Care Coordination between Hospital and Health Home: a Successful Collaboration

An agency's experience and practices with embedding services in a hospital setting to provide measurably effective Care Coordination services.

NADAP, Inc.
Health Home Care Coordination
May 2017

NADAP

Since 1971, NADAP has been working with clients diagnosed with Substance Use Disorders (SUD's); in the early years our primary focus was on employment support services for people recovering from addiction.

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Today, NADAP's person-centered wraparound services enable individuals and families to become healthy, productive, and self-sufficient.

- **Care Coordination for Health Homes**
- Comprehensive Employment Services (CES)
- Project ACE (Assessment- Case Management- Employment)
- Substance Abuse Centralized Assessment Program (SACAP)
- In Person Navigator Program
- Technical Assistance / Professional Training (TAPT)
- Career Compass

Healthcare Reform

"The marketplace is beginning to demand that health care providers develop and provide **outcomes data.**

This is evidenced by managed care companies, business coalitions, and alliances requiring organizations to demonstrate their **effectiveness** and **quality of patient care services.**

This demand for **outcomes measurement** is in addition to the internal business requirements of the organization to measure and monitor performance for the purpose of continuous **quality and process improvement** activities."

NADAP & Care Coordination

- We have been engaged with multiple Health Homes since 2012.
- NADAP works with 35 organizations consisting of outpatient providers, rehabilitation centers, criminal justice organizations and **hospitals** to provide integrated care coordination with direct HH linkage
- We currently serve 4,800 members.
- We currently have 12 Care Coordination teams.
- NADAP works across all 5 boroughs.

Collaboration

noun col·lab·o·rate \kə-ˈla-bə-ˌrāt\

"a process through which parties who see different aspects of a problem [or issue] can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible" (Gray, 1989, p. 5).

Gray, B. (1989). Collaborating. San Francisco, CA: Josses-Bass

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Integration

noun in·te·gra·tion \ˌin-tə-ˈgrā-shən

: to form, coordinate, or blend into a functioning or unified whole

: to unite with something else

: to incorporate into a larger unit

: to end the segregation of and bring into equal membership in society or an organization

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Innovation

noun/ in·no·va·tion / inəˈvāSH(ə)

Innovation can be defined simply as a "new idea, device or method".[1] However, innovation is often also viewed as the application of better solutions that meet new requirements, unarticulated needs, or existing market needs.

From Wikipedia, the free encyclopedia

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NADAP's Hospital Partnerships

NADAP has been partnering with several major hospitals in New York City since 2015, **collaboratively** developing hospital-specific policies and procedures to identify, outreach, and engage patients that qualify for Health Home enrollment and care coordination.

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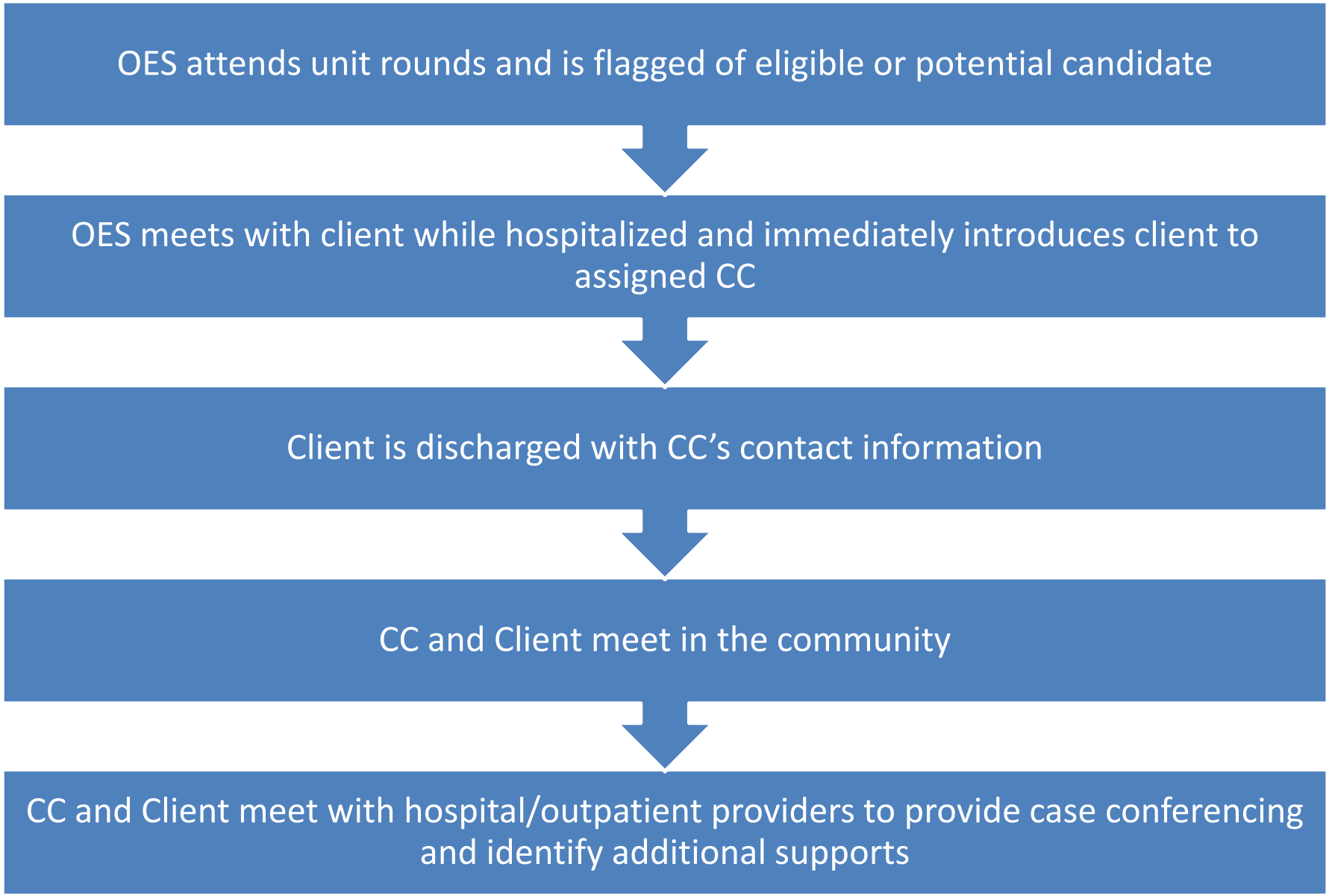
Health Home Care Team Model

The Care Team Model is led by a Care Coordinator who meets with the client in the community to provide the following services:

- Comprehensive **health assessment** of each client to determine:
  - What is needed?
  - What is already in place?
  - Where are the gaps?
- Creation of a person-centered **care plan** based on clients needs and goals.
- **Links client** with needed providers and **maintains communication** with all Care Team members.
- Works on-going with client to **remove barriers** to care and **improve treatment compliance**.


OES attends unit rounds and is flagged of eligible or potential candidate
OES meets with client while hospitalized and immediately introduces client to assigned CC
Client is discharged with CC's contact information
CC and Client meet in the community
CC and Client meet with hospital/outpatient providers to provide case conferencing and identify additional supports

NADAP's Approach

- **Heavy data tracking** through proprietary database:
  - Caseload management
  - Client risk stratification
  - Operational compliance (service provision, documentation timeliness, hospitalization follow up)
- **Specialized teams** for target populations**:**
  - Hospital-based teams (35:1)
  - Intensive Care Coordination team (25:1)
  - Standard Care Coordination (45:1)
- **Leverage data resources:**
  - PSYCKES
  - Healthix
  - MAPP

- **Clinical Support and Quality Assurance:**
  - Clinical Manager and Director of QA
  - Care plan audits
  - Service delivery audits
  - Critical Incident reviews

- **Staff Training** to increase skills and ensure policy compliance:
  - Mental Health and SUD
  - Medical Diagnoses (ie, Asthma, Diabetes, ESRD)
  - Motivational Interviewing
  - Engagement and Assessments
  - Care Planning and Care Team
  - Risk Assessment and Safety Planning

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Impact Analysis

1. Demographics
2. Hospital usage **pre-enrollment** in health home
3. Hospital usage **during enrollment** in health home
4. Hospital usage **post-discharge** from the health home
5. Hospital usage **post-enrollment** in health home regardless of whether client stayed enrolled in services

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Information Resources

1. Psychiatric Services and Clinical Knowledge Enhancement System for Medicaid (PSYCKES)
2. Healthix | Public health information exchange (HIE)
3. Hospital Database
4. NADAP's Internal Database
5. Anecdotal data

Hospital A Study

- NADAP presented a 6-month Summary Report with information and preliminary data obtained during the start-up phase of this new initiative.
- The report focused on 110 patients enrolled during the first three months of HHCC operations and who were still enrolled as of the end of that period.
- Early indications showed promising results for enrolled patients including the following:
    - Increased linkages with primary and specialty care providers
    - Decreased reliance on inpatient and emergency department services
    - Willingness to engage in care coordination and participate in assessments and service planning
    - Receptivity to education about diagnoses and strategies to better utilize community-based care
    - Active participation in work to resolve life and social needs

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Patient study group

In order to evaluate program effectiveness at the one-year point, NADAP used the following methodology:

- NYS Office of Mental Health PSYCKES system was used to access patient hospitalization data
- Utilized cohort of 110 patients in NADAP's six-month summary report:
  - 44 clients were excluded for the following reasons:
    - No data or incomplete data in PSYCKES (33)
    - Transferred to another care setting or care management agency (5)
    - No longer eligible for services (4)
  - 68 patients were divided into two discrete comparison groups:
    - ***Enrolled Patient Group***
    - ***Dis-enrolled Patient Group***
- Average data range was 13 months pre-enrollment and 13 months post-enrollment.
- PSYCKES includes all hospitalizations for the entire period post-enrollment, regardless of whether the patient is still enrolled with NADAP.

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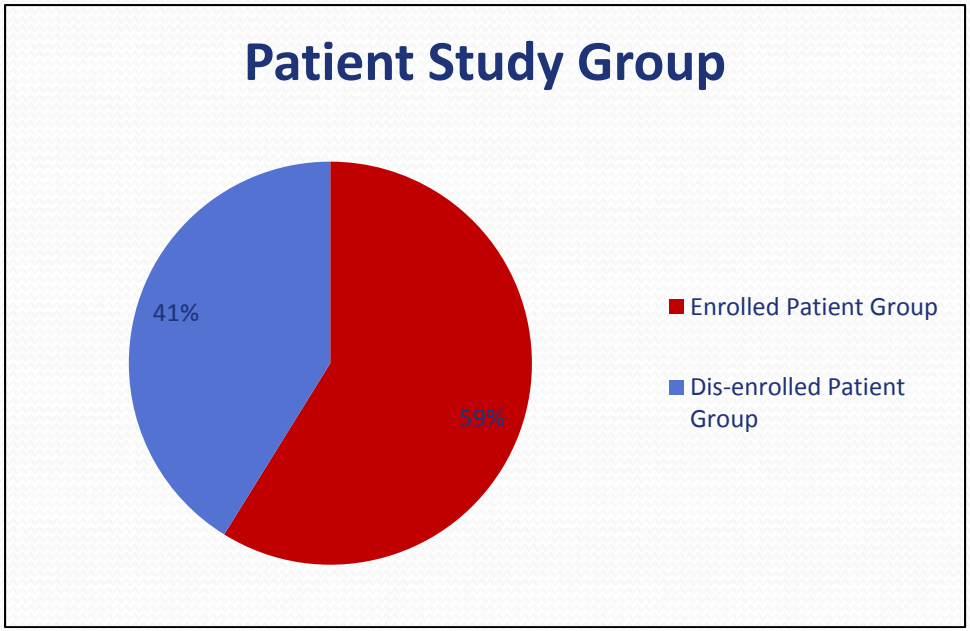
Patient study group

68 patients were divided into two discrete comparison groups:

- ***Enrolled Patient Group*** – Patients still enrolled (40 patients)
- ***Dis-enrolled Patient Group*** – Patient who requested to be dis-enrolled or were dis-enrolled for loss of contact (28 patients)



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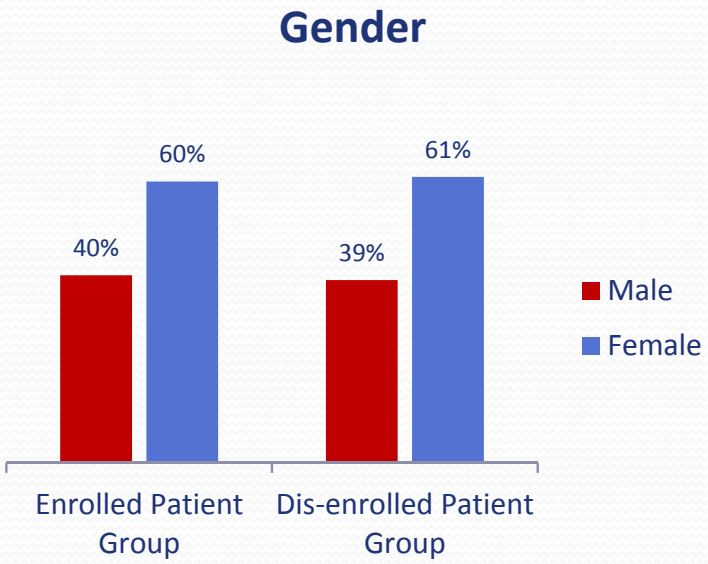
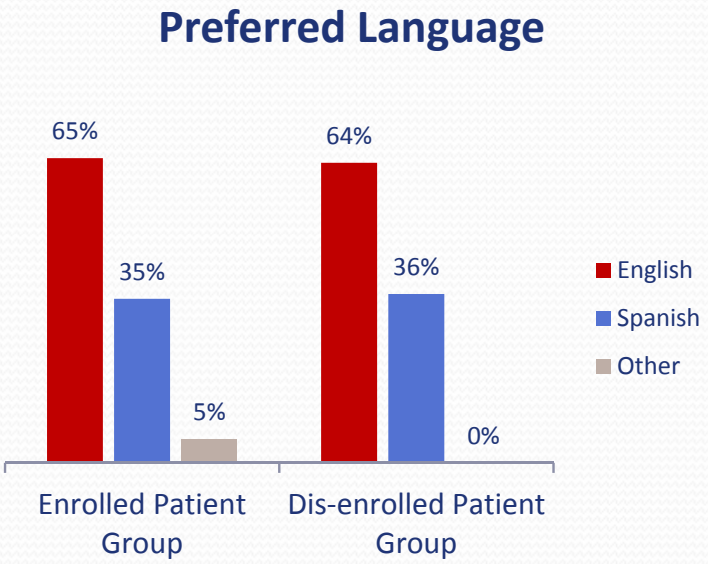
Demographics at Enrollment

No significant difference in gender, age or language.





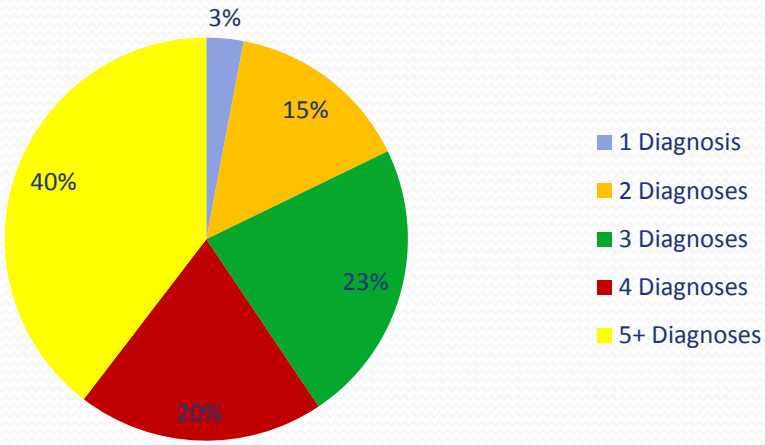
- Average age for both groups: 51.9

Enrolled Patient Group = 40 patients
Dis-enrolled Patient Group = 28 patients

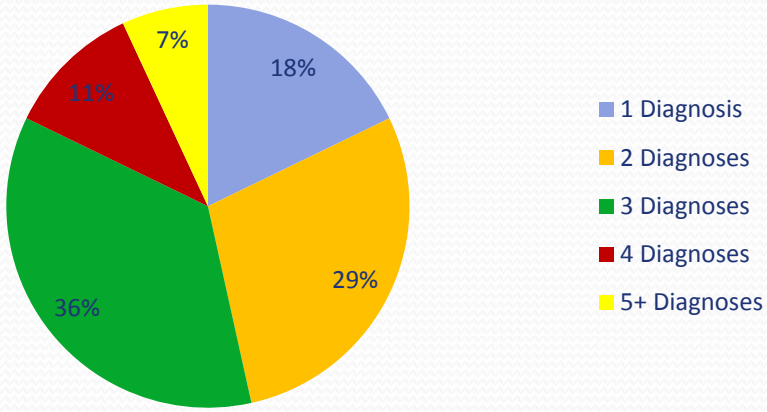
Demographics at Enrollment: Medical Diagnoses

Enrolled patients presented with more medical conditions

Enrolled Patient Group



Dis-enrolled Patient Group



Enrolled Patient Group = 40 patients
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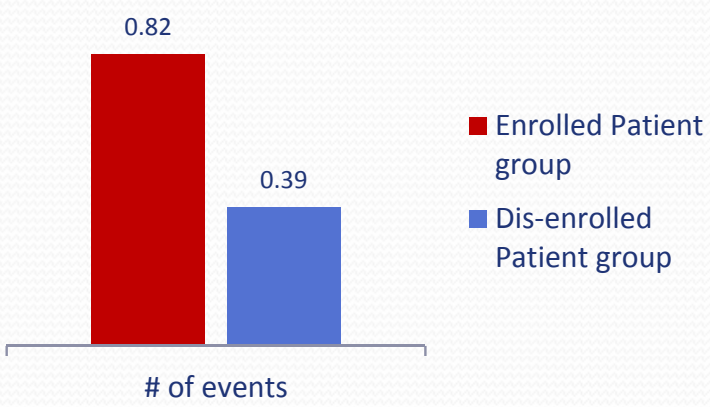
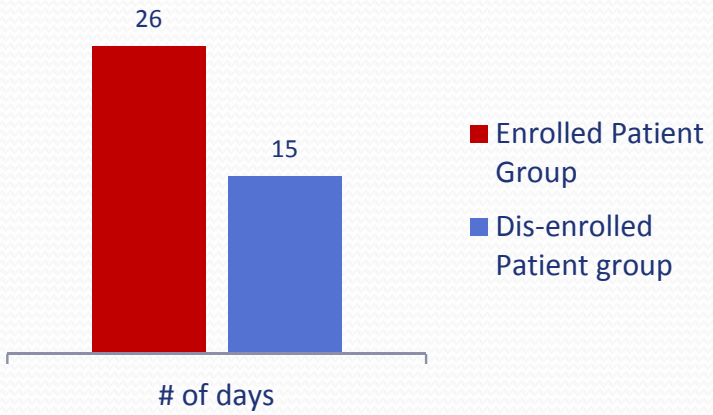
Hospital Utilization Pre-Enrollment

Enrolled Patient Group was hospitalized twice as often as Dis-enrolled group

Hospitalizations per Patient per Month Pre-enrollment



Average Days in Hospital per Patient Pre-enrollment



Based on 13 months average pre-enrollment time period

Enrolled Patient Group = 40 patients
Dis-enrolled Patient Group = 28 patients

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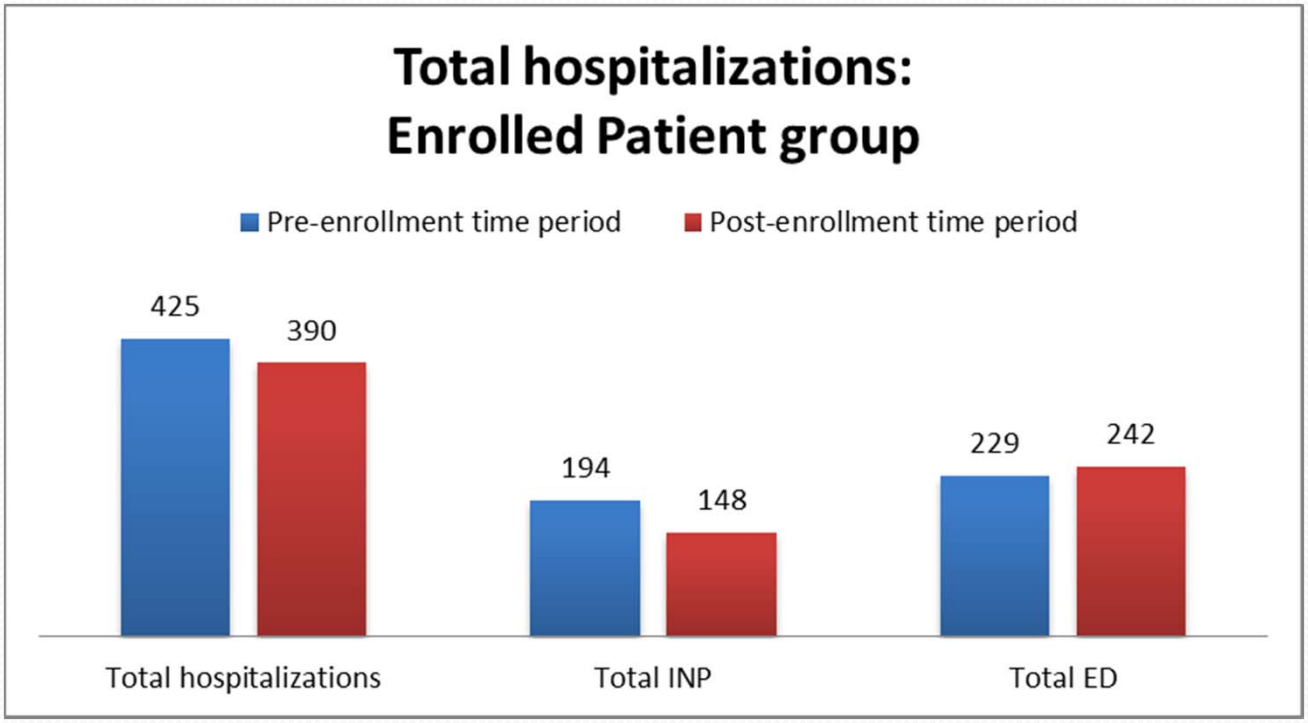
Hospitalization Data Post-Enrollment

- Captured data for each patient from point of enrollment to 7/31/16
- Average post-enrollment period was 13 months
- Using PSYCKES, we were able to see data regardless of whether patient is still enrolled with NADAP
- For the Enrolled Patient Group, all clients were enrolled during the entire post-enrollment time period
- For the Dis-enrolled Patient Group, clients dis-enrolled at different points during the post-enrollment time period. The average length of enrollment was 6.5 months.

Hospitalization Events: Enrolled Group

- Total hospitalizations for enrolled patients **decreased 8%**
- In-Patient visits **decreased 24%** while ED visits **increased 6%**

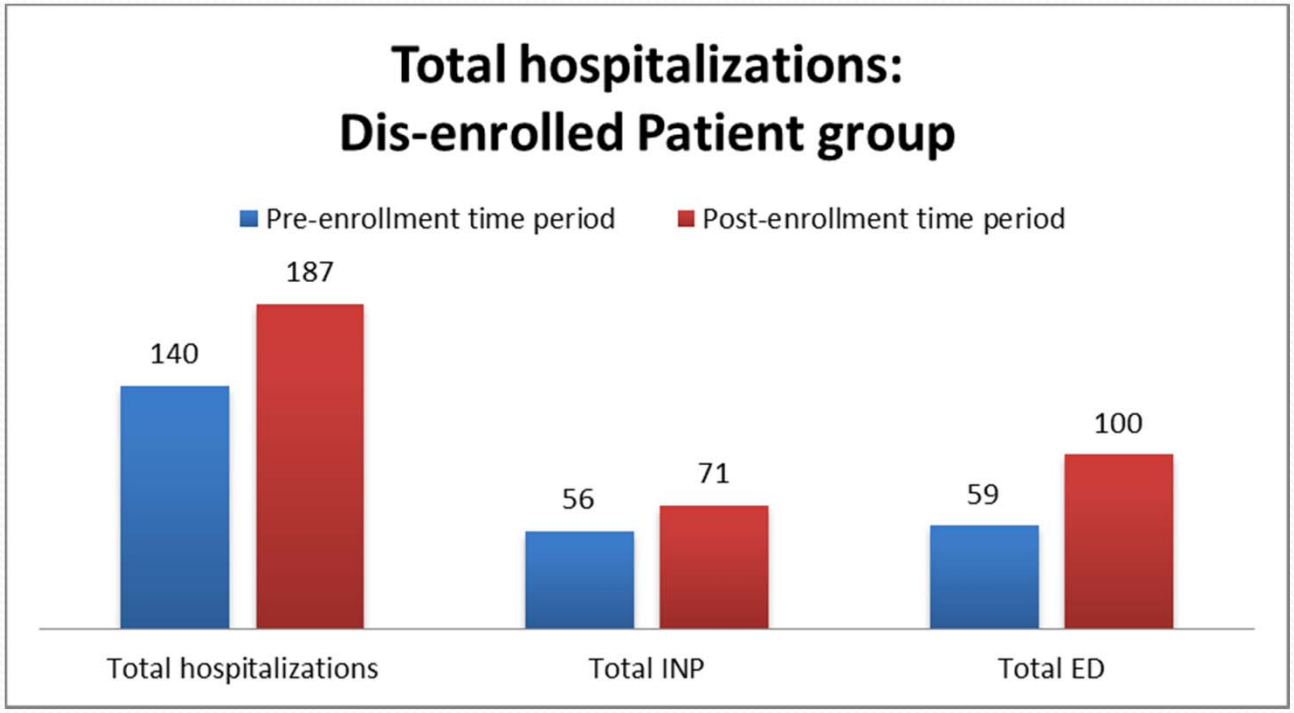


Enrolled Patient Group = 40 patients

PSYCKES does not always identify in-patient or ED designation so subtotals may not equal total hospitalizations.

Hospitalization Events: Dis-enrolled Group

- Total hospitalizations for dis-enrolled patients **increased 34%**
- In-Patient visits **increased 27%** and ED visits **increased 69%**

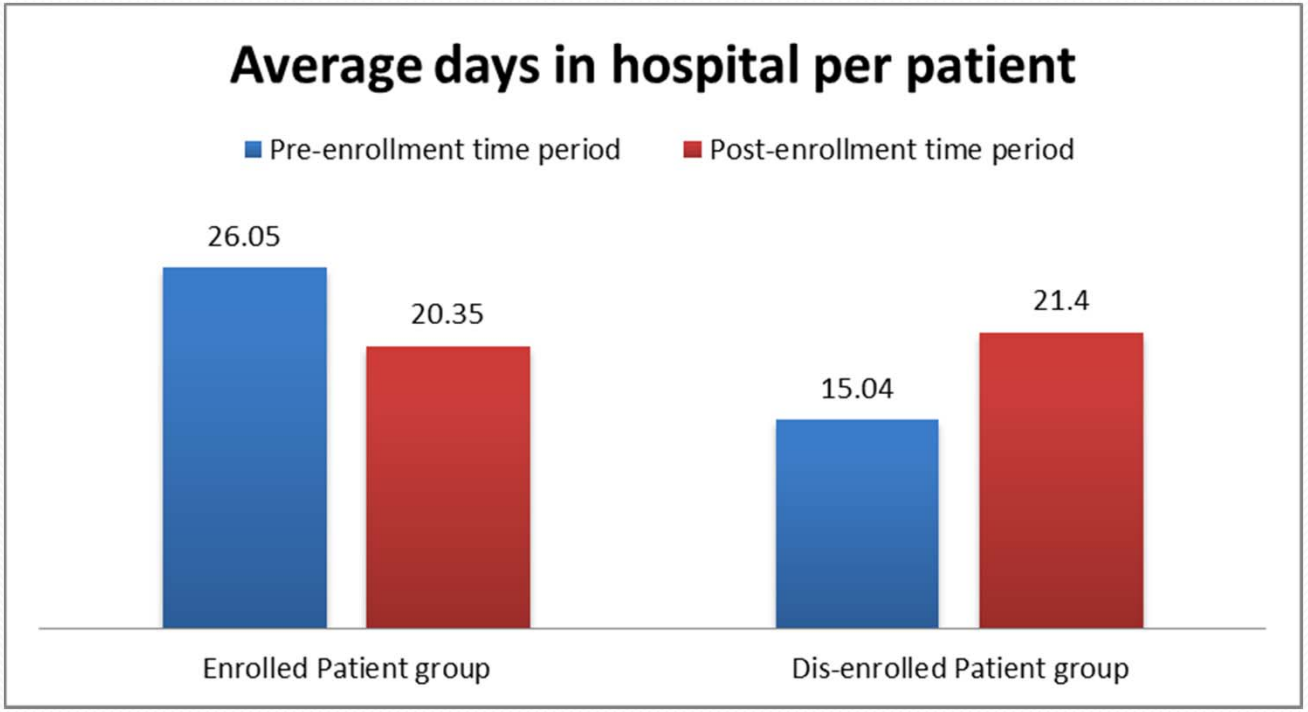


Dis-enrolled Patient Group = 28 patients

PSYCKES does not always identify in-patient or ED designation so subtotals may not equal total hospitalizations.

Days in Hospital

- Enrolled group: average days in hospital **decreased** 22%
- Dis-enrolled group: average days in hospital **increased** 42%



Enrolled Patient Group = 40 patients
Dis-enrolled Patient Group = 28 patients

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Early Lessons and Recommendations

- Although this is a relatively small study group, the data is encouraging.
- NADAP has been successful in retaining HHCC target patients - those presenting with pattern of higher hospital utilization.
- Overall hospitalization rates decreased for patients who stayed enrolled in HHCC services.
    - In-patient visits decreased and ED visits increased
    - Total days in hospital decreased; average days per stay decreased
- Overall hospitalization rates increased for patients who dis-enrolled or were lost to contact.
    - In-patient visits and ED visits increased
    - Total days in hospital increased; average days per stay increased
- Most significant differentiator between groups was days in hospital.

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Conclusions and Recommendations

- Presence of Critical Intervention Specialist (onsite since April 2016) has positively affected enrollment retention.
- Data is crucial for program monitoring and quality improvement.
- We are hopeful that the Hospital High Utilizer meetings will help us increase program impact for the highest need patients.
- Working closely with the hospital's other onsite DSRIP funded programs will help impact 30 day readmission rates.

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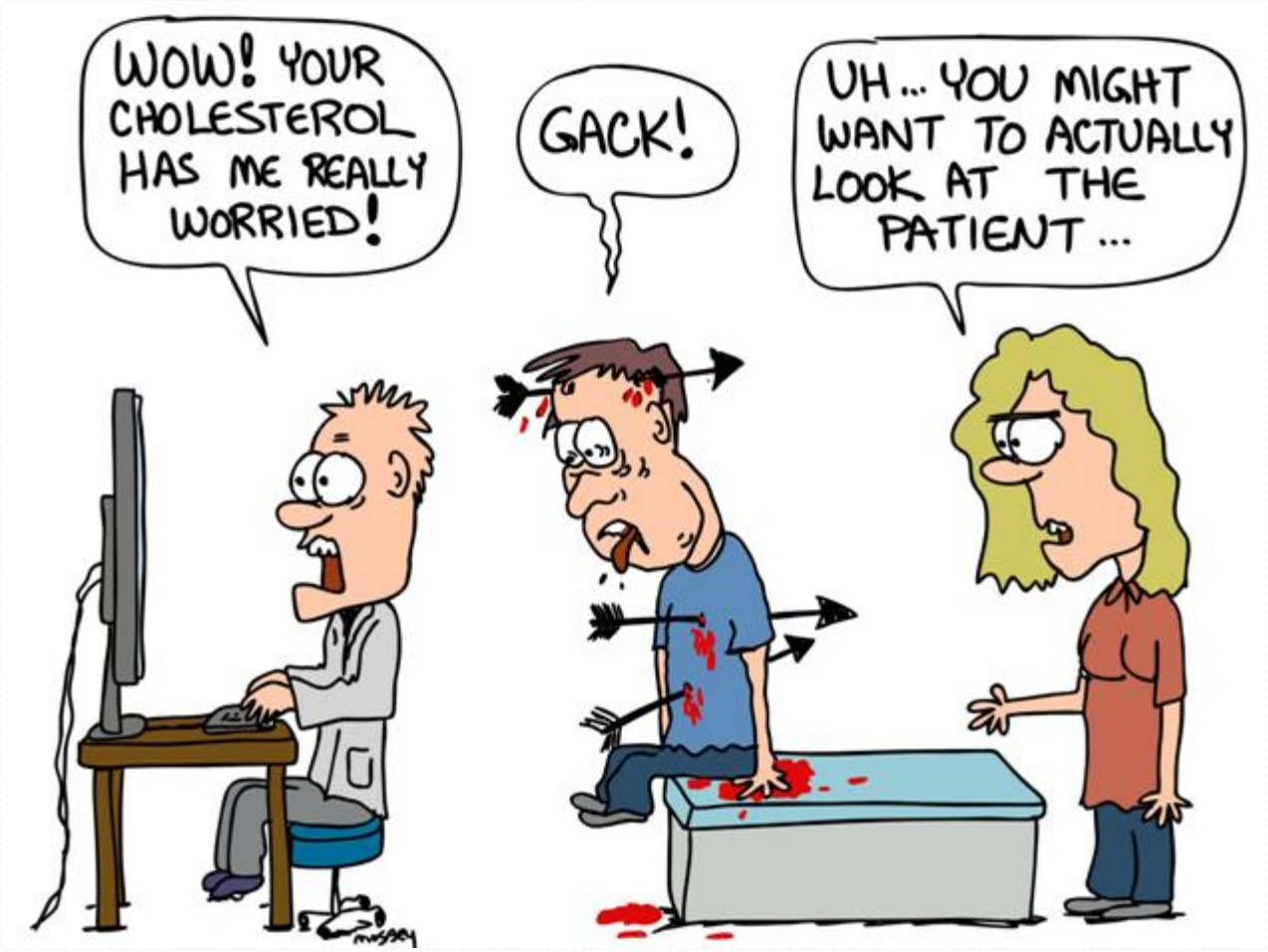
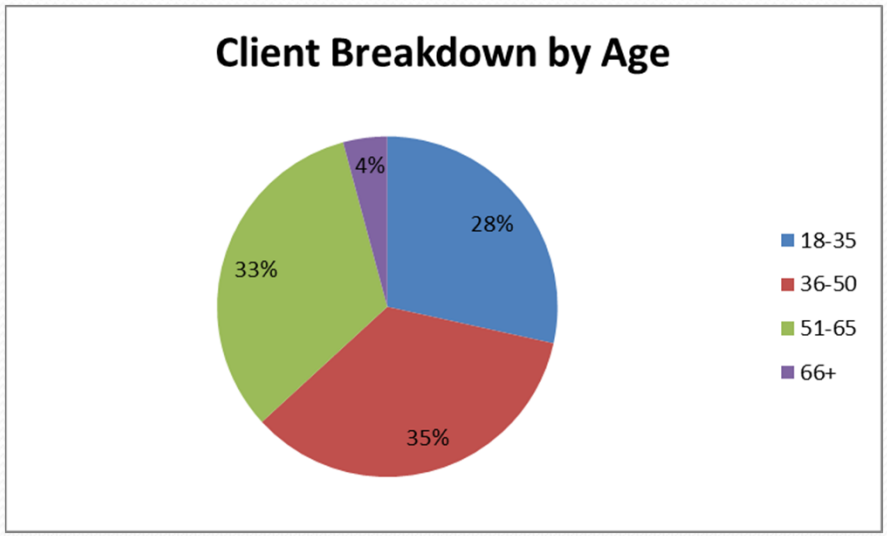
Hospital B Study

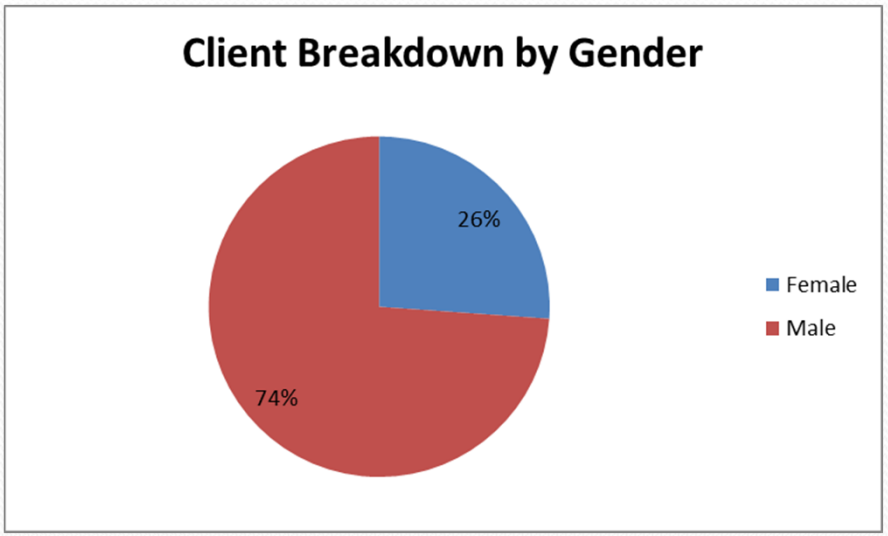
In November 2016, NADAP presented a 6-month Summary Report with information and preliminary data obtained during the start-up phase.

- Initial challenge with client retention post-enrollment
- 37% 3-month retention for clients enrolled in 1st 3-month period (February – April 2016)
- Transient population, fragile state at time of enrollment
- Despite significant follow up, clients went “missing” in the community


WOW! YOUR CHOLESTEROL HAS ME REALLY WORRIED!
GACK!
UH... YOU MIGHT WANT TO ACTUALLY LOOK AT THE PATIENT...

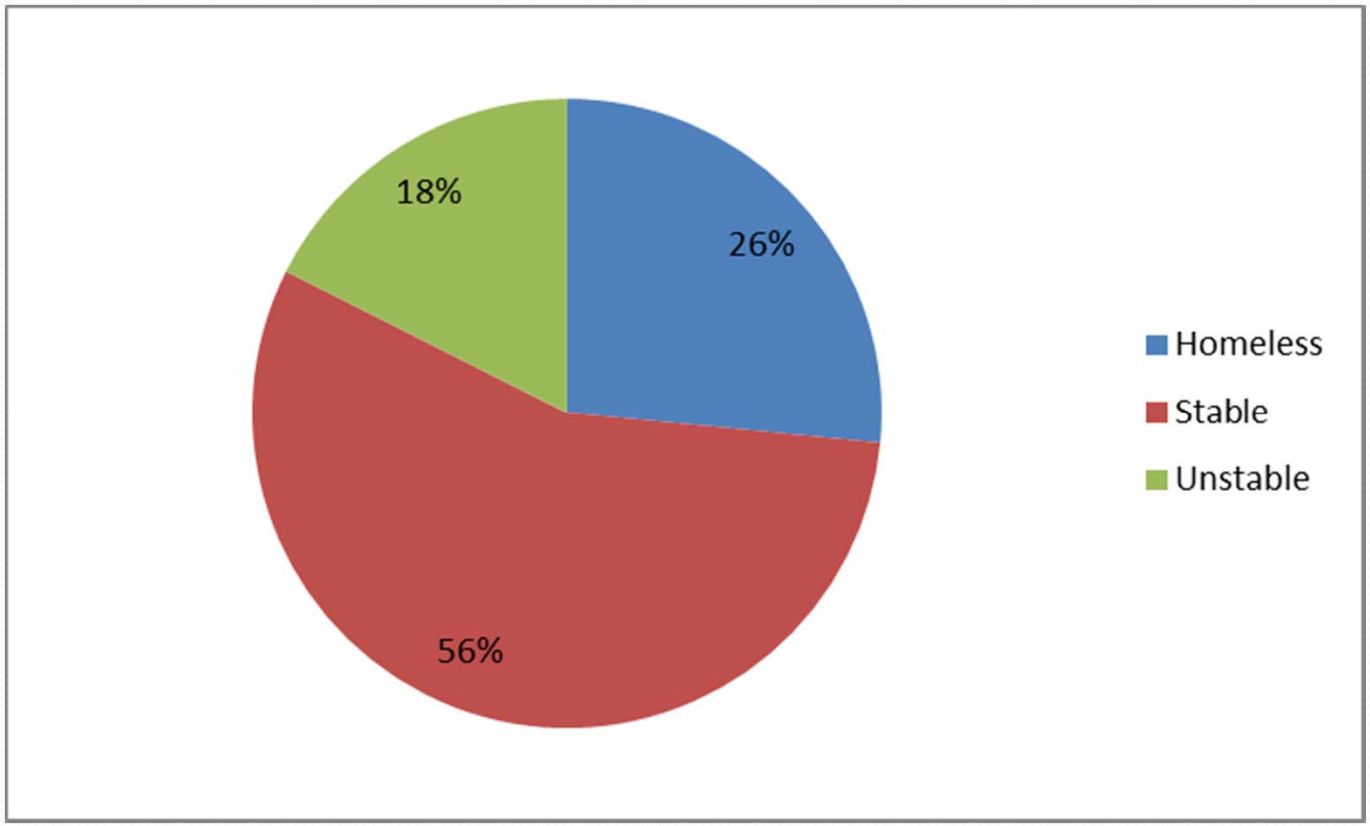
Demographics at Enrollment: Age and Gender



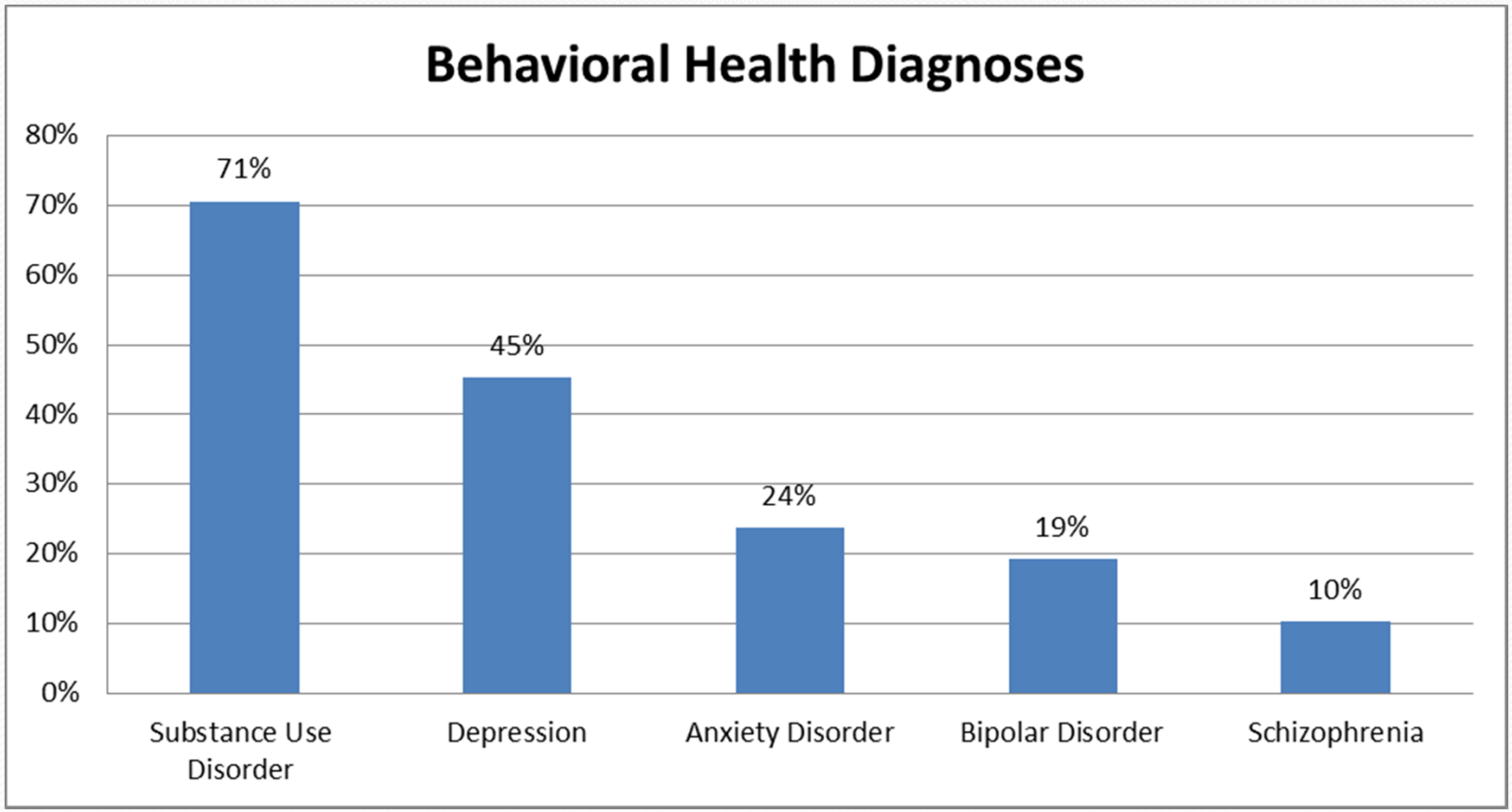


- Average age: 44.5

Demographics at Enrollment: Housing

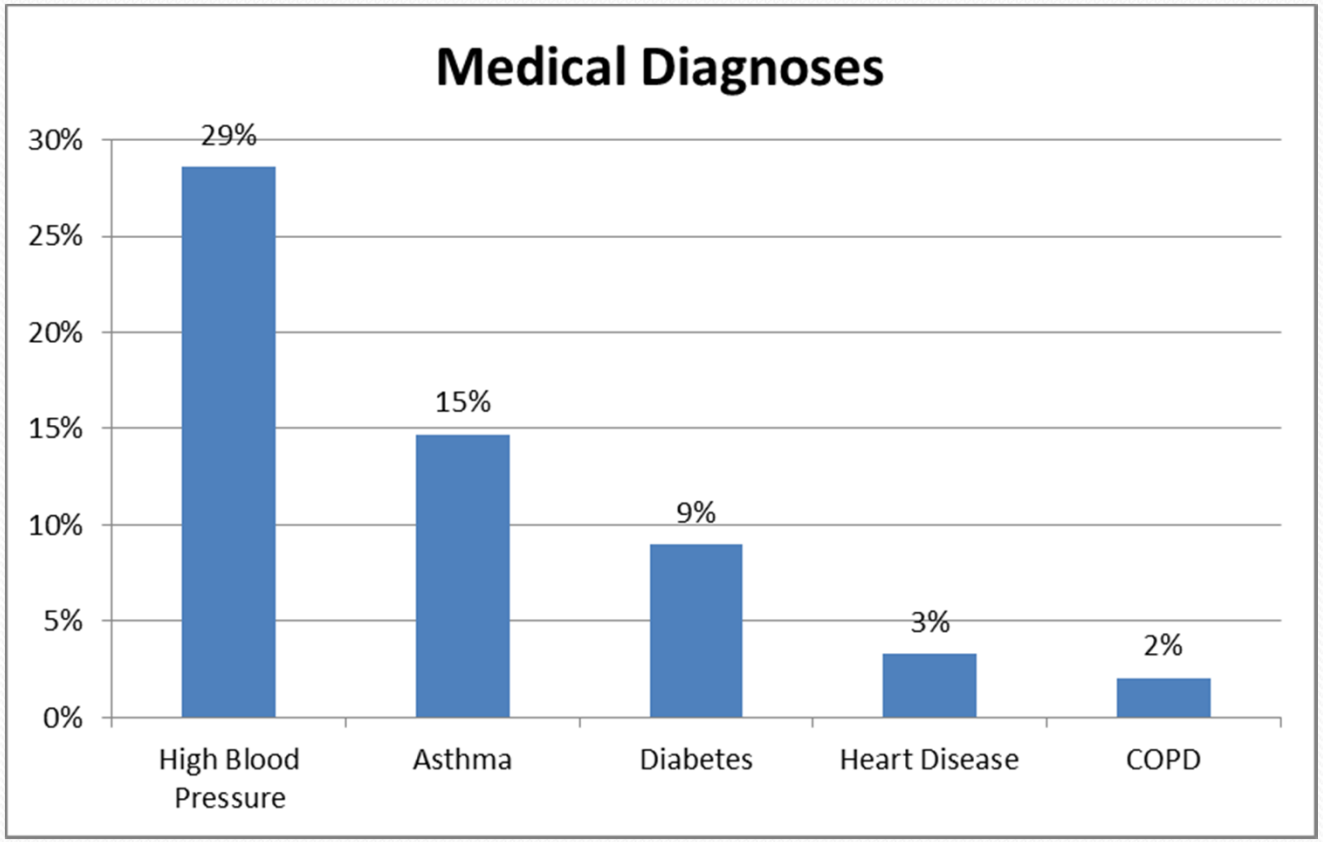


Demographics at Enrollment: Diagnoses



Demographics at Enrollment: Diagnoses

68% of clients presented with a medical diagnosis



Case Study #1

- Client was enrolled with NADAP on 2/9/16 from the Detox Unit
- 61 year old female diagnosed with bi-polar disorder and substance use disorder (alcohol, heroin and Percocet)
- Client was initially not interested in treatment outside of the Detox Unit but through engagement with the Care Coordinator, client began outpatient treatment in May 2016
- Client has maintained sobriety for over 3 months
- Client is currently working to secure employment

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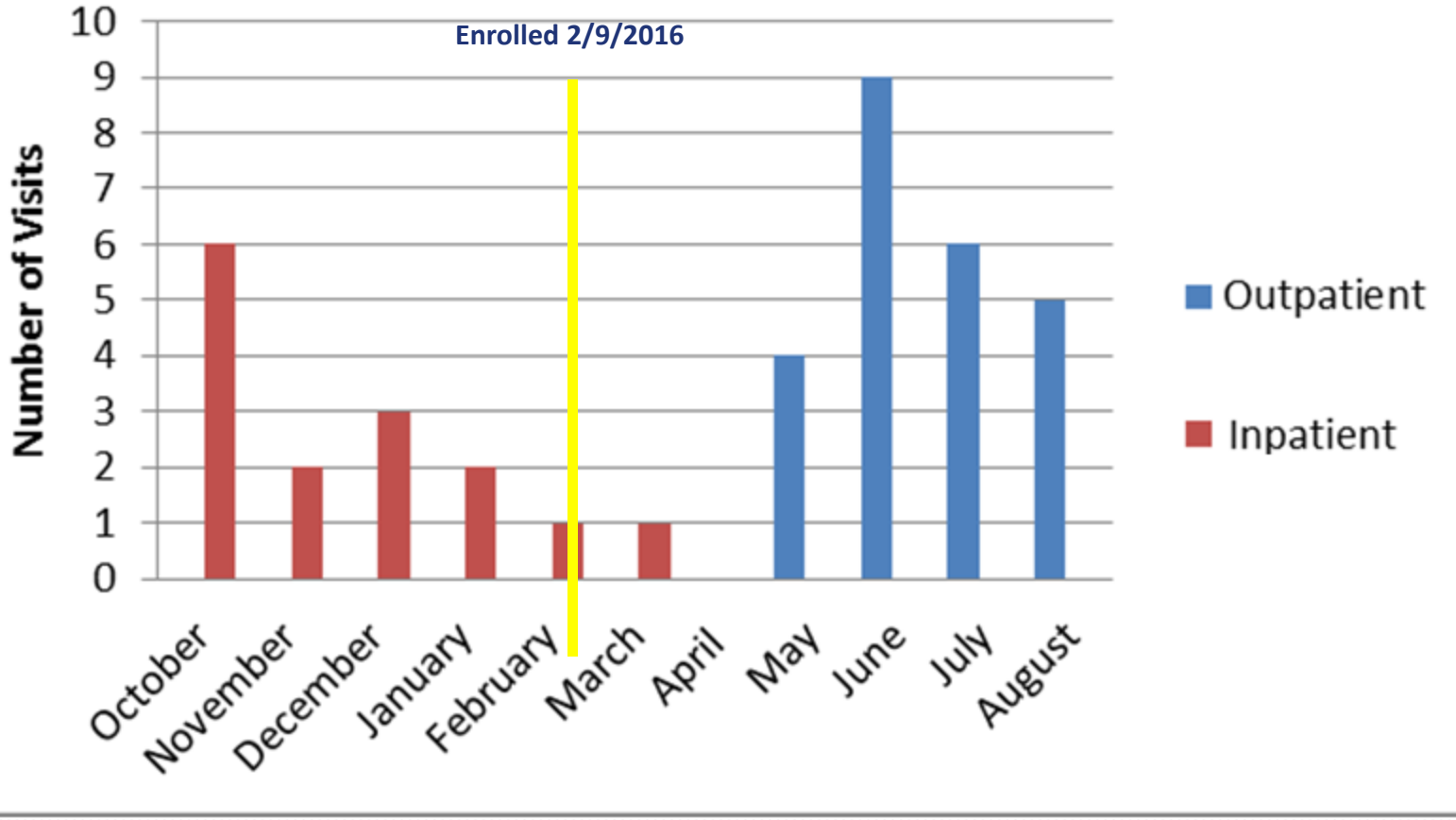
Case Study #1 - Outcomes



Case Study #2

- Client was enrolled with NADAP on 5/24/16 from the Detox Unit
- 38 year old male who worked for many years as a bartender and slowly grew a dependency on alcohol, cocaine and heroin
- Immediately following discharge from the Detox Unit in May 2016, client agreed to go inpatient at a 28-day treatment facility.
- On discharge, client started outpatient treatment and began attending daily NA meetings
- In September, client was approved for benefits allowing him to pay back rent to secure his housing
- Client now has part-time employment in a new field of work

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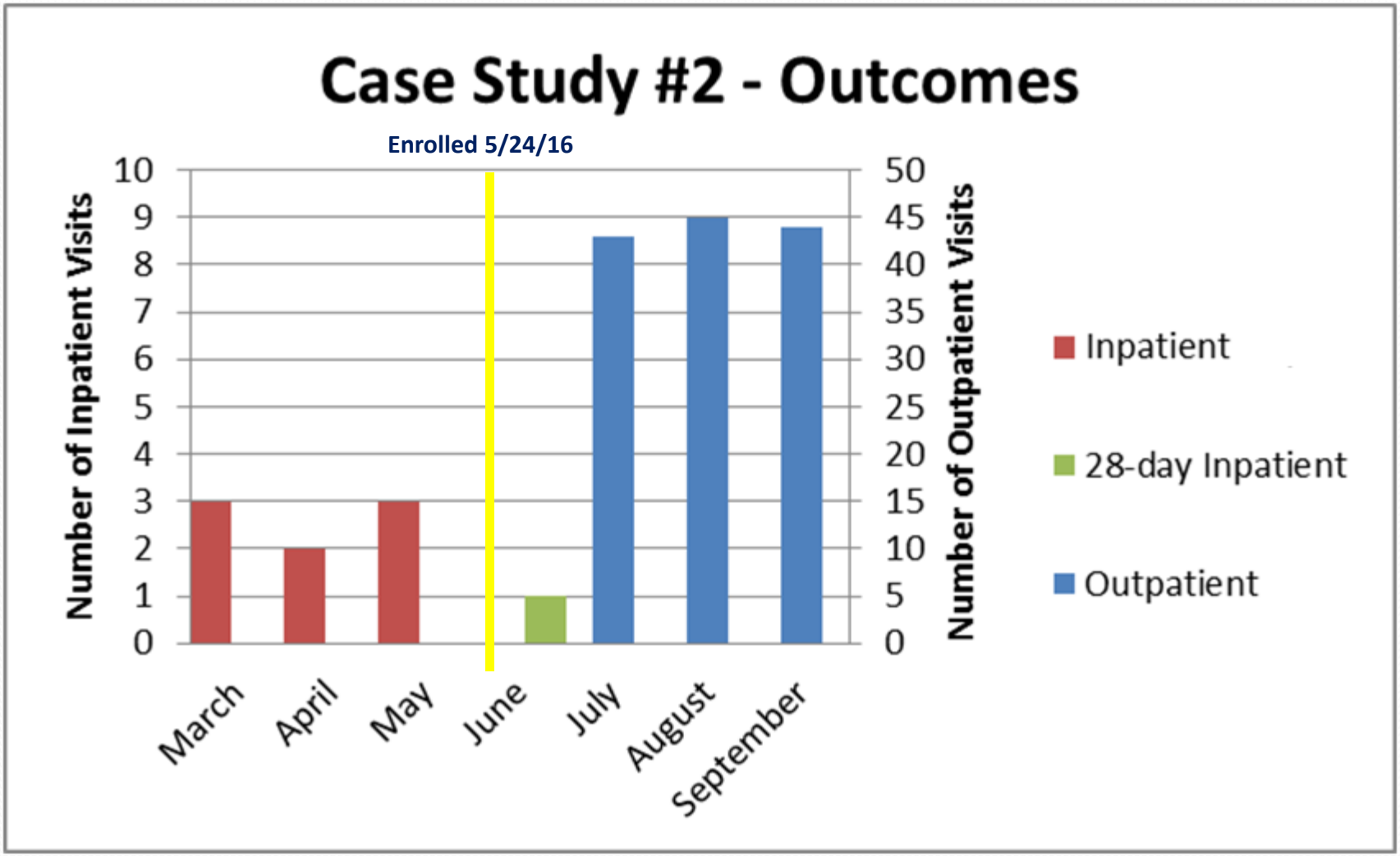
Case Study #2 - Outcomes



Outcomes

- Initial challenge with client retention post-enrollment

  37% 3-month retention for clients enrolled in 1st 3-month period (February – April 2016)

- Onsite engagement with Care Coordinators has positively impacted client retention

  76% 3-month retention for clients enrolled in 2nd 3-month period (May – July 2016)

  Limited private space to meet clients at the hospital is a challenge to ongoing sustainability of this practice

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Early Lessons and Recommendations

Continued collaboration on identified areas of focus:

- Client ambivalence around going to treatment
- Client misuse of Meds/Medication seeking clients
- Frequency of relapse or readmission
- Communication with providers at client's discharged program (rehab, long term treatment, outpatient)
- Being aware of, and understanding, discharge plans

ADAP

“What gets measured gets managed”

– Peter Drucker

Questions?

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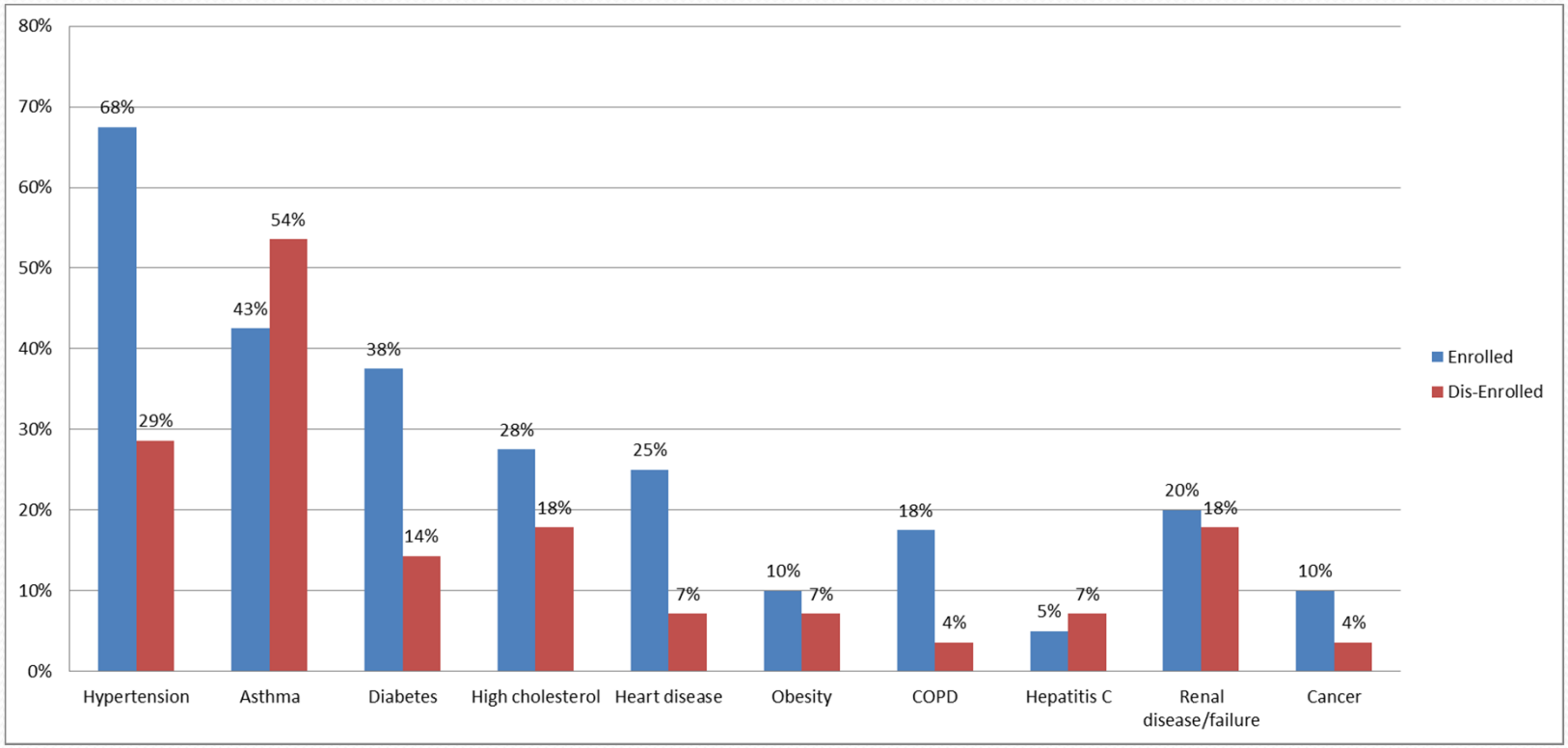
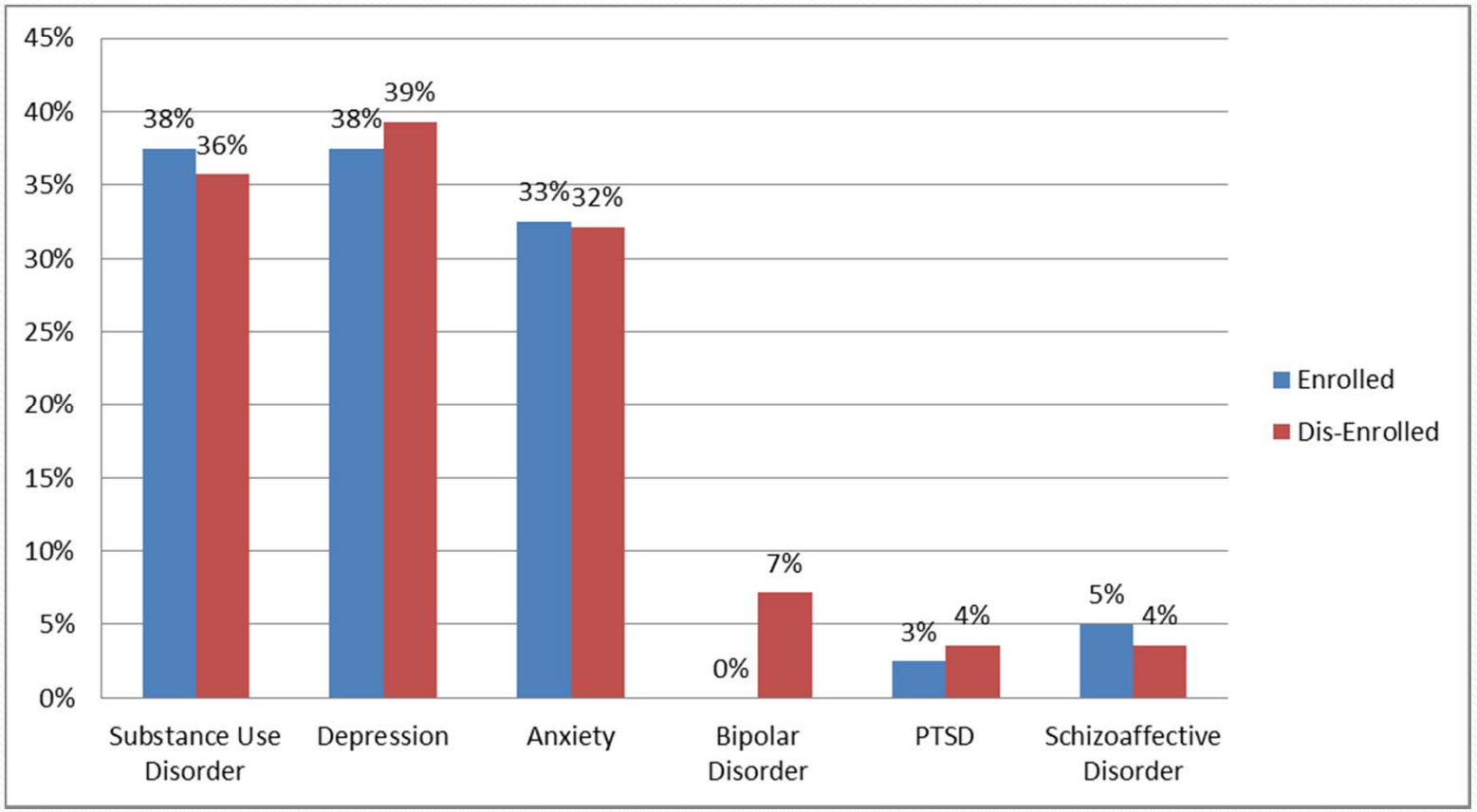
Addendum

Demographics at Enrollment: Medical Diagnoses



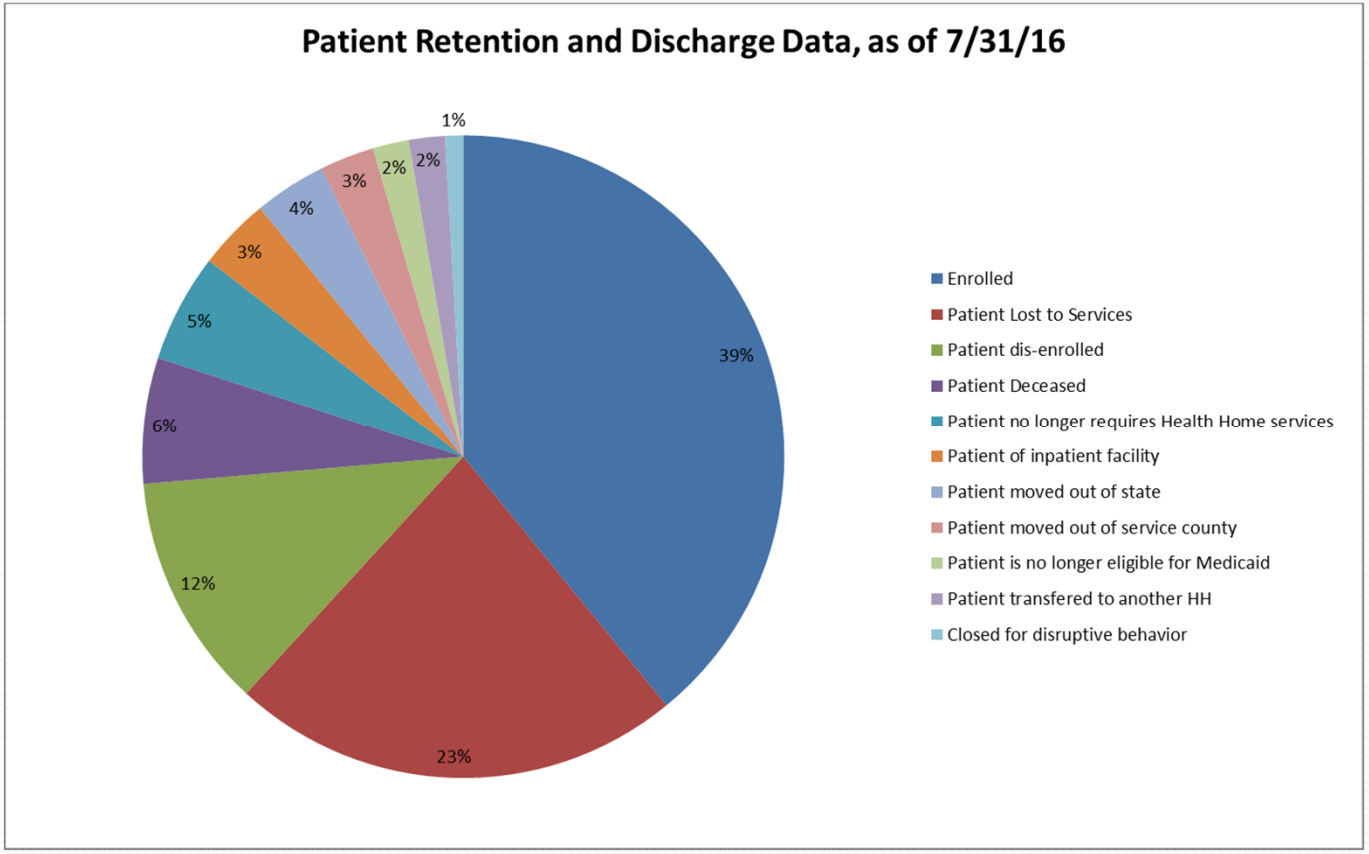
Enrolled Patients - 40
Dis-enrolled Patients - 28

Demographics at Enrollment
Behavioral Health Diagnoses



Enrolled Patients - 40
Dis-enrolled Patients - 28

6-month Study Cohort: Retention breakdown



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Psychiatric Services and Clinical Knowledge Enhancement System for Medicaid (PSYCKES)

- Developed by the New York State Office of Mental Health (OMH), PSYCKES uses administrative data from the NYS Medicaid claims database to generate quality indicators and summarize treatment histories.
- This administrative data is collected when providers bill Medicaid for services.
- Wide range of usage data including hospitalizations, medical outpatient services, behavioral health services, dental services, medication, residential treatment, and transportation.
- Data limitations:
  - Clients with no Behavioral Health category spend within the last 5 years are not included
  - If NADAP does not have client consent, we may not be able to view data
  - Data is limited to Medicaid spend in New York State

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