop and administer protocols for screening and referral
- Collaborate to monitor patient progress
- Adopt comprehensive nutrition standards for PPS facilities
- Leverage Quality Committee to monitor progress & implement improvements

**Secondary Drivers**

- Inventory community-based resources for evidence-based patient self-management programs, including identification of gaps and community partners for program development/expansion
- Select evidence-based program models to support patient self-management (e.g., Stanford Chronic Disease Self-Management Program) and customize for target population (i.e. ensure culturally competent care)
- Identify and address workforce needs, including staffing and training of program staff on patient self-management model/protocols
- Identify and address reimbursement models to sustain and/or expand programs
- Convene clinical committee or working group to review protocols to identify patients with (or at high risk for) hypertension, hyperlipidemia, and/or coronary artery disease, and refer to community-based self-management programs
- Implement protocols and rollout materials/tools to workforce; train workforce as needed and on ongoing basis
- Incorporate protocols into EHR and other technology to facilitate electronic alerts and reminders, improve communication and link to community resources
- Monitor utilization of protocols and outcomes pre- and post-implementation; revise protocols as needed to reflect best practices and population needs
- Develop policies and procedures to facilitate collaboration among referring providers and community-based self management programs
- Conduct outreach to patients as necessary to support self-management activities
- Convene committee or working group comprised of Directors of Food/Nutrition and other relevant staff from across the PPS and identify participating sites
- Select and/or develop nutrition standards for PPS facilities to improve quality of food served to employees, patients and public
- Develop plan for rollout of nutritional guidelines, including working with food vendors to incorporate standards into related contracts
- Develop (or leverage) Quality Committee to monitor program progress and implement improvements
- Establish evaluation process to ensure continuous program improvements

**Other drivers/interventions?**

*New York State has set a goal of a 25% reduction in avoidable hospital use over 5 years.
<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I Hospital-Home Care Transitions</strong></td>
<td>3-6</td>
</tr>
<tr>
<td>• Project Goals and Key Components</td>
<td></td>
</tr>
<tr>
<td>• Example Intervention</td>
<td></td>
</tr>
<tr>
<td>• Draft Driver Diagram</td>
<td></td>
</tr>
<tr>
<td><strong>II Primary and Secondary Chronic Disease Prevention Strategies (Cardio)</strong></td>
<td>8-11</td>
</tr>
<tr>
<td>• Project Goals and Key Components</td>
<td></td>
</tr>
<tr>
<td>• Example Intervention</td>
<td></td>
</tr>
<tr>
<td>• Draft Driver Diagram</td>
<td></td>
</tr>
<tr>
<td><strong>III Access to Chronic Disease Preventive Care &amp; Management (Cancer)</strong></td>
<td>13-16</td>
</tr>
<tr>
<td>• Project Goals and Key Components</td>
<td></td>
</tr>
<tr>
<td>• Example Intervention</td>
<td></td>
</tr>
<tr>
<td>• Draft Driver Diagram</td>
<td></td>
</tr>
<tr>
<td><strong>IV The Medical Neighborhood – Primary to Specialty Care Transitions</strong></td>
<td>18-22</td>
</tr>
<tr>
<td>• Building the Medical Neighborhood</td>
<td></td>
</tr>
<tr>
<td>• Expanding the Medical Neighborhood</td>
<td></td>
</tr>
<tr>
<td>• Draft Driver Diagram</td>
<td></td>
</tr>
</tbody>
</table>
Access to Chronic Disease Preventive Care & Management (Cancer) – Project Goals and Key Components

4.b.ii Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (targets chronic disease not included in 3.b – e.g., cancer)

NYS Toolkit defines project goal as:

“Increase the number of New Yorkers who receive evidence-based preventive care and management for chronic diseases”

Toolkit specifies that the project must include the following key components:

- Establishment or enhancement of reimbursement and incentive models to increase delivery of high-quality disease prevention and management services
- Availability of recommended clinical preventive services and pathways to community-based preventive service resources
- Incorporation of Prevention Agenda goals and objectives into Community Services Plans and coordinated implementation with community partners
- Adoption and use of EHRs, including relevant clinical decision support and registry functionality
- Adoption of medical home or team-based care models
- Creation of feedback loops to, and quality improvement incentives for, clinicians around clinical benchmarks
- Reduction or elimination of out of pocket costs for clinical and community preventive services

What are additional goals for our PPS? Are there other services that may enhance the project?
Example Intervention: Automated Calls

Kaiser Permanente Colorado reaches out to all average-risk members due for colorectal cancer screening through an **automated call** that educates them about the disease and screening options, and then sends them a fecal immunochemical test (FIT) kit that can be completed at home and returned by mail.

**Automated Phone Call**
- Eligible members receive an automated, interactive 1–to-3-minute telephone call in which they respond to a series of questions
- If no one answers the call, the system calls three times, leaving a message with a callback telephone number on the third call

**FIT Kit Mailed**
- All average-risk members who receive a call and do not request a colonoscopy are mailed a FIT kit with instructions and a prepaid return envelope
- Patients who do not send in their kits receive a reminder letter one month later
- **The program sends a FIT kit each year for members who initially chose to screen by FIT and remain eligible for screening**

**Notification & Follow Up**
- Members with negative FIT results receive notification by mail
- For members who test positive, the patient’s primary care provider is notified via the EMR system, and the provider’s office contacts the patient to schedule a follow-up diagnostic evaluation
- Members who did not complete the colonoscopy after a positive FIT test receive a reminder letter at 8 weeks and the provider follows up directly with the member at 16 weeks

**Evidence/Results**
- The educational call and mailed FIT kit increased the rate of screening completion fourfold
- Screening rate among all eligible members rose 25%, from 46% in 2006 (before program launch) to 72% in 2008 (after implementation) [For reference, CRC screening statewide only rose 3% during the same time]
- Other studies have validated that the automatic call is a cost-effective way of enhancing CRC screening rates by about 6% and only raise costs about $3 per patient

The Witness Project is a culturally informed, community-based breast and cervical cancer program designed to increase awareness, knowledge, and motivation, thereby increasing screening and early-detection behaviors among African American Women. In one year, the Project at the University of Arkansas reached more than 700 women and referred more than 250 women for mammograms and clinical breast exams.

Material is presented through story-telling and experiential learning techniques to appeal to adult learners with limited formal education.

Participants are given information about early detection and local breast and cervical cancer screening services.

Local African American breast and cervical cancer survivors serve as “Witness Role Models,” speaking to other women in local churches and community organizations.

Witness Role Models highlight early detection and treatment, teach self-examination, and emphasize the importance of taking responsibility for one’s own health.

**NYS Intervention**

The Witness Project of Buffalo and Niagra invites women to share messages of cancer prevention and early detection with their churches, families, and communities. The Project also provides assistance to cover mammograms and pap tests for women who qualify.
Chronic Disease Preventive Care and Management (Cancer) Driver Diagram

Global Aim*

“Increase the number of New Yorkers who receive evidence-based preventive care and management for chronic diseases”

*New York State has set a goal of a 25% reduction in avoidable hospital use over 5 years.

Primary Drivers

Actions Impacting Goal

- Identify patients in need of chronic disease (cancer) preventive care and management
- Develop and administer evidence-based protocols for cancer preventive care and management in the clinical setting
- Connect patients to community-based preventive care and management resources
- Address reimbursement and/or incentives to promote cancer screening and follow-up treatment

Secondary Drivers

Implementation

- Stratify patient population to identify patients who have not received recommended cancer screenings (i.e., colorectal, breast, cervical, and lung)
- Identify and address barriers to screenings
- Conduct outreach to patients and facilitate screenings
- Develop protocols to follow up on positive screenings

- Develop evidence-based protocols to promote cancer screenings & follow-up; Revise as needed to reflect learnings/best practices and population needs
- Roll out protocols and associated materials/tools to workforce; train workforce as needed and on an ongoing basis—including use of team based care to improve cancer preventive care in medical home setting
- Incorporate protocols into EHR and other technology to facilitate electronic alerts and reminders, and improve communication
- Monitor use of protocols and outcomes pre- and post- implementation

- Survey and inventory community-based resources for cancer screening and treatment; create & share resource list of community-based resources
- Establish linkages to community-based resources, particularly for uninsured patients
- Train care management staff on use of community-based resources
- Document referrals to community-based resources and associated outcomes
- Identify need for additional delivery system or community-based resources to support cancer screening/treatment; work collaboratively to expand capacity

- Identify existing payment models within the service area and nationally that may be leveraged to encourage cancer screening and follow-up
- Collaboratively explore new payment/incentive models for local implementation within PPS; collect and collect pre- and post data to determine impact on outcomes
- Share data to encourage transparency and discussion of best practices; provide feedback on clinical benchmarks

Other drivers/ interventions?
# Table of Contents

<table>
<thead>
<tr>
<th>I</th>
<th>Hospital-Home Care Transitions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Project Goals and Key Components</td>
</tr>
<tr>
<td></td>
<td>• Example Intervention</td>
</tr>
<tr>
<td></td>
<td>• Draft Driver Diagram</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>II</th>
<th>Primary and Secondary Chronic Disease Prevention Strategies (Cardio)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Project Goals and Key Components</td>
</tr>
<tr>
<td></td>
<td>• Example Intervention</td>
</tr>
<tr>
<td></td>
<td>• Draft Driver Diagram</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>III</th>
<th>Access to Chronic Disease Preventive Care &amp; Management (Cancer)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Project Goals and Key Components</td>
</tr>
<tr>
<td></td>
<td>• Example Intervention</td>
</tr>
<tr>
<td></td>
<td>• Draft Driver Diagram</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IV</th>
<th>The Medical Neighborhood – Primary to Specialty Care Transitions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Building the Medical Neighborhood</td>
</tr>
<tr>
<td></td>
<td>• Expanding the Medical Neighborhood</td>
</tr>
<tr>
<td></td>
<td>• Draft Driver Diagram</td>
</tr>
</tbody>
</table>

Page: 3-6, 8-11, 13-16, 18-22
The Medical Neighborhood

What Is a Medical Neighborhood?

AHRQ conceptualizes the medical neighborhood as a PCMH and the constellation of other clinicians providing health care services to patients within it, along with community and social service organizations and State and local public health agencies.

Defined in this way, the PCMH and the surrounding medical neighborhood can focus on meeting the needs of the individual patient but also incorporate aspects of population health and overall community health needs in its objectives.


Key Actors and the Flow of Information in the Medical Neighborhood

Diagram showing the flow of information and key actors in the medical neighborhood.
In 2014, eligible professionals (EP) participating in the Meaningful Use EHR incentive program must report on 9 clinical quality measures (CQMs). EPs may choose from a menu of options, however, CMS has outlined a recommended set of 9 core measures for adults that focus on high-priority health conditions and best-practices for care delivery.

Source: Centers for Medicare and Medicaid Services (CMS), “2014 Clinical Quality Measures (CQMs) Adult Recommended Core Measures Table,” www.cms.gov/ehrincentiveprograms
Building the Medical Neighborhood - Closing the Referral Loop
AMA – Wright Center – PA Dept of Health Pilot Project

Primary Care Physician– Cardiologist collaboration pilot using the Institute for Healthcare Improvement’s (IHI) Learning Collaborative Model to test interventions and approaches that have improved the referral process within individual health care systems.

Three Focus Areas for Improvement
1. Did the referring(requesting) physician get the answer to their question/get the help they asked for/needed?
2. Did the specialist (receiving physician) get what they needed to do the referral that was requested and
3. Did the patient feel that the care was coordinated and did they get what they needed?

<table>
<thead>
<tr>
<th>PCP Measures</th>
<th>Cardiologist Measures</th>
<th>Overall Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>• % decrease in number of open cardiology referrals.</td>
<td>• % decrease in the number of days from referral sent to appointment.</td>
<td>• % decrease # of total days from referral created to referral closed.</td>
</tr>
<tr>
<td>• % increase in number of closed cardiology referrals.</td>
<td>• % decrease in the number of days from appointment to referral closed.</td>
<td>• PCP satisfaction with the referral process.</td>
</tr>
<tr>
<td>• % decrease in the number of days from referral created to referral sent.</td>
<td>• % of complete cardiology referral reports sent by Cardiologist to PCP.</td>
<td>• Cardiologist satisfaction with the referral process.</td>
</tr>
<tr>
<td>• % of complete summary of care records sent with referral to Cardiologist.</td>
<td></td>
<td>• Patient satisfaction with the referral process.</td>
</tr>
</tbody>
</table>

Expanding the Medical Neighborhood
Links to Address Gaps in Care and Social Determinants of Health

As much as 40% of health outcomes may be linked to social and economic factors and poor health is closely tied to inadequate housing, food insecurity, and unemployment or underemployment.

Example Strategies and Interventions to Meet Patients’ Social Needs

Health Leads enables health care providers to write prescriptions for their patients’ basic needs, such as food and heat. Trained volunteers staff desks at hospitals and clinics, connecting patients to local resources that address their needs.

Medical-Legal Partnerships (MLPs) place lawyers and paralegals at health care institutions to help patients address legal issues linked to health status. An MLP in NYC targeting patients with moderate to severe asthma found a 91% decline in emergency department visits and hospital admissions among those receiving services.

Healthify offers an electronic platform that screens patients for unmet social needs in clinical settings, such as clinic waiting rooms. The tool transmits a list of patients’ social needs to their clinicians and provides patients with local, state, and federal resources that could help address their needs.
Primary Drivers

Actions Impacting Goal

- Ensure patients have a primary care medical home
- Primary Care: Conduct effective transfers of patients to appropriate specialty setting
- Specialty Care: Ensure feedback loop to primary care provider
- Augment patient activation
- Connect individuals with supportive community based resources; build community capacity to meet patient needs.

Secondary Drivers

Implementation

- Support Primary Care Providers in becoming a Patient Centered Medical Home
- All providers: educate patients on the importance of primary care; identify and record/update primary care (PCP) contact information for all patients
- Educate broadly – patients, peers, public – about PCMH
- Implement evidence-based protocols for coordination of referrals/transitions of care, to include assessment of patient’s clinical, insurance and logistical needs and utilization of transition checklists/QI tools
- Ensure a transition record clearly summarizing relevant history and reason for referral precedes and accompanies the patient
- Hire/train staff to coordinate referrals and to track completion
- Identify patient barriers to completing referrals/transitions; coach patients on addressing them; build capacity for specialty care where needed
- Provide follow up post-referral or transition
- Close the loop! Identify/record/update PCP for every patient; obtain consent from patient to share visit summary with RHIO and PCP
- Link to RHIO; look for care plans; send care summary /transition records
- Engage patient in maintaining personal health record
- Ask about care managers and Health Home to facilitate care coordination
- PCPs and Specialists use RHIO based Care Plan to create virtual care team for patients
- Ensure care team monitors and tracks patient engagement
- Identify community resources to broadly meet patient needs: primary care; specialty medical care; behavioral health and substance use care; housing; employment; public assistance/benefits; education; transportation; disability resources; food and clothing; daily living skills including financial planning, shopping and cooking; family support; legal counsel/social justice; community & social life; resources for recreational, intellectual and spiritual engagement
- With others build local community capacity to broadly meet patient’s needs

Global Aim*

Reduction in avoidable hospitalization and ER utilization

*New York State has set a goal of a 25% reduction in avoidable hospital use over 5 years.