



TRANSITIONS OF CARE IN WESTERN NEW YORK:
Partnering with Hospitals to Reduce Readmissions

Ageing Concerns Unite Us Conference
Wednesday June 5, 2013

Megan Havey, Manager of Care Transitions

P² 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

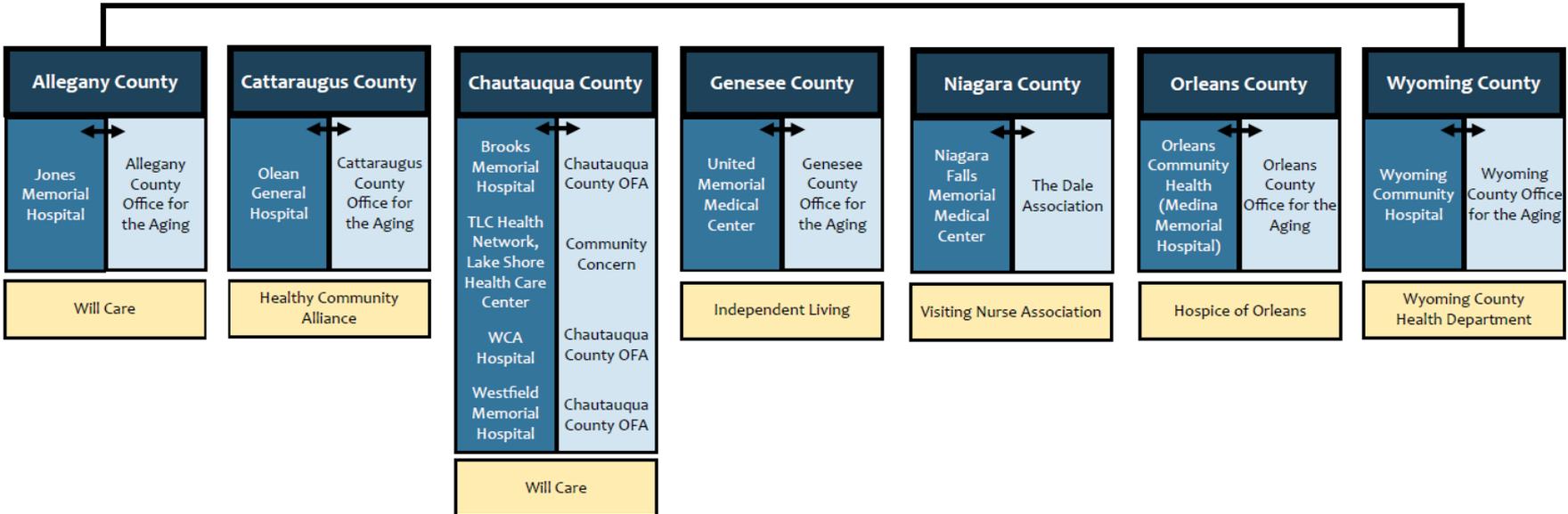
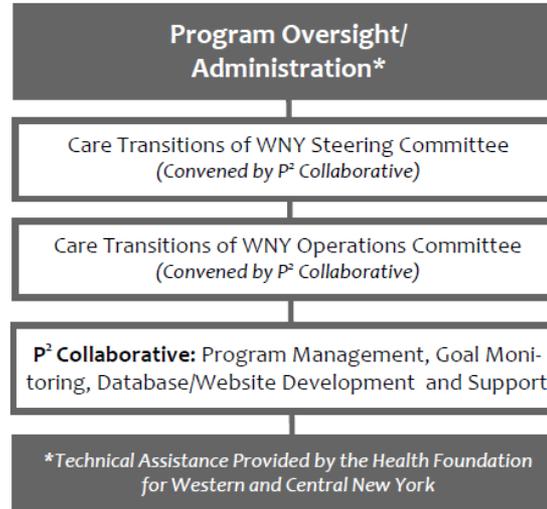


COALITION MAKE-UP

- **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



ORGANIZATIONAL CHART



Key: Hospitals Community-Based Organizations Subcontracting Agencies for Coaching Services

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

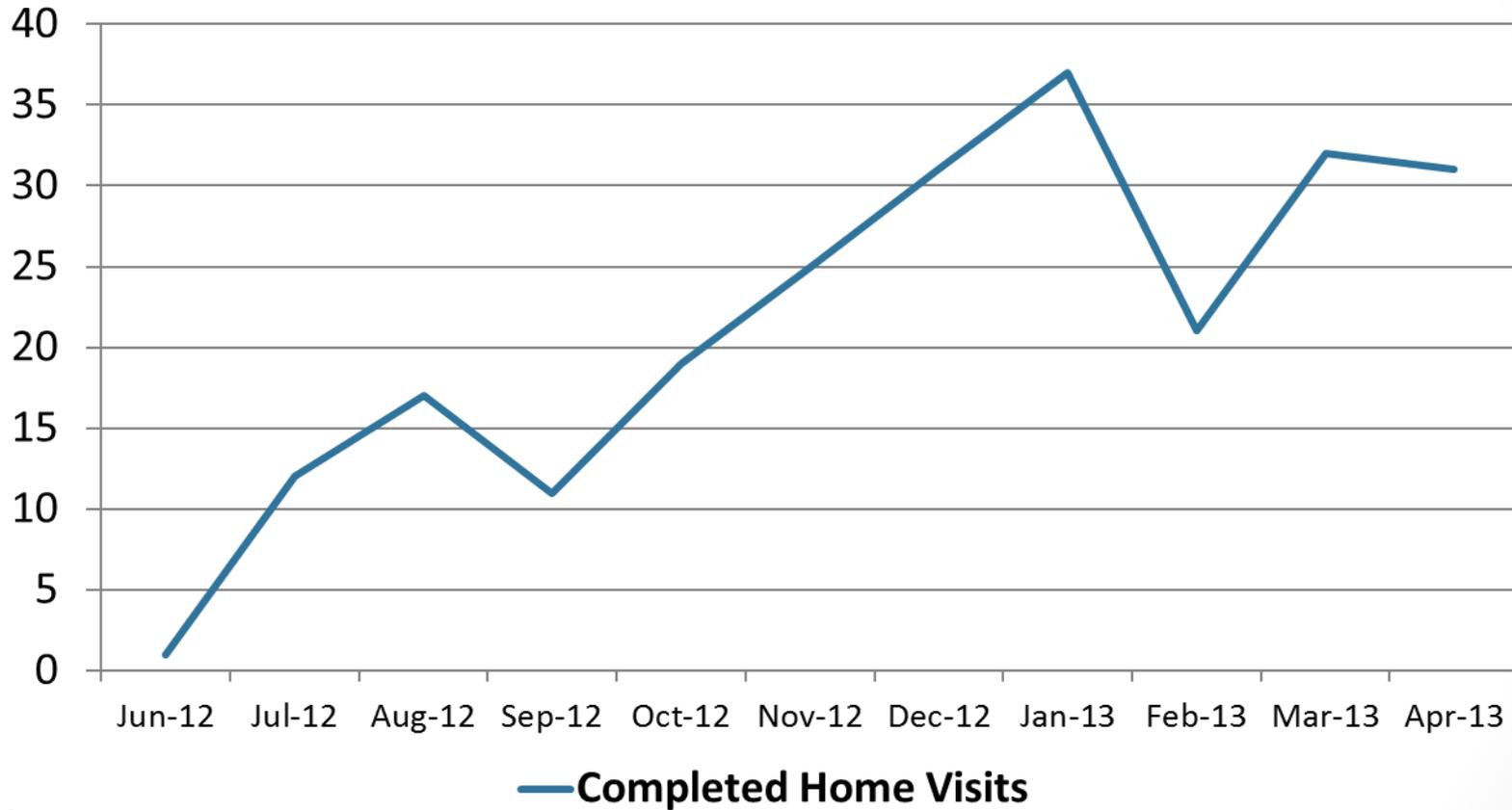
The Steering Committee identified **common gaps in care transitions** that exist throughout WNY:

- 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



Dr. Mary Ann Spanos, Director
Chautauqua County Office for the Aging

**CARE TRANSITIONS: *WHY
SHOULD AAA BE INVOLVED?***

CHAUTAUQUA COUNTY'S JOURNEY

- **2007:** NY Connects Project began
- **2008-9 N4 A Conference:** Understanding the ADRC role
- **2010 & 11 N4A:** Affordable Care Act presentations by AoA & CMS and AAAs involved in Care Transitions Pilot programs



CHAUTAUQUA COUNTY'S JOURNEY CONTINUED

- **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:

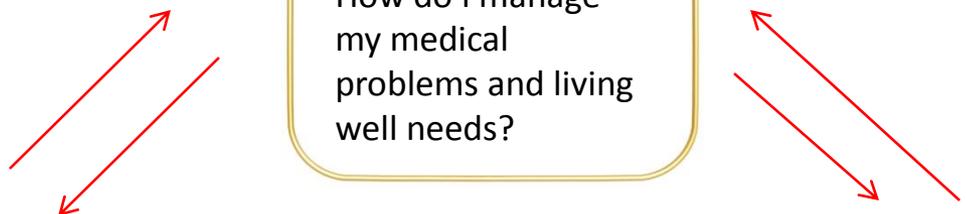
Components

- 1) NY Connects I &A Helpline
- 2) Options Counseling
- 3) Care Transitions
- 4) Assessment &
eligibility determination



Medical Needs

Living Well Needs



**PATIENT
CENTERED
MEDICAL
HOME**

**CHAUTAUQUA COMMUNITY
RESOURCE CENTER**

- I & R/A
- Options (Ins) counseling
- Assessment
- Eligibility Determination
- Transitional Coaching

Information Exchange

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

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

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



CARE TRANSITIONS
OF WESTERN NEW YORK

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



Dana Corwin, RN

Chautauqua County Office for the Aging

OPERATIONALIZING THE COACHING MODEL

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.



CHAUTAUQUA COUNTY OFA

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:



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 Corwin

Becky Blum



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

Keeping Seniors Safe, Healthy and Living Independently!

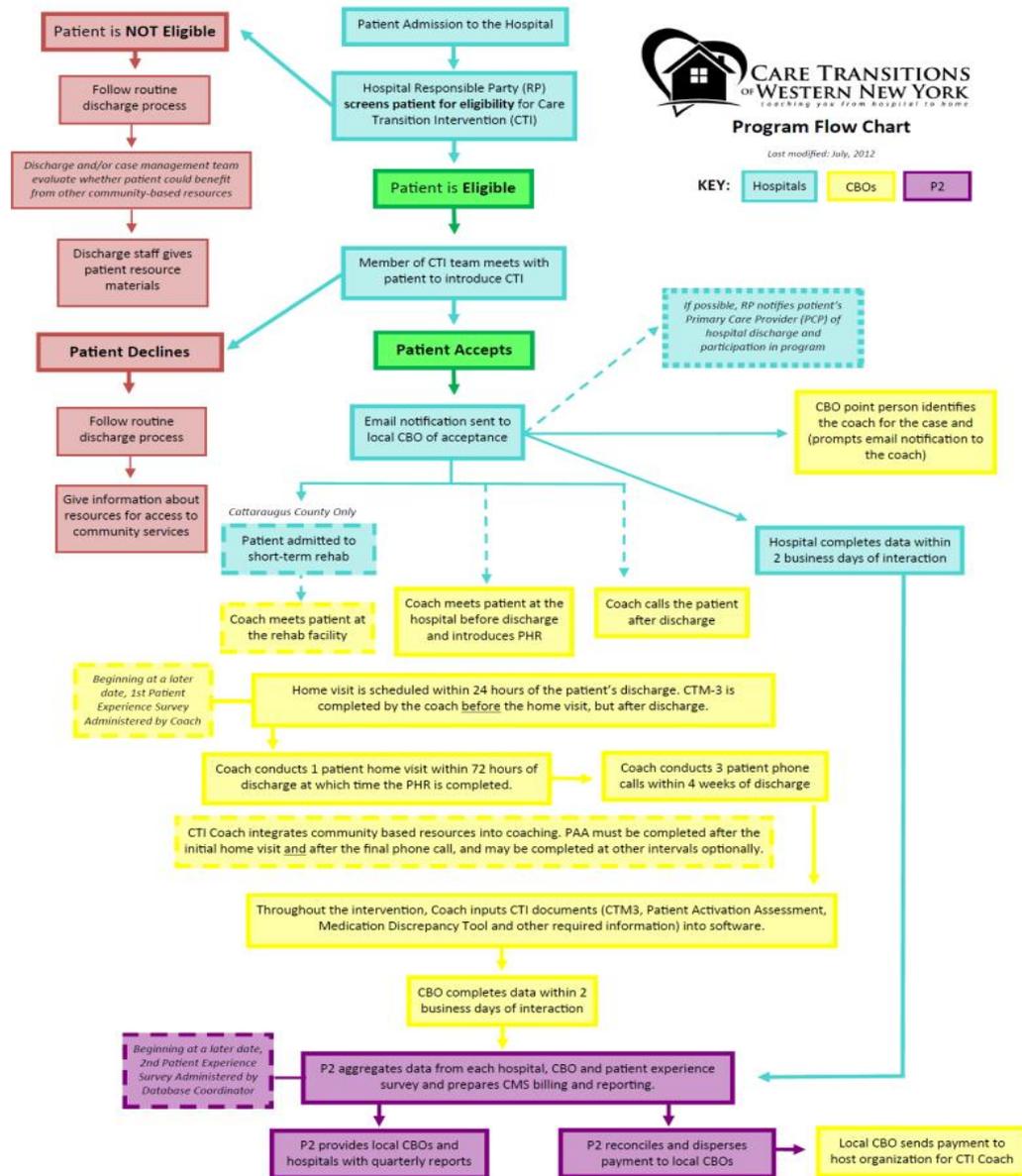
THE STRUCTURE



Program Flow Chart

Last modified: July, 2012

KEY: Hospitals CBOs P2



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 **DO** empower patients with their health care
5. Coaches can assist you and your patients with Medication Reconciliation
6. Coaches are trained professionals
7. Participating patients will be visited in the hospital by the coach with one 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:

- Assert a more active role during care transitions and
- Develop lasting self-management skills



For more information contact:

Name: LuAnne Roberts, WCCH
Phone: (585)786-8940 ext. 4866

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CARE TRANSITIONS OF WESTERN NEW YORK COACHING YOU FROM HOSPITAL TO HOME

You are entitled to participate in this **FREE** 30-day coaching program through your Medicare insurance.

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



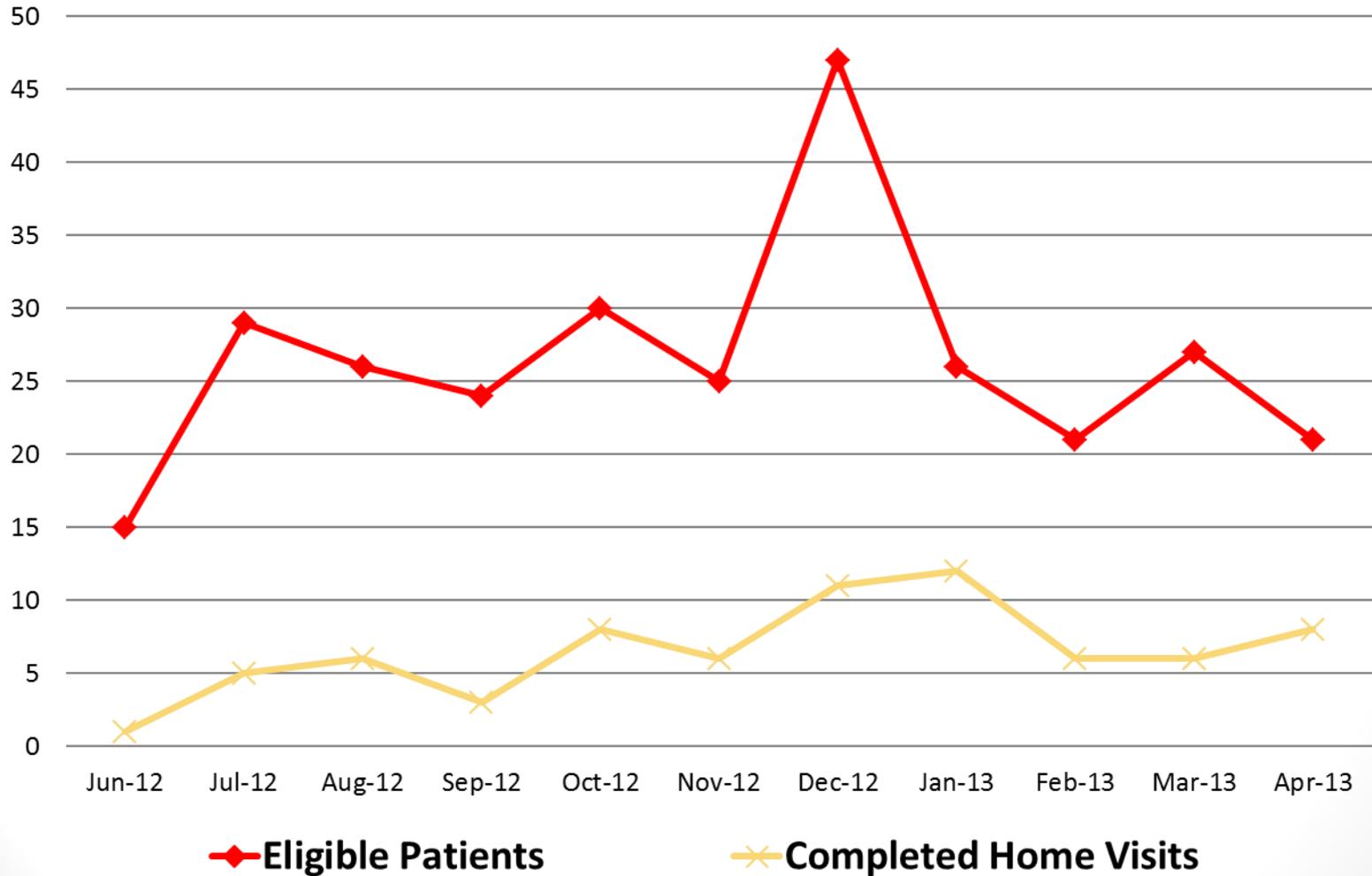
GETTING STARTED

- **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

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!!!



Maureen Wendt, President & CEO

The Dale Association

LESSONS LEARNED & OPPORTUNITIES FOR GROWTH

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)