Mini Summit II: AAA-Funded Senior Services Programs in the CCTP

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Heights and Hills

- Heights and Hills is a 43-year old community based agency (CBO) that receives OAA funding through the NYC Department for the Aging, the local AAA. Over 3,000 community-dwelling older adults and their families are served annually through Case Management, Caregiver Services, Friendly Visiting and other services.

New York Methodist Hospital

- New York Methodist Hospital is a 651-bed academic medical center located in Brooklyn, New York. In 2010, NYMH had nearly 8,000 Medicare fee for service discharges. 1,950(24.3%) were readmitted within 30 days. Of these readmissions, 3,475 (44%) were discharged to a Skilled Nursing Facility (SNF) or Certified Home Health Agency (CHHA)

Background

- Historically, Heights and Hills' only contact with the hospital was at discharge, when a patient would be referred for case management or home delivered meals, or more likely would be referred by the hospital to a Certified Home Health Agency (CHHA), who would refer to Heights and Hills at the point of discharge from the CHHA. Most often this would be in the form of a telephone message.

Along came the Affordable Care Act....

- Hospitals financially penalized for high readmissions
- Through Section 3026 of the Affordable Care Act, a door opened that allowed us to break down the silos and bridge the worlds that were traditionally separate – "medical" vs. "social services"
- Required partnership between hospitals (particularly those with high readmission rates), and AAA-funded CBO's

The Challenge

What can we do together to get patients/clients through these transitions more smoothly, leading to a reduction in readmissions?

Initial stumbling blocks

- Finding a champion
- Linguistic competency
- Understanding who is at highest risk (was not necessarily intuitive)
- Choosing the right partners
- Making the case

Project Goals

- To decrease the 30 day readmission rate greater than 20% in our high risk cohort

- Define High Risk Population

Who is at highest risk for readmission?

- Patients discharged to Skilled Nursing Facility (SNF) or Certified Home Health Agency (CHHA)
  - 3,475 (44%) Medicare fee for service patients
- 30 day readmission from post acute care partner
  - SNF 1.75x more likely
  - CHHA 1.4x more likely
  - Regardless of medical diagnosis
- Combined SNF/CHHA 30-days readmission rate
  - 31.5% (1,095/3,475)
- Most occur within the first week of discharge

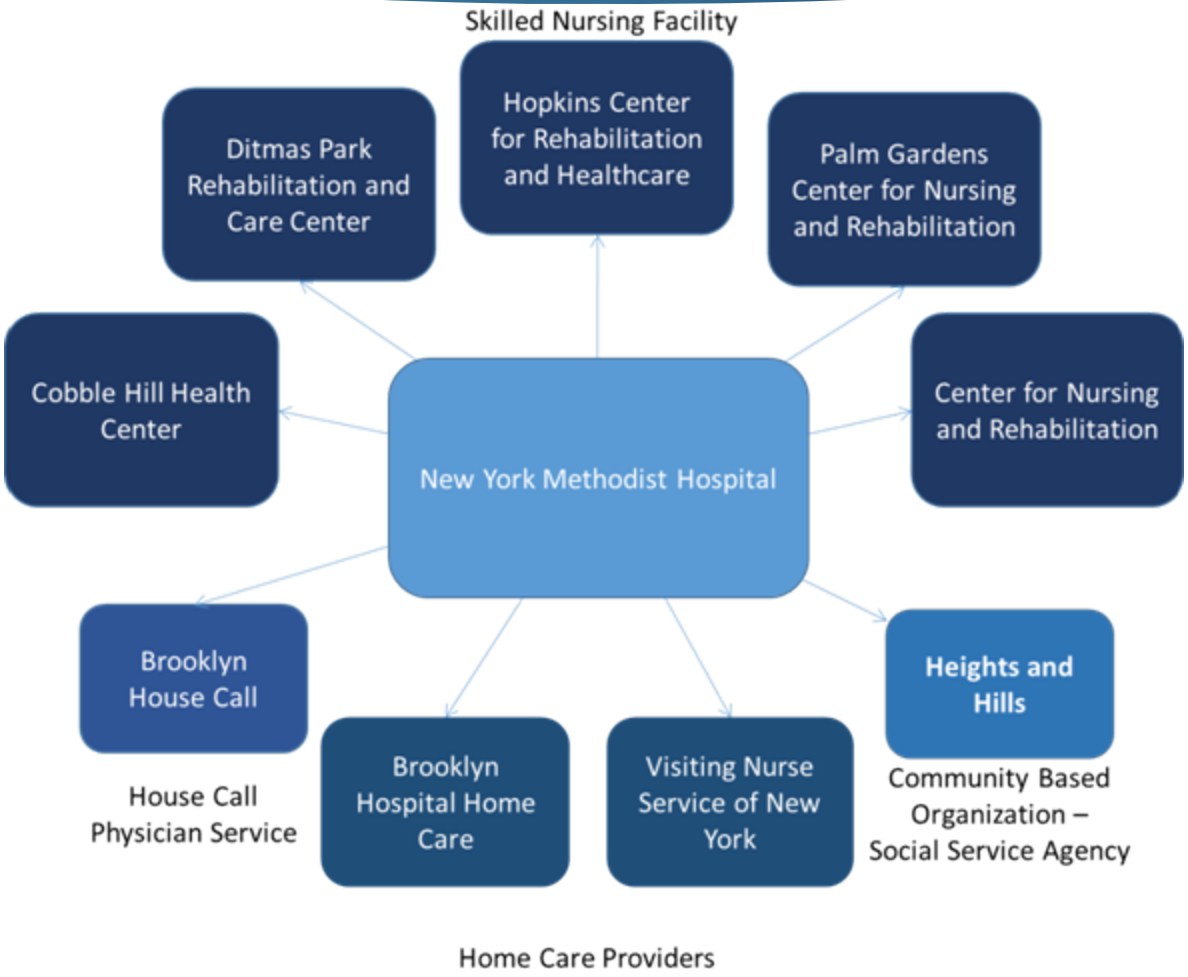
Project Goals

- Give post-acute care providers an accurate assessment of patients condition and goals of care
- Establish partnership between sending and receiving organizations
- Establish a system of “warm handoffs”

Collaboration

- Form the New York Methodist Community Partnership (NYMCP)
- Unique 10 organization partnership
  - New York Methodist Hospital
  - Heights and Hills, Bridge to Home Program
  - 5 Skilled Nursing Facilities
  - 2 Certified Home Health Agencies
  - House Call Physician Service

Collaboration



In-hospital Interventions

- Patient and family caregiver communication is essential
  - Identification of in the Electronic Medical Record (EMR) as part of nursing initial evaluation
  - Hospital Case Management confirms family caregiver role during discharge planning
- Hospital Case Managers communicate with primary care physicians in community
  - Alert of current hospital stay
  - Sends discharge summary
  - Currently CHF, expanding to other diagnoses.

Transition Interventions

- All Partners have designated Transitional Care Assets (TCA)
  - Individual(s) whose primary responsibilities are to focus on the longitudinal care needs of the patients
  - Identify potential patients at admission
  - Perform “Warm Hand-offs”
- Enhanced Communication/Checklists
  - Medications
  - Advance Directives
  - Goals of Care
  - General Condition
  - Presence of “Lines, Tubes and Drains”

Transition Interventions

- Communication between Hospital/Emergency Department and SNF/CHHA/CBO
  - Goals of Care
  - Transfers
  - Physician to Emergency Dept (ED) Physician Hotline
- Developed alternatives to ED transfers
  - PICC Line Insertion, Elective Transfusions, PEG tube insertion, etc

Bridge to Home Program

- Heights and Hills established the Bridge to Home Program, based on the Bridge model of transitional care – a 30-day telephonic social work intervention
- Bridge to Home MSW/Care Coordinator meets patient at bedside
- Provides critical intervention once discharged to community
  - Links Patients and Family Caregivers to community services
  - Not necessarily medical in nature
  - Meals-on-Wheels, transportation, access to care etc
- Follows patients throughout discharge process from hospital to home
- Functions as “trouble shooter”/ concierge

Certified Home Health Interventions

- Visiting Nursing Service of New York (CHHA) and MJHS
  - Have physical presence in hospital
  - Participates in daily rounds and discharge planning
- Communicates with Heights and Hills at first visit
  - Opens communication for coordinated care
  - Identifies possible obstacles in patient care

Brooklyn Skilled Nursing Facilities

- Five nursing facilities, each has a designated Transitional Care Asset
- Emphasis on “warm handoff”
- Discharges to SNF’s have been lower than anticipated

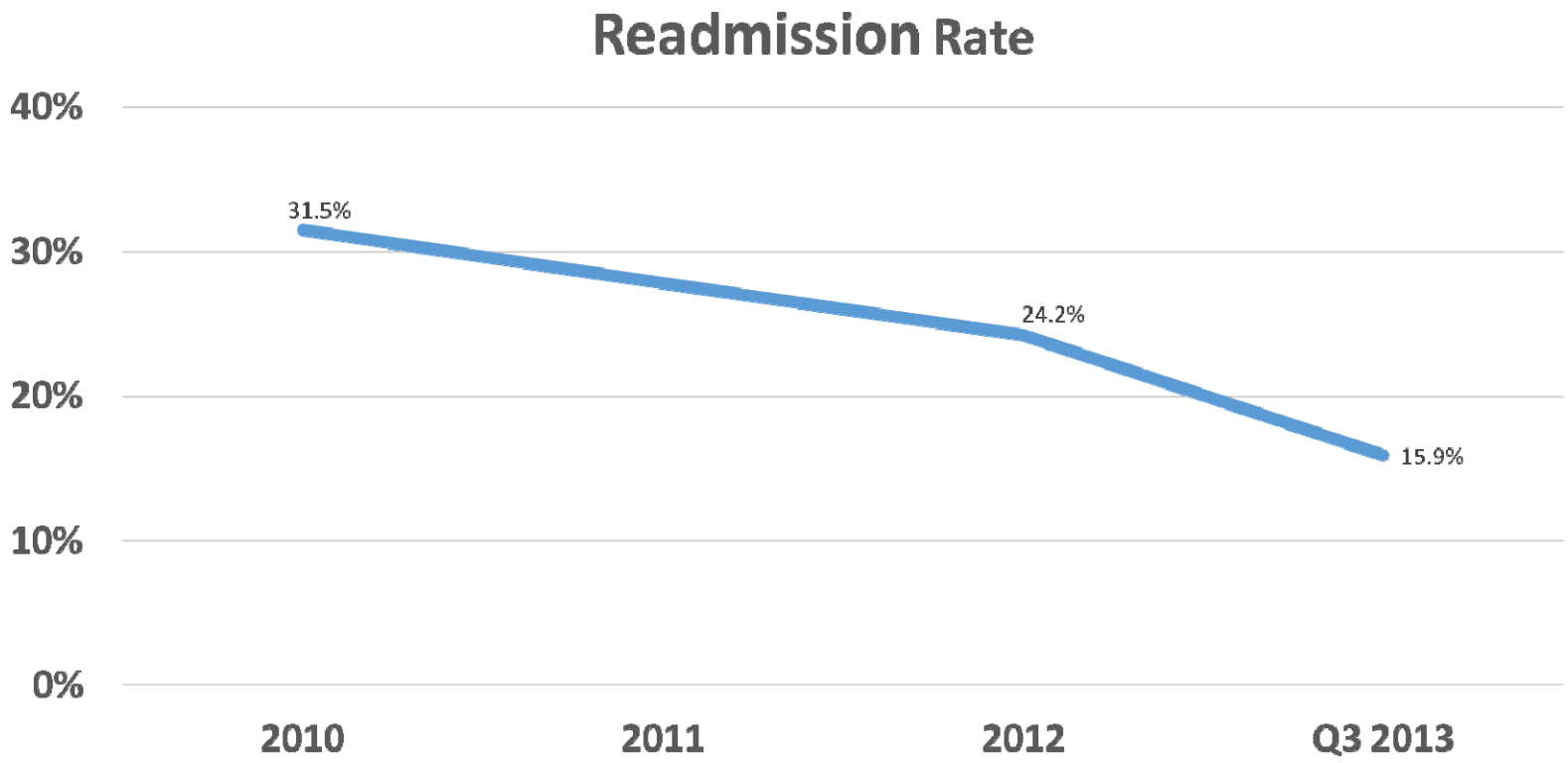
Brooklyn Housecall Interventions

- House Call Physician Service
  - Debilitated/immobile/unable leave home
  - TCA can establish visiting physician within 30days of discharge from hospital
- Partners are allowed, HIPPA compliant, access to EMR

Results

- Operational phase since January 2013
- 339 Patients enrolled into program Jan - Oct
  - 301 (88.8%) patients discharged to CHHA
  - 38 (11.2%) patients discharged to SNF
- Pre-implementation readmission rate
  - 31.5%

Results


Readmission Rate
40%
30%
20%
10%
0%
31.5%
24.2%
15.9%
2010
2011
2012
Q3 2013

Results

- 54 patients readmitted
- Readmission Rate 15.9% (54/339)

- 50% readmission reduction in target population
  - Exceeded goal of 20% readmission reduction

Conclusion

- Significant reductions in preventable readmission is achievable
- Our success realized through a unique and closely aligned 10-member acute and post-acute care partnership