

**WMC DSRIP PPS Project Plans**

**Application Section 4**

*Submitted December 22 2014*

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

**Project Response & Evaluation:**

**1. Project Description and Justification**

**1a. 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.**

In our broader region, overall rates of adult and child hospital admissions that might have been avoided with appropriate ambulatory care were better than the NYS average (2011-2012). However, there were significant “hot spots” that indicate opportunities for improvement. Ulster, Orange and Dutchess counties had higher than average rates of avoidable hospital admissions for adult respiratory disease; rates were above average for hypertension in Orange County and for diabetes in Ulster and Westchester counties.

Congruent with our hot spot analysis, patients discharged from some hospitals within our PPS demonstrated a higher rate of Potentially Preventable Readmissions (PPRs) than was reported statewide in 2012, including some of the highest and lowest risk adjusted PPR rates in NYS: Blythedale Children’s Hospital, 32.39; Ellenville Regional Hospital, 18.3; WMC, 6.98; Northern Westchester Hospital, 4.48; Northern Dutchess Hospital, 1.09.

In addition to geographic and socioeconomic disparities, research conducted as part of our CNA indicated patient with certain diagnoses or co-morbidities were more likely to experience potentially preventable admissions or readmissions. Medicaid beneficiaries with behavioral health (BH) diagnoses (e.g. mental health, substance abuse) experience PPRs over 3.5 times more frequently than beneficiaries without BH diagnoses. The rate for follow up after hospitalization for mental illness within 7 days and within 30 days is lower compared to overall regional and statewide rates. In Rockland, rates are 28.9% and 41% respectively compared to 38.5 and 54.4 for NYS; rates are also lower for 7 day follow up in Orange and Dutchess.

Our CNA convened meetings and conducted interviews with partners involved in care coordination and reducing admissions. Identified gaps to best practice care transitions included inconsistent discharge protocols and processes; the lack of coordinated medication reconciliation, information technology, and care plan exchange constraints; and shortages in community based resources.

To achieve the ambitious statewide DSRIP goal of reducing avoidable admissions across the Medicaid population by 25%, it will be necessary to not only reduce variation by addressing

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outlier performance, but to broadly reduce all avoidable admissions, including readmissions and ambulatory sensitive admissions to best-in-class levels. To advance this goal, our PPS will convene a Quality Committee to compare and standardize discharge transition protocols among participating hospitals and primary care organizations. We will involve MCOs, Health Homes, and participating home care agencies to ensure protocols are feasible and will bring early implementation results back to the committee so protocols can be adjusted based on what works. Our PPS will establish an analytics platform to incorporate data from participating partner EHRs to track patients and to support evaluation. Our project will specifically address factors that may contribute to excess hospitalization of patients with severe or chronic BH conditions who often lack connection with a primary care professional (PCP) and will assess engagement with PCPs as a component of discharge planning and ensure participating hospitals send complete and timely care transition records to PCPs and other outpatient providers. After discharge, patient confusion about medications is a frequent cause of medical error. Our project will have a strong component of pharmacist assisted Medication Reconciliation, which may be particularly needed for patients whose BH medications may impact their physical health.

To support all of these efforts, we will enhance and/or develop four region-wide capabilities, discussed in greater detail below: (1) care coordination and analytics platforms, (2) risk stratification tools, (3) a centralized inventory of social service organizations, and (4) health information exchange capabilities.

**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 for this project will be attributed patients discharged from hospitals in our PPS who receive ambulatory care from affiliated PCPs. The project will focus on adult patients with discharge diagnoses related to diabetes, heart or respiratory disease, or a mental and/or behavioral health disorder. To be sustainable, an intervention at transition of care must tailor the intensity of the intervention to the patient risk of readmission. One of the first tasks of the project will be to review and compare risk stratification tools and to reach consensus with project partners.

Our CNA process identified the importance of discharge disposition (particularly to rehabilitation, home, or home with home care services), assessing patient engagement using the Patient Activation Measure (PAM) or similar instrument, and assessing the social determinants of health when evaluating risk for readmission. We will use the Area Deprivation Index (ADI), a well-accepted measure of neighborhood socioeconomic disadvantage. The ADI is a factor-based index that uses 17 U.S. census poverty, education, housing, and employment indicators and has been linked to hospitalizations and readmission rates. We will be able to link

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our patients' zip codes to an index which will provide our PPS with a snapshot of the broader risk factors challenging our beneficiaries and inform patient care decisions.

Those identified at increased risk of readmission will receive the care coordination appropriate to their level of risk and post-discharge setting. A 30-day transition period will be defined with appropriately scaled intensity of follow-up established for all discharged patients. Those at highest risk will receive a home visit. Others may be followed by phone or attendance at scheduled appointments will be monitored. Particular attention will be paid to connecting eligible patients with Health Home services and with advanced primary care offered by our PCMHs. We recognize that to impact PPRs, patients with behavioral health needs will be of particular concern. Our project will ensure that admission, discharge, and care transition protocols reflect the needs of this special population and will be coordinated with our work to integrate BH and primary care services in our project 3.a.i and the establishment of BH crisis intervention supports in our project 3.a.ii.

**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.**

Across the region, our PPS Participants deploy a range of post-discharge strategies, processes, and tools. WMC developed a sophisticated algorithm to predict readmission risk from information available to the hospital at the time of discharge. St. Luke's Cornwall Hospital implemented the Coleman model to follow patients post discharge and rolled out its effective "Taking it to the Streets" discharge program. Bon Secours Community Hospital and WMC participated in Project Red, a national project to reduce admissions. They found a successful transition care plan rests on the ability of the ambulatory care team to manage the patient in the community. HealthAlliance addressed patient hand-offs to ambulatory providers in their Ulster County Care Transition Coalition that includes their community partners.

Among outpatient providers, initiatives are underway to notify PCPs of ED visits, admissions, and/or discharges. Crystal Run Healthcare (CRHC), a large multi-specialty group partner, has established a post-discharge home visiting program. Discharged patients at higher risk of readmission receive a home visit from a CRHC Nurse Practitioner (NP) within two days of discharge. In 41% of cases, the NP has intervened to make some an adjustment to treatment. As a result of this program, CRHC readmission rates have decreased from 20% to 12%.

Home care agency partner Dominican Sisters won a CMMI innovation award to test the effectiveness of home visits in preventing readmissions in another region of NYS and will bring the benefit of their learnings to our PPS.

Enhancing these assets, our PPS will utilize an analytics platform to enable identification and tracking of beneficiaries in the project and evaluation of process and outcome measures. We are currently evaluating systems that draw data from multiple source including hospitals, community based providers, ancillary providers, state immunization registry and other

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databases. We will also expand care management capacity, particularly linked to primary care. Whereas care management has often been located in hospitals and behavioral health agencies, we believe that primary care providers' ability to manage and coordinate care is critical to successfully preventing readmissions. The protocols, training, and tools needed to achieve will be developed as part of this project.

Our PPS includes the regions three Health Homes. Health Home care teams are currently able to share care plans via a common care coordination management platform, InsightPlus, which is used by over 40 agencies and hundreds of individual users. InsightPlus is expected to establish connectivity capabilities with HealthlinkNY in 2015, which we will leverage to share care plans among providers who coordinate post discharge care.

In order to calibrate the intensity of the post-discharge intervention appropriately, we will deploy a risk stratification tool. As noted above, several risk stratification tools are currently in use, and we will work with our PPS Quality Committee to determine standard elements, methodologies, and weights and support broader adoption.

Our PPS formation process has also resulted in the creation of a robust network of over 275 community-based organizations in a WMC Community Resource Database, which serve a wide spectrum of social service needs. To facilitate referrals to and connections with vital community-based assets that are critical in minimizing readmissions, we will enable this database to be patient facing, linking it to a searchable tool that can assist patients and families to locate needed services.

While the Hudson Valley's Regional Health Information Organization, HealthlinkNY, can provide automated admission, discharge, and transfer (ADT) alerts to providers and care teams, the functionality is not widespread. We have begun discussion with HealthlinkNY on strategies to expand connectivity to and utilization of its automated ADT alert functionality.

**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 barrier to care, provider availability, coordination challenges, language and cultural challenges, etc. Please include plans to individually address each challenge identified.**

One project objective is to have a transition care manager visit the patient in the hospital prior to discharge. It is desirable to involve members of the care team from the ambulatory side prior to discharge, and we will implement when feasible. However, this requirement underscores the complexity of expanding care management. Care managers may be affiliated with MCOs, Health Homes, hospitals, or primary care. Coordinating the coordinators will be a challenge. NYS has invested heavily in Health Homes precisely to address this need, however, most Health Home care managers are currently affiliated with BH care and have only tenuous relations with primary or other clinical care providers. Few Health Home care managers have nursing or

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medical backgrounds and may not be qualified to evaluate deteriorating medical conditions post-discharge. While it is desirable to have a single, consistent care manager working with a patient, it will be necessary at times to have a hospital-based RN care manager or primary care affiliated care navigator work in tandem with their Health Home colleagues until a transition is complete.

A second challenge is access to timely data. Our PPS needs data from many sources, and providers must be able to participate in health information exchange to support sharing of transitional care plans, to perform medication reconciliation, and to link patients with community services. As discussed above, our approach is two-folded: we will foster connections to the community-level record through HealthlinkNY and encourage data sharing between providers through IT and standard policies.

A final challenge relates to scale. The goal of achieving a significant reduction in avoidable admissions across the Medicaid population will require that the project include patients who receive care from hospitals and/or PCPs not affiliated with the PPS. This will be accomplished through cross-PPS collaboration and alignment.

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

Under DSRIP, patients may receive care from any provider, some participating in multiple PPSs. Cross-PPS collaboration, coordination and alignment of clinical implementation will be critical to achieving DSRIP goals across our region and State. The three PPSs serving our region, led by Montefiore Medical Center, Refuah Health Center, and WMC, will establish a provider-led Regional Clinical Council to support development of a regional system of efficient and effective care, patient safety, and quality improvement.

The Council, with input from providers, payers, government agencies, and others, will review DSRIP project and implementation plans and make recommendations to align overlapping approaches. Region-wide coordination, requirements, and expectations will minimize providers' implementation burdens and create consistent, high quality patient experiences. The Council will identify region-wide care improvement goals and serve as a forum to share and evaluate clinical strategies and practices. The Council will support the rapid and widespread adoption of agreed-upon clinical protocols and evidence-based practices across the region and payers.

Continuing the cooperation that resulted in the creation of a common CNA, the PPSs in our region have embraced collaboration throughout the selection, design, and development phases of their respective DSRIP projects. While the other PPSs in our region may not have expressly selected project 2.b.iv, common protocols and shared best practices for transitions in care will be a critical foundational component of many DSRIP projects. Our PPS Quality Committee and

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associated workgroups focused on the 30-day readmission reduction project will communicate the standardized discharge transition protocols to the other PPS via the Council to inform their own policies and procedures as appropriate.

## **2. Scale of Implementation**

*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:*

**2a. Please indicate the total number of sites, programs and/or providers the PPS intends to include in the project by the end of Demonstration Year (DY), or sooner as applicable. These numbers should be entered in the table as Total Committed.**

***See accompanying Speed & Scale Excel document***

**b. Please indicate the total expected volume of patients the PPS intends to engage throughout this project by the end of Demonstration Year (DY) 4. This will become the Expected # of Actively Engaged Patients. Patient scale is measured by the total number of patients that are expected to be actively engaged by the end of Demonstration Year 4.**

***See accompanying Speed & Scale Excel document***

## **3. Speed of Implementation/Patient Engagement**

*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:*

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**3a. Please indicate the Demonstration Year (DY) and Quarter by which all participating hospitals will achieve project requirements. Project speed is measured by how fast all the project requirements for all chosen locations are met.**

PPSs will be expected to meet these requirements for all of the providers, sites, or other categories of entities included in the PPS “total committed” scale metric, unless otherwise specified in the Domain 1 DSRIP Project Requirements Milestones and Metrics.

***See accompanying Speed & Scale Excel document***

**b. Please indicate the expected timeline for achieving 100% engagement of total expected number of actively engaged patients identified. For example, the PPS may indicate that 25% of targeted patients will be actively engaged by the end of Demonstration year 1, 50% by the end of Demonstration year 2, etc.**

***See accompanying Speed & Scale Excel document***

**4. Project Resource Needs and Other Initiatives**

**4a. Will this project require Capital Budget funding? (Please mark the appropriate box below)**

Yes	No
X	

**Please describe why capital funding is necessary for the Project to be successful.**

The WMC-led PPS will seek capital funds to develop a shared, health IT infrastructure that supports region-wide population health management efforts. The population health management system will include: (1) a centralized care management platform; (2) a patient registry; (3) equipment and software for telehealth and remote monitoring; (4) enhancement of partners' EHR and HIE capabilities; and (5) analytic tools and reporting systems for network management. Collectively, these tools support critical communication and coordination among our PPS partner organizations and will enable providers and patients to improve post-discharge activities. The capability will be shared across all 11 DSRIP projects.

**4b. 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?**

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Yes	No
X	

**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.**

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Cedar Manor Nursing & Rehabilitation Center	Community-based Care Transitions Program (CCTP)	2013	2014	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
Dominican Sisters Family Health Service, Inc.	Community Based Care Transitions Program	2013	2017	The Medicare Community-based Care Transitions program tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
The Greater Hudson Valley Family Health Center, Inc.	Health Center Program (Section 330) Grant Program (HRSA)	6/1/12	5/31/17	Supports the provision of care to medically underserved areas and populations in the service area.
Open Door Family Medical Center, Inc.	Hospital Medical Home Demonstration Program	2012	2014	The Hospital-Medical Home Demonstration is a federally funded State Medicaid program for qualified hospitals to improve care in sites that train residents to become primary care physicians. Participating sites must get PCMH recognition. Funding supports improved care

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				coordination, inpatient/outpatient care teams, communication through IT, and care transitions.
Park Manor Acquisition II LLC dba Middletown Park Rehabilitation center	Hospital Medical Home Demonstration Program	2012	2016	The Hospital-Medical Home Demonstration is a federally funded State Medicaid program for qualified hospitals to improve care in sites that train residents to become primary care physicians. Participating sites must get PCMH recognition. Funding supports improved care coordination, inpatient/outpatient care teams, communication through IT, and care transitions.
The Institute for Family Health	Hospital Medical Home Demonstration Program	2012	2014	The Hospital-Medical Home Demonstration is a federally funded State Medicaid program for qualified hospitals to improve care in sites that train residents to become primary care physicians. Participating sites must get PCMH recognition. Funding supports improved care coordination, inpatient/outpatient care teams, communication through IT, and care transitions.
Visiting Nurse Service	Health Workforce	2014	2015	The Health Workforce Retraining Initiative supports organizations that train or retrain health

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of New York	Retraining Initiative			care workers to obtain the necessary qualifications for new or changing positions. Funding supports the training of Population Care Coordinators and certified home health aides through the Partners in Care Program.
Open Door Family Medical Center, Inc.	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
The Institute for Family Health	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
Mount Vernon Neighborhood Health Center Network	Health Homes for Medicaid Enrollees and Chronic Conditions	2013	ongoing	New York's Health Home program provides a suite of care management services to Medicaid enrollees with two chronic conditions or a qualifying

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				condition (HIV/AIDS or serious mental illness). Health Homes use a care model emphasizing care team communication to ensure patient needs are addressed in a comprehensive manner.
United Hebrew Geriatric Center	Institutional Special Needs Plans Program	2014	Ongoing	Institutional Special Needs Plans assess early change in the health status of Medicare beneficiaries to avoid unnecessary hospitalization.

**4c. 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.**

The work of the Participants listed above closely aligns with the project our PPS plans to implement to decrease hospital readmissions. We plan to build on what is existing in our area to expand the scope and reach a larger population. For example, The Community based Care Transitions program targets Medicare patients. Our PPS will build on the Participants’ experience and expertise of these Participants to establish a customized standard care transitions models across the region and expand the model to support Medicaid patients. Our PPS will also work closely with Open Door to leverage the organization’s expertise gained from this demonstration as we seek to expand care coordination, care teams and care team communication, and smooth care transitions. This DSRIP project will expand these services to a much larger population, including to our Participant hospitals and many other Participant sites. Further, this funding is ending and therefore will not be supplanted or duplicated through DSRIP.

The Health Home program, particularly the experience and capacity of our participating Health Homes and downstream care management agencies, is a strong foundation for many of our DSRIP projects and the experience Health Homes hold in care management will help inform this project. However this project will not replace this but rather build on this work, and serve a larger group of Medicaid patients, including those who are not currently eligible for Health Home services, expanding the reach of the care management knowledge, techniques and experiences to populations not served by Health Homes.

ISNP are useful tools in addressing unnecessary hospitalization among Medicare beneficiaries. This DSRIP project, however, is being implemented at the Participant/provider, not plan level,

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and is distinct from and will supplement INSP services. And, as noted above, this project will extend to all of our actively engaged population, not just those enrolled in ISNPs.