Care Transitions: Hospital to Home

Long Term Care Planning Project Presentation:
Evidence-Based Programs and Innovative Models
in Aging and Long-Term Care

May 13, 2019

Agenda

- JASA Introduction
- Care Transitions Program Overview
- Summary of Results
- Next Steps

JASA Overview

- Founded in 1968 – 51 years of service to New Yorkers
- Deep knowledge of neighborhoods and key stakeholders
- 50+ locations
- 1,900+ staff members
- 10+ languages spoken by staff
- Reaches 43,000 older adults

JASA Services

Three primary service areas to support aging in place:

- Quality housing for 2,400 low-to-moderate income older New Yorkers
- Homecare to nearly 900, tailored to individual needs
- Comprehensive home and community-based services:
  - 22 senior centers provide nearly 400,000 meals
  - Deliver over 500,000 meals to homes
  - 5,100 clients receive case management
  - Over 2,800 receive protective services or guardianship
  - NORCs reach 5,300 clients
  - Nearly 1,800 receive elder abuse prevention and legal representation

Program Overview: Project Description

JASA's home-based care transitions (CT) intervention aims to prevent avoidable readmissions and other adverse events post-discharge, as well as address the social determinants of health.

JASA's CT intervention:

- Utilizes evidence-based models (i.e., the Coleman Model, Stanford Chronic Disease Self-Management) as a foundation, and leverages JASA's extensive experience working in the community with CT and related interventions
- Addresses physical, mental and social health needs
- Delivers services both in the hospital and at home to provide continuity across settings
- Connects older adults and their caregivers to community resources that enable stable home-based functioning

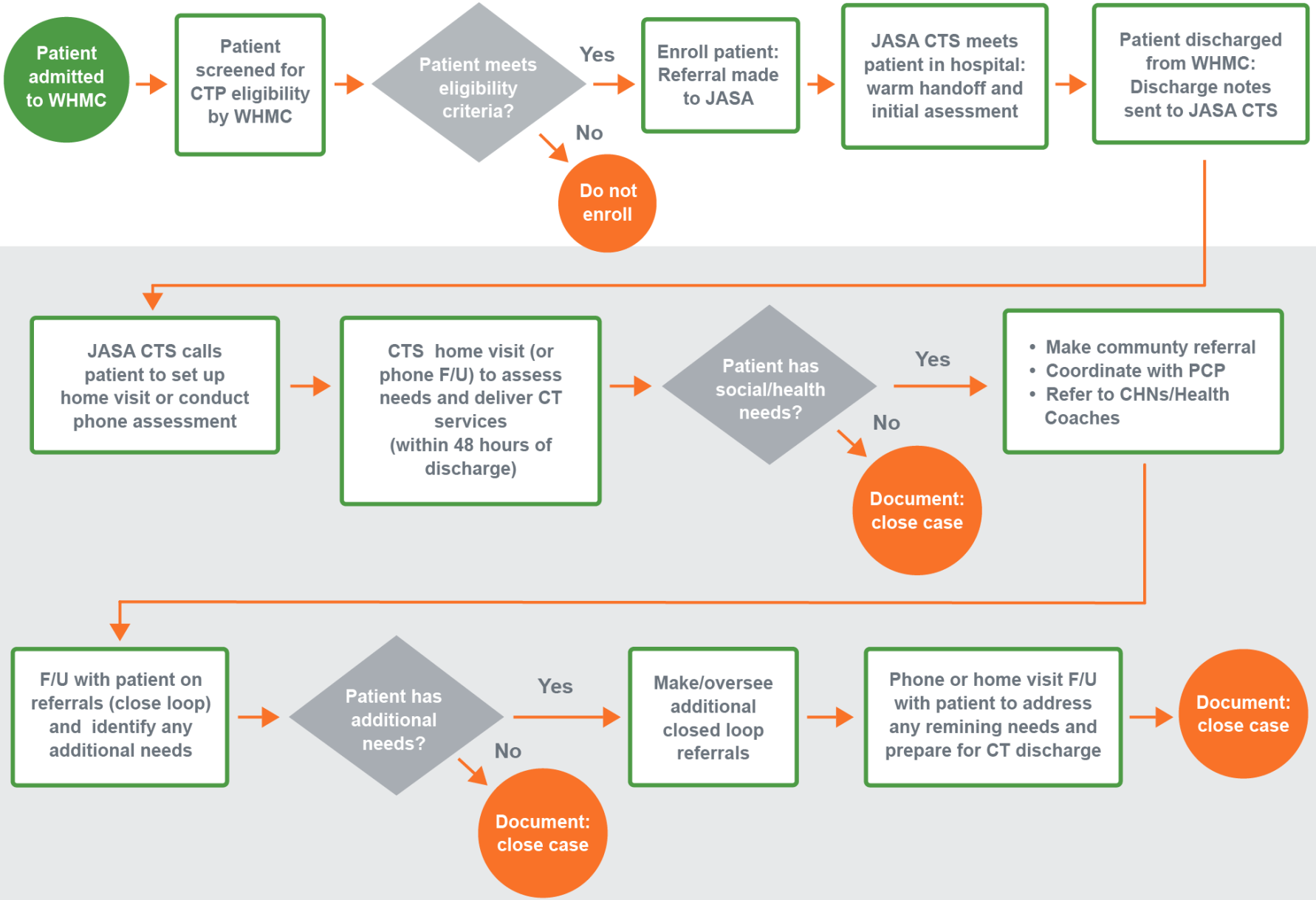
Program Overview: Target Population

- Inpatient admissions at Wyckoff Hospital who reside in Bushwick, Ridgewood, Bed-Stuy, East New York, Cypress Hill and Williamsburg
- 55 years or older
- Medicaid, Medicare, Dual Eligibles and the Uninsured
- Speaks English or Spanish
- Have comorbidities or complex medical conditions, focusing on CVD, DM, and COPD
- May be affected by factors such as food insecurity, language barriers, or lack of social supports

Program Overview: Innovative Staffing Model

Care Transitions Specialist: International Medical Graduate	Care Transitions Specialist: Social Worker	Community Health Navigator: Peer Coach

• Discharge Instructions Review & Translation
• Medication Support
• Physician Follow-Up
• Patient Education & Disease Management
• Primary Care & Community-Based Services Linkages
	• Social Needs Assessment and Referrals (e.g., Nutrition, Transportation, Medicaid, Home Care, Caregiver Support)
	• Mental Health Support and Referrals
		• Health Coaching & Chronic Disease Self-Management Support
		  • Blood Pressure Control
		  • Blood Glucose Monitoring
		  • Healthy Eating
		  • Social Visits/Connect to Community Services
		  • Falls Prevention
		• Ongoing Social Support and Companionship


Patient admitted to WHMC
Patient screened for CTP eligibility by WHMC
Patient meets eligibility criteria?
Yes
No
Do not enroll
Enroll patient: Referral made to JASA
JASA CTS meets patient in hospital: warm handoff and initial asessment
Patient discharged from WHMC: Discharge notes sent to JASA CTS
JASA CTS calls patient to set up home visit or conduct phone assessment
CTS home visit (or phone F/U) to assess needs and deliver CT services (within 48 hours of discharge)
Patient has social/health needs?
Yes
No
Document: close case
• Make communty referral
• Coordinate with PCP
• Refer to CHNs/Health Coaches
F/U with patient on referrals (close loop) and identify any additional needs
Patient has additional needs?
Yes
No
Document: close case
Make/oversee additional closed loop referrals
Phone or home visit F/U with patient to address any remining needs and prepare for CT discharge
Document: close case

Summary of Results: Program Snapshot

	Year 1	Year 2	Year 3
WHMC patients referred to JASA	245	375	353
Readmission rate	8%	11%	11%
JASA Care Transitions Services			
% of patients visited in the hospital	86%	86%	92%
% of patients visited at home	60%	60%	68%
% of phone call follow-ups (no home visit)	21%	18%	`18%

Summary of Results: Key Services Provided

JASA Care Transitions Direct Services	Year 3
Wyckoff Hospital Patients Referred to JASA	353
% of patients who needed/received help understanding their discharge instructions	66%
% of patients who needed/received help with their medication	67%
% of patients who needed/received patient education (e.g., disease management, red flags, medication)	82%
% of patients who needed/received help with physician follow-up visits	45%

Closed Loop Service Referrals

	Year 3
Wyckoff Hospital Patients Referred to JASA	353
Health Coaching/Peer Support (Healthy Eating, Blood Glucose Monitoring, Blood Pressure Control, Falls Prevention, Social Visits)	39%
Nutrition Services (MOW, SNAP, Food Pantry, Congregate Meals)	25%
Transportation	16%
Mental Health Services (Psychotherapy, PEARLS)	12%
DME/DMS	12%
Medicaid	10%
Home Care	10%
Skilled Services (PT, OT, CHF/COPD Services)	6%
Housing Services (Legal, Help Center)	4%
Urgent Care/Physician Housecalls	4%
Caregiver Support	1%
Adult Protective Services/LEAP	1%

Summary of Results:
Patient Satisfaction Survey

Patient Satisfaction	Yes		No		Not Sure		No Answer		Total	
The Care Transitions Team helped me to understand my health conditions and how to manage them.	76	95%	2	3%	1	1%	1	1%	80	100%
The Care Transitions Team helped to understand red flags and health risks, and how to prevent future hospitalizations.	72	90%	2	3%	5	6%	1	1%	80	100%
The Care Transitions Team improved my understanding of my discharge intructions and how to mange my health at home post-hospitalization.	75	94%	3	4%	1	1%	1	1%	80	100%
The Care Transitions Team made me aware of services in the community that can help to maintain or improve my health, and prevent future hospitalizations.	72	90%	1	1%	6	8%	1	1%	80	100%
Were you satisfied with JASA's Care Transitions Team?	75	94%	0	0%	4	5%	1	1%	80	100%
Would you recommend JASA's Care Transitions Program to a family member or a friend if they were hospitalized?	72	90%	3	4%	4	5%	1	1%	80	100%

= # of patients = % of patients

Next Steps

- Continue work with Wyckoff Hospital
- Launch new programs at three additional hospitals in June 2019
- Begin partnership with managed care partner in Fall 2019
- Assess the value of services to develop value-based payment models
  - Reduction in hospital use – avoidable (re)admissions and ED visits
  - Achievement of additional program targets: Medicare Stars Measures
  - Improved patient/client satisfaction
  - Improved health outcomes

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