Megan Havey, Manager of Care Transitions
P^2 Collaborative of Western New York

COALITION OVERVIEW
INTRODUCTION TO THE P² COLLABORATIVE

• Regional convener

• Three major focuses:
  • Care Transformation
  • Health Engagement
  • Community Health Improvement

P² Collaborative of Western New York
Creating the healthiest community, one neighborhood at a time
COMMUNITY-BASED CARE TRANSITIONS PROGRAM (CCTP)

- Mandated by section 3026 of the Affordable Care Act
- Partnership for Patients Goals:
  - 40% reduction in hospital acquired conditions
  - 20% reduction in hospital readmissions
- Funds designated for community-based organizations partnering with hospitals
- Contract established between CMS & WNY Coalition
COALITION MAKE-UP

• **P² Collaborative of Western New York**
  • **Role**: Facilitation and administrative support

• **Ten hospitals**
  • **Role**: Screen for eligible patients and encourage patients to participate

• **Eight Community-Based Organizations**
  • **Role**: Deploy coaches and coordinate the intervention
COMING TOGETHER

• Regional information meeting
  *Facilitated by the P² Collaborative, IPRO and the Health Foundation for Western & Central NY*

• Hospitals selected CBO partners

• Launched root cause analysis process

• RCA analysis and proposal development
KEY FINDINGS

The Steering Committee identified common gaps in care transitions that exist throughout WNY:

• Discharge processes do not ensure that patients and caregivers understand their diagnosis and treatment options;

• The hospital discharge process does not include sufficient assessment of patient and caregiver ability to self-manage the post-discharge plan; and

• There are insufficient linkages to community-based resources to assist patients transitioning from hospital to home.
RCA-DRIVEN
TARGET POPULATION

• Care Transitions Intervention™ (CTI) selection

• Target Populations:
  • Regional – Medicare FFS patients with a 30-day readmission
  • County Variation – Specific target conditions were identified by each hospital/CBO partner based on RCA.
PROGRAM TO DATE

Completed Home Visits
CARE TRANSITIONS: WHY SHOULD AAA BE INVOLVED?

Dr. Mary Ann Spanos, Director
Chautauqua County Office for the Aging
CHAUTAUQUA COUNTY’S JOURNEY

• **2007**: NY Connects Project began
• **2008-9 N4A Conference**: Understanding the ADRC role
• **2010 & 11 N4A**: Affordable Care Act presentations by AoA & CMS and AAAs involved in Care Transitions Pilot programs
2012 Healthcare Reform Law: Highlights providing services in the homes of high need Medicare beneficiaries; preventing hospital readmissions; improve health outcomes; reduced cost; high patient satisfaction.

2012 N4A Conference: Kathy Greenly talks about the opportunities for AAA to be a partner and solution for the new direction healthcare.

Strategic Planning locally with our Long-term Care Council
CHAUTAUQUA’S LTC MODEL: COMMUNITY RESOURCE CENTER

Aging and Disability Resource Center as the hub of Community Care:

Components

1) NY Connects I &A Helpline
2) Options Counseling
3) Care Transitions
4) Assessment & eligibility determination
How do I manage my medical problems and living well needs?

**Medical Needs**
- Hospital
- Medical Equipment
- Specialists
- Medical Tests
- Allied Health (PT, OT, Speech)
- Skilled Nursing
- Certified Home Health
- Medical Day Care
- Pharmacy

**Living Well Needs**
- Transportation
- PERS
- Licensed Homecare
- Social Adult Day
- Food
- Housing & repairs
- School services
- Govern. programs
- Wellness programs
- Faith based Organiz.
- Support Groups

**Information Exchange**

**PATIENT CENTERED MEDICAL HOME**

**CHAUTAUQUA COMMUNITY RESOURCE CENTER**
- I & R/A
- Options (Ins) counseling
- Assessment
- Eligibility Determination
- Transitional Coaching
DOES CARE TRANSITIONS MAKE SENSE FOR MY AAA?

**PROS**
- New source of Revenue
- Under ACA Healthcare needs community supports to be successful: meals, HIICAP transportation, etc.
- Healthcare needs someone to follow client into their homes
- OFA already touching most Medicare beneficiaries through our programs

**CONS**
- Medicare billing (scary)
- Healthcare speaks a different language
- Don’t know each other well
- Capacity
- Training for a new program
CARE TRANSITIONS INTERVENTION

Dr. Coleman’s Model: community coach model
- Medication reconciliation
- Follow-up with MD (medical transport)
- Personal health record & goals
- Patient education about red flags

- Patient empowerment/Self Determination
- Medical background not needed
- Links community with services & supports

OFA’s work compliments Coleman’s model
HOW DID WE GET STARTED

- Met with leadership from 3 Hospital
- Brokered by CCHN, LTCC member
- Health Reform: Readmissions penalties 2013
- Opportunity under 3026
- Offered OFA & NY Connects as solution
- CMS preference for AAA to be the CBO
  - Connection with other resources
    - Meals
    - Transportation
    - Home Care
    - Linkage to other community supports.
P² & CHFWCNY GETS INVOLVED

• P² Applies on behalf of 7 counties in WNY
• 6 of 8 communities have AAA as their CBO
  • Allegany County OFA
  • Chautauqua County OFA
  • Community Concern of WNY
  • Cattaraugus County OFA
  • The Dale Association (Niagara County)
  • Genesee County OFA
  • Orleans County OFA
  • Wyoming County OFA
APPLICATION PROCESS

- Root Cause Analysis: Hospitals
- Consumer input: Utilized LTCC members to survey recently discharged patients
- Coaching costs
  - Analyzed employee wages, fringes & mileage
  - Based on 5 hour intervention
  - Added Admin costs for local CBO
- Admin for Mega CBO
  - Bills Medicare
  - Train coaches
  - IT help & other technical support
OTHER BENEFITS

• Connecting medical care with Community LTC services & supports
• Promotes & expands NY Connects which acts as intake for Care Transitions
• Allowed us to increase staffing of NY Connects
• Lump sum Fee for Service under Medicare
• OFA can do with own staff or sub-contract
• Any profit can be invested in programs for clients like meals, transportation, PERS
OPERATIONALIZING THE COACHING MODEL

Dana Corwin, RN
Chautauqua County Office for the Aging
NEW YORK STATE OFA

Our Mission is to help older New Yorkers be as independent as possible for as long as possible through advocacy, development and delivery of person-centered, consumer-oriented, and cost-effective policies, programs and services which support and empower older adults and their families, in partnership with the network of public and private organizations which serve them.
The mission of the Chautauqua County Office for the Aging is to provide information and services to seniors and their families to promote independence, optimal health and wellness in a safe secure environment.
This printing of the Chautauqua County Senior Handbook is in commemoration of a new partnership between four area hospitals, Community Concern, and the Chautauqua County Office for the Aging, working together to ensure a smooth transition from hospital to home for older adults in our communities.

Care Transitions Program Partners include:

- **Brooks Memorial Hospital**
- **Lake Shore Hospital**
- **Westfield Memorial Hospital**
- **WCA Hospital**
- **Community Concern**

Care Transitions is a service in addition to discharge planning using community coaches through the Office for the Aging to assist patients in managing their discharge to home. These community coaches help to guide patients after discharge by ensuring proper follow up, supporting medication reconciliation, establishing health goals and providing information about community resources that can assist them while they are recovering at home. The Chautauqua County Office for the Aging is pleased to be able to offer this service with our hospital and community partners.
CHAUTAUQUA COUNTY CTI PROGRAM

• FFS Medicare Clients (could be dual eligible’s)
• CHF, COPD, pneumonia, all cause 30 day diabetes, myocardial infarction (MI)
• Hospital Visit: OFA coach or contract with Certified HCA
• Home Visits & 2-3 Phone calls
• 4 OFA staff trained including Spanish CM
• Contact with Hospice for end stage clients
• Reciprocal agreements with other OFA’s & Community Concerns
4 PILLARS OF CTI

- PCP Follow Up
- Red Flags

- Medication Management
- Personal Health Record
Chautauqua County
CARE TRANSITION TEAM

Lillian Divine    Sandy Harle    Lynn Austin    Michelle Swan    Dana Conwin    Becky Blum

Hospitals, Doctors & Office for the Aging
- Working Together to Keep You at Home -

Keeping Seniors Safe, Healthy and Living Independently!
THE STRUCTURE

[Diagram of program flow chart showing patient assessment, eligibility determination, and intervention processes with various steps and decision points involving patient admission, discharge, and coaching follow-up.]
CARE TRANSITIONS
Client Information

Hospital:_______________

Date:_______________

P2:____________

CCHN:___________

Primary Care Doctor:_________________________________________

Name:_________________________________________

Address:_________________________________________

Phone:_________________________________________

DOB:_________________________________________

Emergency Contact:_________________________________________

Admit Date:_________________________________________

Diagnosis:_________________________________________

(If 30 day readmit, also list original diagnosis)
Room #:_________________________________________

Est. Discharge Date:____________________________________
COMMUNICATIONS

10 FACTS Providers Need to Know About Coaches

1. There is NO cost to you or your patients for coaching
2. Coaches DO NOT interfere with your patient care
3. Coaches DO NOT practice clinical medicine or direct patient care
4. Coaches empower patients with their health care
5. Coaches can assist you and your patients with Medication Reconciliation
6. Coaches are trained professionals
7. Patients will be visited in the hospital by the coach once follow-up in their home (NOT to give direct care) and several phone contacts over a 30-day period
8. Coaches assist patients with transitions across care settings
9. Coaches will be assigned to patients with high-risk for readmissions
10. To learn more about coaches and their role visit: www.caretransitions.org

Care Transition Coaching® is designed to:
- Transfer skills
- Build patient/caregiver confidence
- Provide tools to support self-management

The goal is to coach patients/caregivers to actively engage in self-management skill development.

The primary role of the Care Transition Coach® is to empower the patient/caregiver to:
- Assist in a more active role during care transitions and
- Develop lasting self-management skills

Care Transitions of Western New York

For more information contact:
Name: LaArlane Roberts, WCCH
Phone: (544) 000-0000 ext. 4866

This document adapted from material prepared by: Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization for Pennsylvania, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication No. 0160-P-000-14, 07-14.

ABOUT CARE TRANSITIONS:
A trained Care Transition Coach™ will work with you for 30 days to help you improve your health and meet your goals.

This program is nationally recognized to help patients stay healthy and at home.

WHY YOU SHOULD PARTICIPATE:
Your coach will work with you and your caregiver to:
- Sort through and keep track of your medications
- Recognize signs that your health is getting worse
- Understand and participate in your health care

Your hospital recommends you for Care Transitions!

QUESTIONS?
Contact: ____________________________
Phone: ____________________________
Dear Doctor:

We are excited to write you about an innovative program that has recently launched in our region: **Care Transitions of Western New York**.....

Using Dr. Eric Coleman’s Care Transitions Intervention™, trained coaches support patients for thirty days ... The coach also supports the patient in reaching out to their primary care provider to schedule a visit after their hospitalization. **This intervention is proven both locally and nationally to significantly reduce hospital readmissions**....

Here are a few ways we need your help.....

- **Know what to expect if your patient participates:** Your patient will bring a “Personal Health Record”....
- **Help us schedule appointments faster for patients discharged from the hospital**....

We have enclosed additional information for your reference. Please feel free to contact one of us with any questions you may have or if you would like to set-up a time to speak with us....

[Enclosures: Personal Health Record, 10 Facts Providers Should Know about Care Transitions, Program Introduction]
Mary Bosek, LCSW, Director of Case Management
WCA Hospital

THE HOSPITAL PERSPECTIVE
WHY DO THIS?

• Nationwide focus on readmissions as both a patient safety and cost issue.
• High Medicare population in our community
• It’s good for our patients
GETTING STARTED

• Root cause analysis
   Case reviews
   Analysis of hospital readmission data

• Meetings with community partners

• Process
   Hospital staff to identify the eligible patients and refer to OFA
   Hospital staff makes an initial introduction of the program
   CCTP Coach makes hospital visit and subsequent home visit and phone contacts

CARE TRANSITIONS
OF WESTERN NEW YORK
OVERCOMING CHALLENGES

• Initial referral/acceptance numbers were low
• CBO/Hospital meeting
• Identified obstacles to patient acceptance
• Increased education to providers
• Revised the process for hospital visit
IMPROVEMENT!!!
LESSONS LEARNED & OPPORTUNITIES FOR GROWTH

Maureen Wendt, President & CEO
The Dale Association
BACKGROUND

• The Dale Association’s Mission:
  • Is to provide comprehensive services and coordinate connections for adults in Niagara and neighboring counties which enhance their health and wellness and empower them to strengthen bridges to their communities.

• The CBO’s Role:
  • Deliver 30 day intervention utilizing trained coaches
LESSONS LEARNED

• Process
  • Going from Concept to Implementation

• Patients
  • Self Management Focus

• CBO/Hospital Relationship
  • Success in Teamwork
  • Communication key
THE PROCESS:
Moving from concept to implementation

• 2 Separate entities with common goal
• Cultural integration / Logistical process new
  • To hospital staff
  • To coaches
  • To patients
• Staffing /skill development/training
• Communication
  • Sharing patient information
  • Expected discharge date/ timing
  • Patient education
PATIENT FOCUSED

• Helping patients and caregivers better understand diagnosis
• Helping to enhance patients’ / caregivers’ ability to self manage care
• Success depends on patients embracing concept beyond 30 day intervention
• Community based referrals & linkages important to continued success
• Patients who identified goals more engaged
• Concept of “Care Coach” still new to patients
• Family involvement (with permission) – played important role
HOSPITAL/CBO RELATIONSHIP

• Need engaged, committed and consistent leadership from both
• Need well defined workflow
• Timeliness of referrals / ability to respond
  • Hospital visit critical to securing home visit
  • Home visit critical to success of intervention
• Coach duties/ flexibility
• Internal “marketing”
• Build relationship between partners in care
• Communication
• Willingness to evaluate and re-evaluate successes and obstacles to success
OPPORTUNITIES FOR GROWTH

• Increase Volume
• Improvement to Acceptance Rates
• Expanding Criteria for eligibility
• “Embedded” coach
• Increase awareness of benefits of service (to patients)