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

Project Objective: To provide a 30-day supported transition period after a hospitalization to ensure discharge directions are understood and implemented by the patients at high risk of readmission, particularly patients with cardiac, renal, diabetes, respiratory and/or behavioral health disorders.

Project Description: A significant cause of avoidable readmissions is non-compliance with discharge regiments. Non-compliance is a result of many factors including health literacy, language issues, and lack of engagement with the community health care system. Many of these can be addressed by a transition case manager or other qualified team member working one-on-one with the patient to identify the relevant factors and find solutions. The following components to meet the three main objectives of this project, 1) pre-discharge patient education, 2) care record transition to receiving practitioner, and 3) community-based support for the patient for a 30-day transition period post-hospitalization.
Additional resources for these projects can be found at www.caretransitions.org and http://innovation.cms.gov/initiatives/CCTP/.

Project Requirements: The project must clearly demonstrate the following project requirements. In addition, please be sure to reference the document, **Domain 1 DSRIP Project Requirements Milestones and Metrics**, which will be used to evaluate whether the PPS has successfully achieved the project requirements.

1. Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.
2. Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.
3. Ensure required social services participate in the project.
4. Transition of care protocols will include early notification of planned discharges and the ability of the transition case manager to visit the patient while in the hospital to develop the transition of care services.
5. Establish protocols that include care record transitions with timely updates provided to the members' providers, particularly delivered to members' primary care provider.
6. Ensure that a 30-day transition of care period is established.
7. Use EHRs and other technical platforms to track all patients engaged in the project.

Project Response & Evaluation (Total Possible Points – 100):

1. Project Justification, Assets, Challenges, and Needed Resources (Total Possible Points – 20)

a. 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.

Data show there is opportunity to reduce Potentially Preventable Readmissions (PPRs) to hospitals. PPR risk-adjusted O/E ratios are 1.04 in Brooklyn, 1.13 in the Bronx, 1.17 in Manhattan, and 0.79 in Queens. In Brooklyn, the highest readmission ratios are found in north-central Brooklyn, Downtown, Bedford-Stuyvesant and Bushwick, and in Coney Island. In the Bronx, hotspots include Williamsbridge, Fordham-Bronx Park, Belmont, East Tremont, Claremont Village, Morrisania and Mott Haven. In Queens, service areas range from 0.64 to 1.50. Behavioral health 30-day readmission rates (all ages) are high: Brooklyn (22%), Bronx (17.9%), Manhattan (23%), Queens (25%).

Twenty-one UHF neighborhoods have risk-adjusted O/E ratios greater than one (indicating a gap in care) for four Prevention Quality Indicator (PQI) measures: PQI for COPD or asthma; PQI for respiratory composite; PQI for chronic composite; PQI for heart failure. Given that these neighborhoods include a significant proportion of the PPS's total Medicaid population (69%), we will enhance patient engagement activities in these areas.

Our PPS identified several factors that contribute to patients' lack of engagement in follow-up care. First, HHC analyses estimate that 41% of patients who had an ED visit did not have a PCP. CNA interviews revealed that care management staff have difficulty reaching a patient's PCP to arrange follow-up. Patients noted having trouble finding and accessing a PCP. PCP appointments may not be available for weeks and may involve lengthy waits during the visit. This contributes to a lack of adherence to discharge regimens and how to deal with adverse drug events (see CNA need 2).

Second, care management programs are often inadequate to address follow-up needs of discharged patients with complex medical conditions and other risk factors (e.g., homelessness, substance abuse, co-morbid behavioral and physical health conditions) (see CNA need 5). Programs may not adequately engage families in caring for recently discharged patients. CNA interviews revealed that post-discharge, individuals have difficulty adhering to medical recommendations in under-resourced and stressful home environments. Providers "have no clue, for the most part, as to where these homeless people are landing… what connection they have to medical services." Providers "don't even ask the question – is there enough food in the home or do you need a referral to a food pantry or Meals on Wheels program?"

Third, the health care system lacks data connectivity. This results in delayed transfer of a complete discharge summary to follow-up providers, lack of health information exchange and system interoperability between all parties (e.g., providers, managed care plans).

Fourth, there is a lack of effective patient education materials that address topics such as management of chronic diseases, how to access a PCP during and after hours, and availability of specialized programs (e.g., substance abuse, behavioral crisis management) that are also responsive to patients culture, language and health literacy needs (see CNA need 3).

To address these gaps, our PPS will pursue a two-pronged approach. First, we will enhance and standardize Project RED (Re-engineered Discharge) in all hospitals. Second, we will strengthen coordination of medical and social services outside the hospital walls.

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 patient population we expect to engage includes all uniquely attributed patients with one or more discharges from hospitals in the PPS. Our PPS will intensify efforts to engage patients in medical and professional shortage areas, and the 21 neighborhoods with consistently poor PQI performance (e.g., ratios greater than 1.0 for respiratory conditions, chronic diseases, and heart failure), including Bedford/Stuyvesant/Crown Heights; Highbridge/Morrisana; Washington Heights/Inwood; Pelham/Throgs Neck; Flatbush/E. Flatbush; Jamaica; Williamsburg/Bushwick; East New York; Hunts Point/Mott Haven; Central Harlem/Morningside Heights; NE Bronx; Canarsie/Flatlands; E. Harlem; Downtown/Heights/Slope; Rockaway; Stapleton/St. George; Chelsea/Clinton; Upper W. Side; Kingsbridge/Riverdale; Upper E. Side; and, Gramercy Park/Murray Hill. Project efforts will be closely coordinated with 2.d.i activities to engage low- and non-utilizers (see CNA need 1).

Among the 21 targeted neighborhoods, the 10 poorest have 21-43% of the population below 100% FPL. These 10 neighborhoods also have 11%-26% who are non-US citizens, 7%-36% who speak English "less well," 20%-40% of adults with less than a high school education, and 9%-17% living with a disability.

At-risk patients will be identified using a standardized risk assessment tool, which will look at frequent admissions in the past year (e.g., more than 2-3), readmissions within 30 days within the past year, specific diseases within cardiac, renal, diabetes, respiratory and/or behavioral health disorders, substance abuse, sickle cell, diabetes with peripheral vascular disease, ESRD with CHF), use of high alert medications/polypharmacy, health literacy, socio-economic support/status including homelessness, and need for chronic pain management (see CNA needs 3, 4, 5).

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.

Our PPS has a number of assets and resources to support this project. Our PPS has pilot tested care transition models, including Project RED, and has established an Integrated Care Management Council. CHF was the initial focus of Project RED and approximately five facilities expanded to include COPD in early 2014. MetroPlus's existing care management programs, including the House Calls program, will be leveraged, as will expertise gained through learning collaboratives on care management and care transitions.

With this foundation, our PPS will pursue a two-pronged approach. First, we will extend Project RED to all hospitals in the PPS and will target all at-risk patients. Currently, with one exception, Project RED is implemented to some degree in the PPS's acute care hospitals but still lacks standardized protocols and risk assessment tools. At-risk patients (e.g., cardiac conditions, renal failure, diabetes, respiratory

conditions, behavioral health, and other socio-economic factors) will be identified and provided with more intensive care management. Tools will be standardized and will emphasize patient and family engagement. All PPS hospitals will address the medical conditions targeted for this project; however, each will phase-in interventions based on the prevalence of their respective readmission trends.

Although Project RED calls for a two-day patient follow-up post discharge, care management teams at most of the PPS's acute hospitals already follow patients for the desired 30 days post-discharge. Any remaining PPS hospitals will be brought up to this 30-day standard.

Second, our PPS will enhance Project RED by strengthening coordination outside the hospital walls with PCPs, post-acute providers and other CBOs. The latter is particularly important given that CNA key informants noted that "we have absolutely zero knowledge of community resources." Relationships include building on our already strong collaboration with the four Health Homes in our PPS (e.g., HHC, CBC, CCMP, CHCN) and relationships with CBOs that provide Health Home-related services via subcontract. In addition, we will work closely with PPS and community physicians, diagnostic testing centers, PCMHs, skilled nursing facilities, the NYC Department of Homeless Services and other partners.

Our PPS will develop standard processes and protocols to ensure accountability for safe and effective transition of care between the hospital and post-acute partners. We will also develop protocols for patient education materials on disease management, lifestyle, and medication management that meet patient's culture, language and health literacy needs.

To support the project, our PPS will retrain and redeploy staff as care managers, navigators, and care coordinators. For patients needing ambulatory withdrawal management services, we will explore opportunities to expand capacity. A newly developed CSO will house the PPS's care management and care coordination services.

Our PPS will enhance IT systems to support a range of functions. Care management staff will, for the most part, be able to arrange follow-up PCP appointments for patients through expanded and enhanced centralized scheduling systems and make greater use of open access scheduling. We will work with PCPs to expand capabilities to electronically communicate with patients. Enhanced data connectivity will support the sharing of timely and standardized inpatient discharge information to follow-up providers, exchange of information across members of the care team, and the establishment of feedback mechanisms from community partners to care management teams. We hope to pilot test alert and early notification systems to inform providers when a patient presents to the ED.

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

Limited capacity at the primary care clinics hinders timely appointments with PCPs for follow-up care (see CNA need 2). To address this, our PPS will work internally and with partners to implement one or more of the following strategies: extend hours, expand capacity, hire staff, improve open access

capabilities, and expand use of telehealth services. We also plan to strengthen Health Home services by contracting with CBOs to provide outreach and care coordination, work with MetroPlus's Housecalls program which delivers remote care management services and leverage experience gained through work on our Medicare MSSP ACO to enhance outreach and engagement efforts.

Care coordination for homeless patients is challenging (see CNA need 5). According to the CNA, providers "have no clue, for the most part, as to where these homeless people are landing… what connection they have to medical services." The PPS will work with the NYC Department of Homeless Services to address issues that hinder the access of homeless patients to care.

Conveying information about health care and services is complex given the ethnic and racial diversity in each borough (see CNA need 3). According to focus groups, information is best shared by "people seeing people who look like them, that are like them, who speak like them…" The PPS will work with many CBO partners familiar with local neighborhoods to develop and disseminate educational materials that meet patient's culture, language and health literacy needs.

Many aspects of the proposed interventions rely on enhanced IT systems. The PPS will address five foundational elements of the IT system including: (1) centralized population health management data capabilities; (2) functional capabilities to support operations and measure performance; (3) care coordination and management capabilities; (4) alignment of electronic health records within the PPS and with partners, including assistance with meeting Stage 2 Meaningful Use attestation; and (5) HIE with RHIO/SHIN-NY and private HIE.

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

As part of planning activities to date, our PPS has collaborated with Bronx Partners for Healthy Communities (BPHC) and Community Care of Brooklyn (CCB). We have achieved a number of important goals, including aligning project selection for this and other projects, and beginning to identify areas for collaboration during implementation and operations.

During implementation and operations, we intend to continue our collaboration with BPHC and CCB. We expect this collaboration to focus on: ensuring alignment and coordination of standardized protocols; developing common risk assessment methodologies; development of workforce strategy, including common job descriptions and functional capabilities; workforce training efforts; data sharing; and selection of culturally competent patient education resources to support this project.

Post-application, we intend to broaden our collaboration efforts to include other PPSs in our service area. We believe this coordination will be crucial to reducing the burden on providers and CBOs by addressing key capacity and workforce needs, improving clinical outcomes and patient experience.

2. <u>Scale of Implementation</u> (Total Possible Points - 40):

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.

Please use the accompanying Speed & Scale Excel document to complete this section.

3. Speed of Implementation/Patient Engagement (Total Possible Points - 40): DSRIP projects

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.

Please use the accompanying Speed & Scale Excel document to complete this section.

4. Project Resource Needs and Other Initiatives (Not Scored) a. Will this pr

Yes	No
☒	☐

If yes: Please describe why capital funding is necessary for the Project to be successful.

The PPS will enhance IT systems with required capabilities. Care transition teams will, for the most part, arrange follow-up PCP appointments for patients through expanded and enhanced centralized scheduling processes and greater use of open access scheduling. The PPS will work with PCPs to expand capabilities to "see" patients via telephone, email, or video chat. Enhanced data connectivity will support timely and standardized inpatient discharge information to follow-up providers and establish feedback mechanisms from community partners to care management teams regarding the patient's engagement to ensure coordination with any future inpatient services. This connectivity will also ensure timely exchange of information across members of the care team (e.g., between care managers and providers, and between providers from various specialties).

In addition, capital investment is required for the construction or renovation of existing space for patient-friendly and accessible wellness centers which will provide culturally and linguistically competent education on disease management, blood pressure checks, and patient navigator support on how to access a PCP during and after hours and availability of specialized programs (e.g., substance abuse, behavioral crisis management).

b. 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?

Yes	No
☒	☐

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.

Please note: *if you require more rows in order to list all relevant initiatives, please make a note of this in your response to question (c.) immediately below and attach a separate document with these projects listed.*

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
New York City Health & Hospitals Corporation (HHC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	HHC is a NYS-designated Health Home.
Community Care Management Partners (CCMP) Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CCMP is a NYS-designated Health Home.
CBC Pathways to Wellness Health Home	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CBC Pathways to Wellness is a NYS-designated Health Home.
Community Health Care Network	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CHN is a NYS-designated Health Home.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Health People	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Health People provides services to NYS Medicaid Health Homes under subcontract. The organization provides outreach, engagement, follow-up, care retention and relevant self-care education for Medicaid enrollees with chronic conditions.
Leake & Watts	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	Leake & Watts provides a Health Home for children through the Children's Collaborative, a collation of children-and family-focused agencies that provides Health Home services for children.
PSCH	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	PSCH provides services to NYS Medicaid Health Homes under subcontract, including care coordination services to individuals with complex and/or multiple chronic conditions.
The Osborne Association /Osborne Treatment Services, Inc.	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2015	The Osborne Association provides services under subcontract to Health Homes in Bronx and Brooklyn.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
Community Health Project, Inc. d/b/a Callen-Lorde Community Health Center	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	Callen-Lorde participates in the Mount Sinai Health Homes network. Callen-Lorde has been assigned approximately 150 patients and 85 are actively enrolled. The program is growing, with two new Health Home positions are anticipated in the next two months. The program will scale up to 300+ patients by 2016.
R.A.I.N.	Community-Based Care Transitions Program	2015	2018	R.A.I.N. provides coordination and linkage to providers who specialize in disease management.
Total Care Pharmacy, Inc., Specialty Care Pharmacy, Amato Pharmacy, Medical Center Pharmacy, Total Care Pharmacy Bx, Inc.	Community-Based Care Transitions Program	2014	2018	Total Care Pharmacy provides transitional services when patients are discharged, including follow-up on medication adherence and side effects.
Health People	NYS Balancing Incentive Program, Innovation Fund (BIP)	2014	2015	Health People trains peer educators to deliver Stanford Diabetes Self-Care and Lower Extremity Amputation Prevention education and links clinical referrals of Medicaid patients with diabetes to Health People through the Quality and Technical Assistance Center electronic system.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
New York City Health & Hospitals Corporation (HHC)	Medicare Shared Savings Program	June 2012	December 2016	HHC ACO, Inc. (the HHC ACO) was formed by HHC in June 8, 2012, to further the goals of the Medicare Shared Savings Program (MSSP).
Arms Acres and Conifer Park	Health Homes for Medicaid Enrollees with Chronic Conditions	2014	2018	Arms Acres and Conifer Park provides services to NYS Medicaid Health Homes under subcontract. Services include coordination of behavioral health services for patients with chronic medical and behavioral conditions.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health and Recovery Plan (HARP)/1915i Health & Community Based Services	2015	2018	ASCNYC 1915i HCBS services include independent living skills development, health education and navigation services, supportive recovery networks, comprehensive peer supports, and engagement in ASC's extensive array of support and activity groups.
AIDS Service Center of Lower Manhattan, Inc. (ASCNYC)	Health Homes for Medicaid Enrollees with Chronic Conditions	2015	2018	ASCNYC is a Health Home care management provider, providing culturally competent care management team services comprised of licensed social workers and trained Peer Health Coaches.

Name of Entity	Medicaid/Other Initiative	Project Start Date	Project End Date	Description of Initiatives
New York City Health & Hospitals Corporation (HHC)	CMS Innovation Center Health Care Innovation Awards (HCIA)	April 2014	March 2017	As part of this CMMI Round 2 grant (ED Care Management Initiative: Preventing Avoidable ED/Inpatient Use), HHC uses an interdisciplinary team to facilitate and coordinate care for patients who can be safely treated and released from ED. The target population for this initiative is patients with ambulatory sensitive conditions.
CAMBA	CMS Innovation Center Health Care Innovation Awards (HCIA)	2012	2016	CAMBA provides Health Home care management services, under subcontract, to individuals with serious mental illness as part of Maimonides Medical Center HCIA initiative.
CAMBA	Health Homes for Medicaid Enrollees with Chronic Conditions	2012	2018	CAMBA is a Health Home care management provider, serving over 2200 members and conducting outreach to between 300 – 900 members per month.
See additional entities at end of document	See additional initiatives at end of document			See additional descriptions at end of document

c. 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 HHC ACO focuses on Medicare Fee-for-Service (FFS) beneficiaries linked to participating PCPs. Financial performance and shared savings/losses pertain to services rendered to Medicare beneficiaries only. The HHC ACO is specifically designed to deliver seamless, coordinated, high quality care to Medicare FFS beneficiaries through an organized group of HHC affiliated physicians, 11 hospitals and other healthcare providers who have agreed to work together to treat a defined population of patients across care settings–including primary and specialty care, hospitalizations and long-term care–and

become accountable for the quality, cost and overall care delivered. DSRIP builds on HHC's MSSP experience by extending redesigned care processes for high quality and efficient service delivery to Medicaid patients and the uninsured.

The experience and capacity of our participating Health Homes and downstream care management and care coordination agencies, is a strong foundation for this DSRIP project. Our work will build on work already underway, but will serve a larger group of Medicaid patients, including those not currently eligible for Health Home services.

The Balancing Incentive Program provides funding to support service enhancements, such as patient monitoring to improve non-institutional long-term services and supports (LTSS). While our PPS can leverage participating providers' experiencing improving care for this specialty Medicaid population, our PPS will not duplicate activities provided by BIP funding as BIP does not target the type of chronic disease management provided through this project.

The Community-Based Care Transitions (CBCT) supports care transitions for Medicare beneficiaries. Our PPS will leverage this experience to establish a customized, evidence-based standard care transitions for the Medicaid population in participating hospitals. Funds will not be provided if doing so would supplant or duplicate CBCT funding.

The HARP program offers specialized managed care products with integrated medical and behavioral health services and expanded recovery-oriented benefits. HARP service providers and behavioral health enrollees are likely to participate in this project. However, this DSRIP project will extend to all of our actively engaged population, not just those enrolled in HARP plans.

5. Domain 1 DSRIP Project Requirements Milestones & Metrics:

Progress towards achieving the project goals and project requirements specified above will be assessed by specific milestones for each project, measured by particular metrics as presented in the attachment **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Domain 1 Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals.

PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in March 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards completion of

project requirements, scale of project implementation, and patient engagement progress in the project.

a. **Detailed Implementation Plan:** By March 1, 2015, PPS will submit a detailed Implementation Plan to the State for approval. The format and content of the Implementation Plan will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application. Speed and scale submissions with the project application will directly impact Domain 1 payment milestones.

b. **Quarterly Reports:** PPS will submit quarterly reports on progress towards achievement of project requirements as defined in **Domain 1 DSRIP Project Requirements Milestones & Metrics**. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.