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The Accountable Community for Health of King County

Project Workgroup: Transitional Care – Hospitals

May 7, 2018



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Transitions of Care: Hospital Discharges for High Risk Medicaid Clients

Project Goal

Immediate: Implement the Care Transitions (Coleman) model demonstrated by assessment of a patient's clinical and social needs to support patients as they transition from one care environment to the other, particularly from the hospital care environment to post-discharge settings such as skilled nursing facilities or home, with the goal of preventing avoidable emergency department visits and hospital admissions.

Long-term: Improvement in health outcomes for vulnerable populations, ensured continuity of care, and redirect resources available to focus on long-term prevention and promotion rather than short-term crisis response.

Focus Populations

High-risk Medicaid beneficiaries transitioning from hospitals, including older adults and people with disabilities.

Prism score of 1.5 or above, at least one inpatient admission, not currently enrolled in a Health Home

Interventions

The Coleman model provides a four-week program for individuals with complex care needs (and family caregivers) to work with a coach and learn disease self-management skills and other tools to ensure their needs are met during the transition from hospital (or other facility) back home.

The Coleman Model process:

- Providers will screen patients before discharge and if the appropriate criteria is met, the patient is assigned to a care coordinator. Matching criteria for the assignment of a care coordinator will include language and cultural competency.
- Care coordinators will meet with patients and their family caregivers before hospital discharge to develop a comprehensive transition plan based upon an assessment of needed community services and supports.
- After patient is discharged the care coordinator will conduct a home visit and follow-up by phone in service of the following goals:
    - Increased self-management skills
    - Personal goal attainment
    - Continuity across the transition
- Care coordinators will work with patients on medication management. They will encourage the patient to share their medication list with their PCP and will have patients rehearse their medication questions before medical visits to communicate more clearly with providers.

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Innovations

- Culturally and linguistically competent care coordinators to reach marginalized populations.
- Coordinated, team-based care
- Stronger linkages to community-based organizations addressing social determinants

Metrics

Patient Engagement Metric

The number of participating patients who receive discharge instructions that include patient self-education, medication reconciliation, and follow-up appointments, prior to discharge.

Clinical Metrics

- All-Cause Readmission Rate (30 Days)
    - Among Medicaid beneficiaries age 18-64 years old, the percent of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission within 30 days.
- Inpatient Hospital Utilization
    - For members 18 years and older, the risk-adjusted ratio of observed to expected acute inpatient discharges during the measurement year.
- Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence
    - The percent of discharges for members 18 years and older who had a visit to the ED with a primary diagnosis of alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of alcohol or other drug dependence, reported separately for follow-up within 7 and 30 days after discharge.
- Follow-up After Emergency Department Visit for Mental Health
    - The percent of discharges for members 18 years and older who had a visit to the ED with a primary diagnosis of mental health during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health, reported separately for follow-up within 7 and 30 days after discharge.
- Follow-up after hospitalization for Mental Illness
    - The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner, reported separately for follow-up within 7 and 30 days of discharge.
- All Cause Emergency Department Visits per 1000 Member Months
    - The rate of Medicaid beneficiary visits to emergency department per 1000 member months, including visits related to mental health and substance use disorder, reported for three age groups: 10-17 years, 18-64 years, and 65 years and older.
- Percent Homeless (Narrow Definition)
    - The percentage of Medicaid enrollees who were homeless in at least one month in the measurement year. Excludes “homeless with housing” living arrangement code within the DSHS database ACES, reported for three age groups: 0-17, 18-64, and 65 and older.
- *30-day Psychiatric Inpatient Readmissions

    - For members 18 years of age and older, the number of acute inpatient psychiatric stays that were followed by an acute readmission for a psychiatric diagnosis within 30 days.
- *Substance Use Disorder Treatment Penetration
    - The percentage of members with a substance use disorder treatment need who received substance use disorder treatment in the measurement year. Separate reporting for three age groups: 12-17 years, 18-64 years, and 65 years and older.
- *Mental Health Treatment Penetration (Broad Version)
    - The percentage of members with a mental health service need who received mental health services in the measurement year. Separate reporting for three age groups: 6-17 years, 18-64 years, and 65 years and older.

*Metrics in addition to Healthier Washington pay for performance metrics for this project

References/Guidelines

- http://caretransitions.org

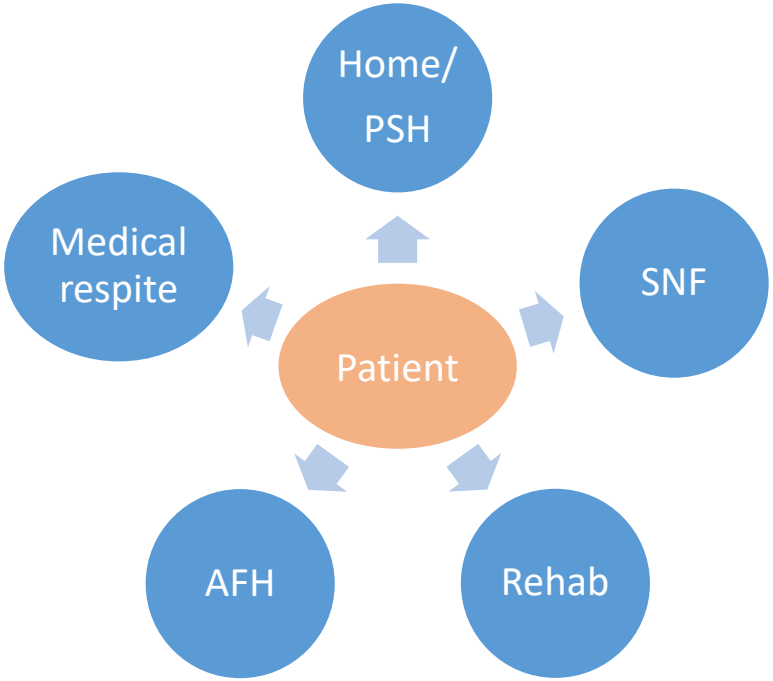
Evidence-Based Approaches: Transitional Care

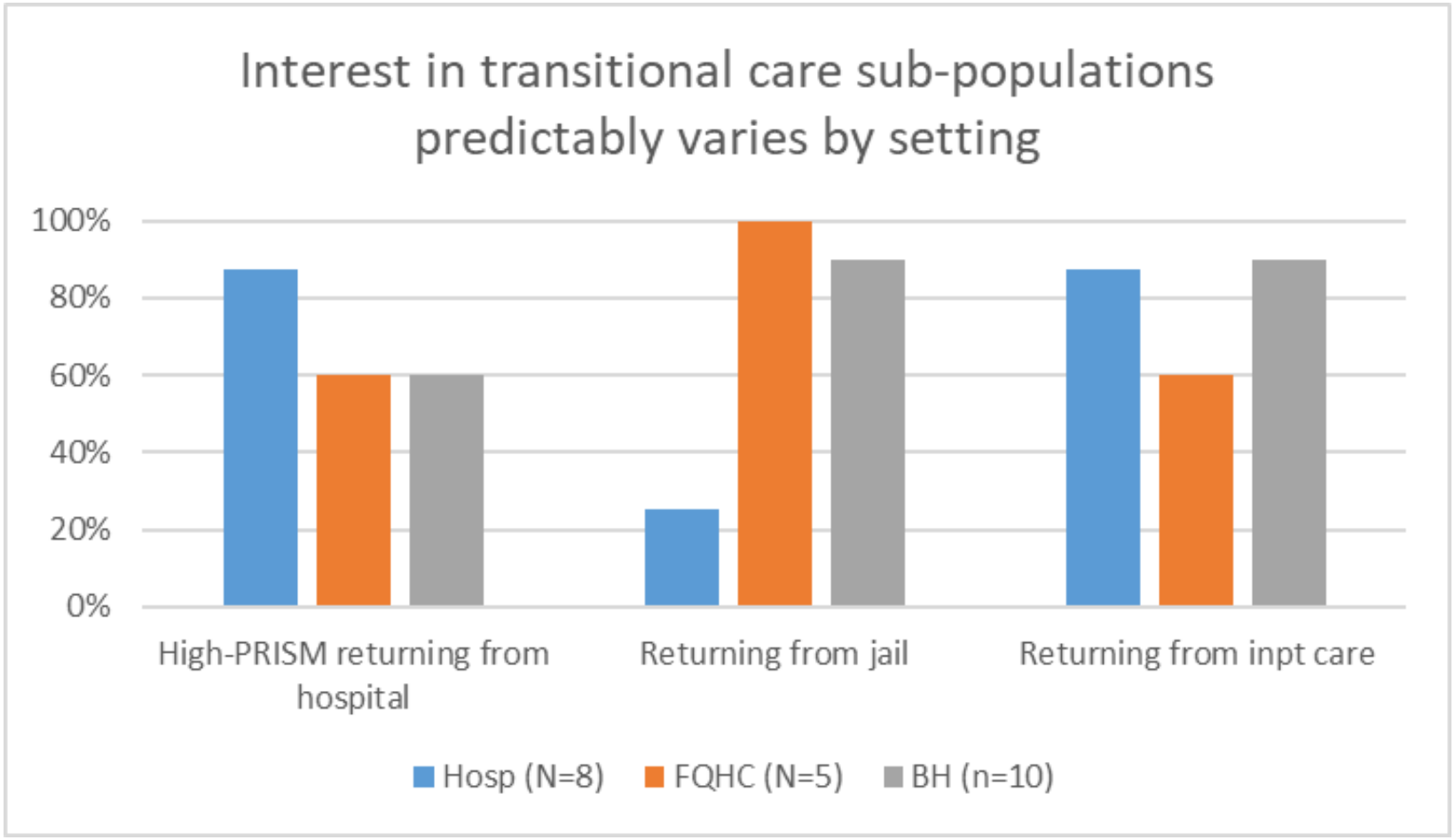
Evidence Based Approach	Model Target Population	Model Description
A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders (APIC)	Target Population #: 1 Medicaid members returning to the community from **prison or jail.**	Set of critical elements (Assess, Plan, Identify, Coordinate) that are likely to improve outcomes for person with co-occurring disorders who are released from jail.
Peer Bridger Program	Target Population #2: Medicaid members with **serious mental illness or substance use disorder** discharged from inpatient care, including psychiatric inpatient facilities and psychiatric units in hospitals.	Peer Bridger is a community/home-based outreach service designed to be short term community support. Peers are state-certified Peer Support Specialists who have lived with mental illness or substance use and are in recovery.
Care Transitions Intervention/Coleman Model	Target Population #3: Adults and people with disabilities **transitioning from inpatient care and long-term care facilities** who could benefit from the Care Transitions Intervention, also known as the Coleman Model.	The Care Transitions Intervention® is also known as the Coleman Model® and is a 4-week program where patients, with complex care needs, and family caregivers receive specific tools and work with a Transition Coach to learn self-management skills that will ensure their needs are met during the transition from hospital to home.

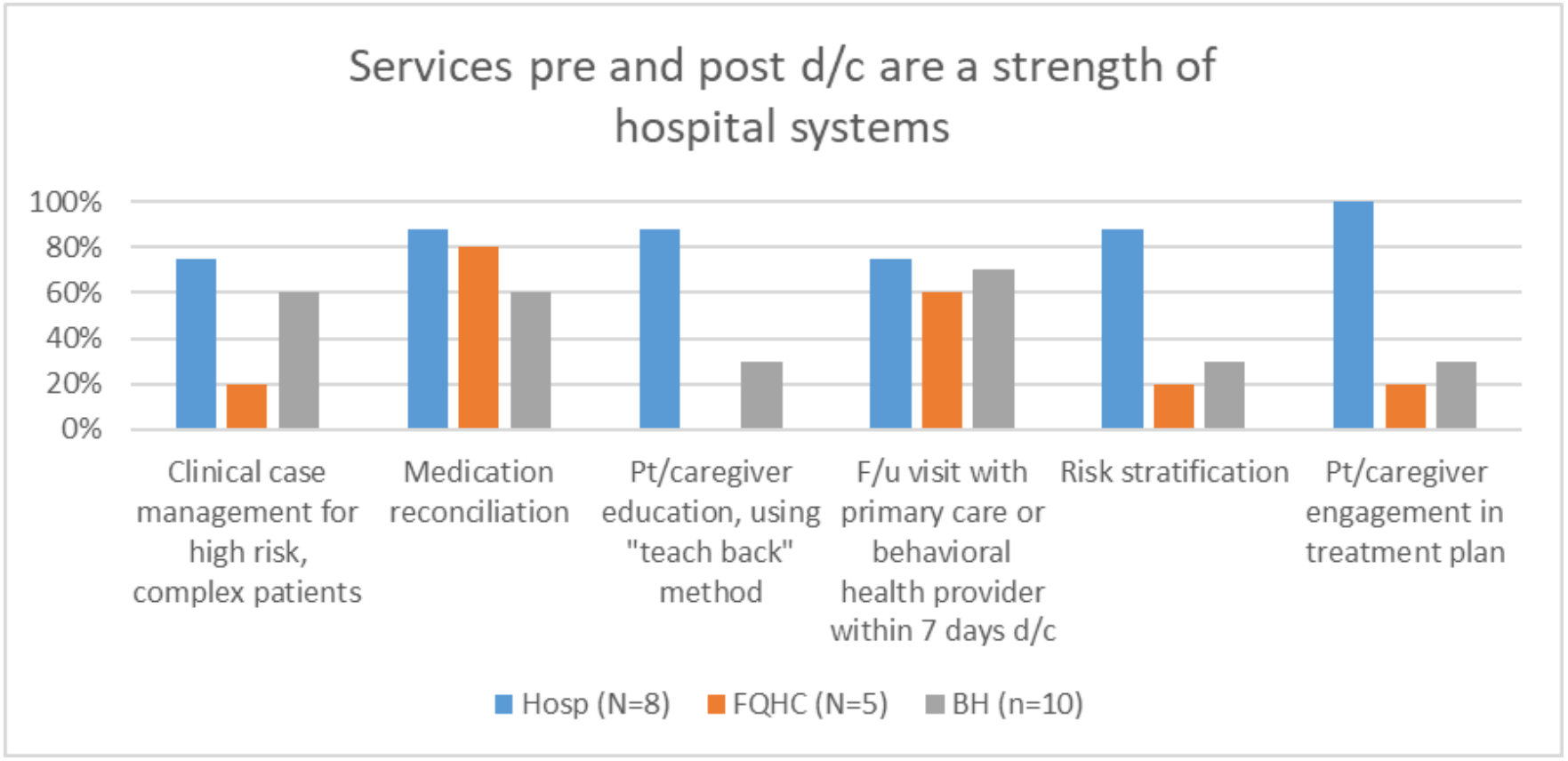
Transitional Care Approaches: Care Transitions Intervention (CTI)/Coleman Model

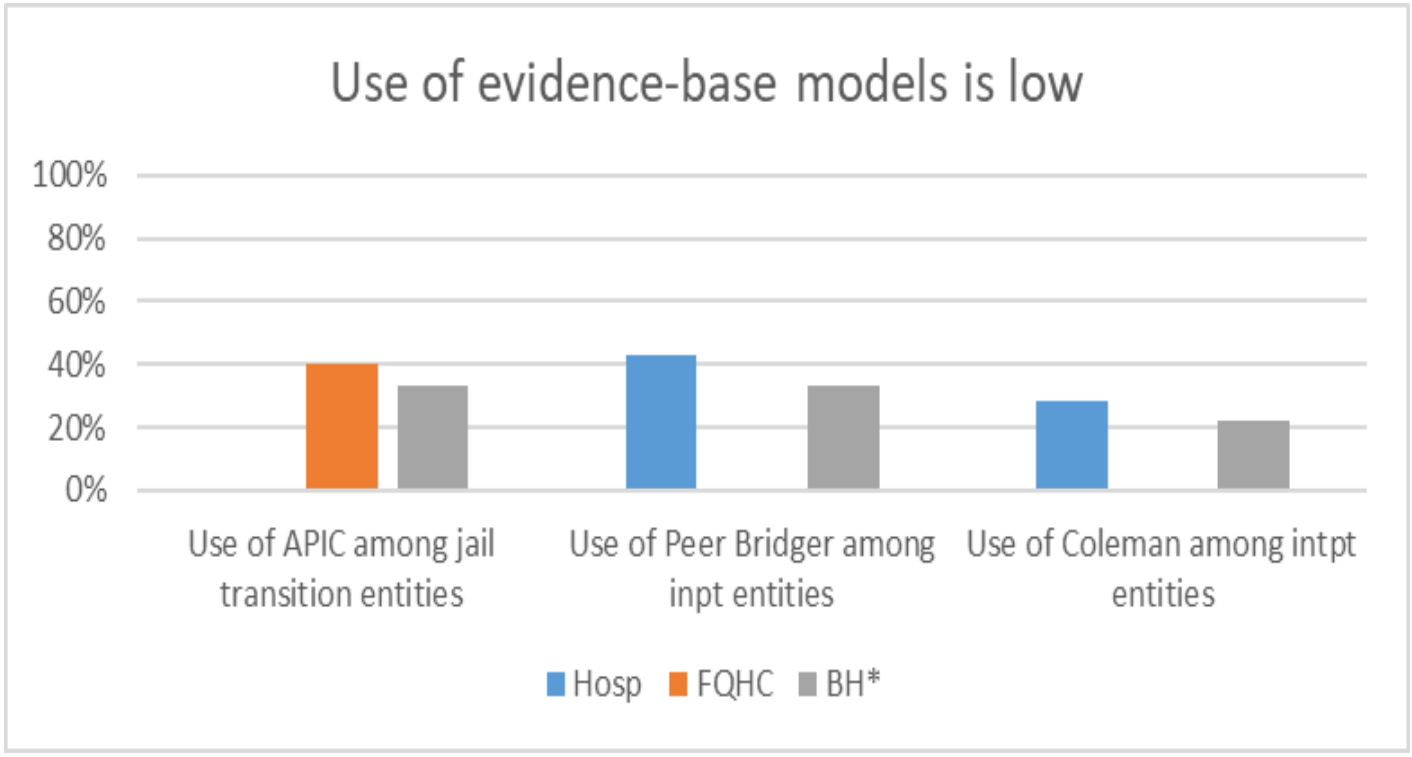
- The Care Transitions Intervention® (CTI) is also known as the Skill Transfer Model™, the Coleman Transitions Intervention Model®, and the Coleman Model®.
- A 4-week program where patients, with complex care needs transitioning from the hospital to home, and family caregivers receive specific tools and work with a Transitions Coach® to learn self-management skills that will ensure their needs are met.
- A low-cost, low-intensity evidence-based intervention model comprised of a home visit and three phone calls.
- The Coleman Model of assessing readmission risk and education/self-care prior to, during, and post-discharge has a proven history of lowering complications and reducing readmissions and unplanned medical appointments post-discharge.

Transitional Care: Project-specific Current State Assessment Results




Interest in transitional care sub-populations predictably varies by setting
100%
80%
60%
40%
20%
0%
High-PRISM returning from hospital
Returning from jail
Returning from inpt care
Hosp (N=8)
FQHC (N=5)
BH (n=10)


Services pre and post d/c are a strength of hospital systems
100%
80%
60%
40%
20%
0%
Clinical case management for high risk, complex patients
Medication reconciliation
Pt/caregiver education, using "teach back" method
F/u visit with primary care or behavioral health provider within 7 days d/c
Risk stratification
Pt/caregiver engagement in treatment plan
Hosp (N=8)
FQHC (N=5)
BH (n=10)



"Other" models

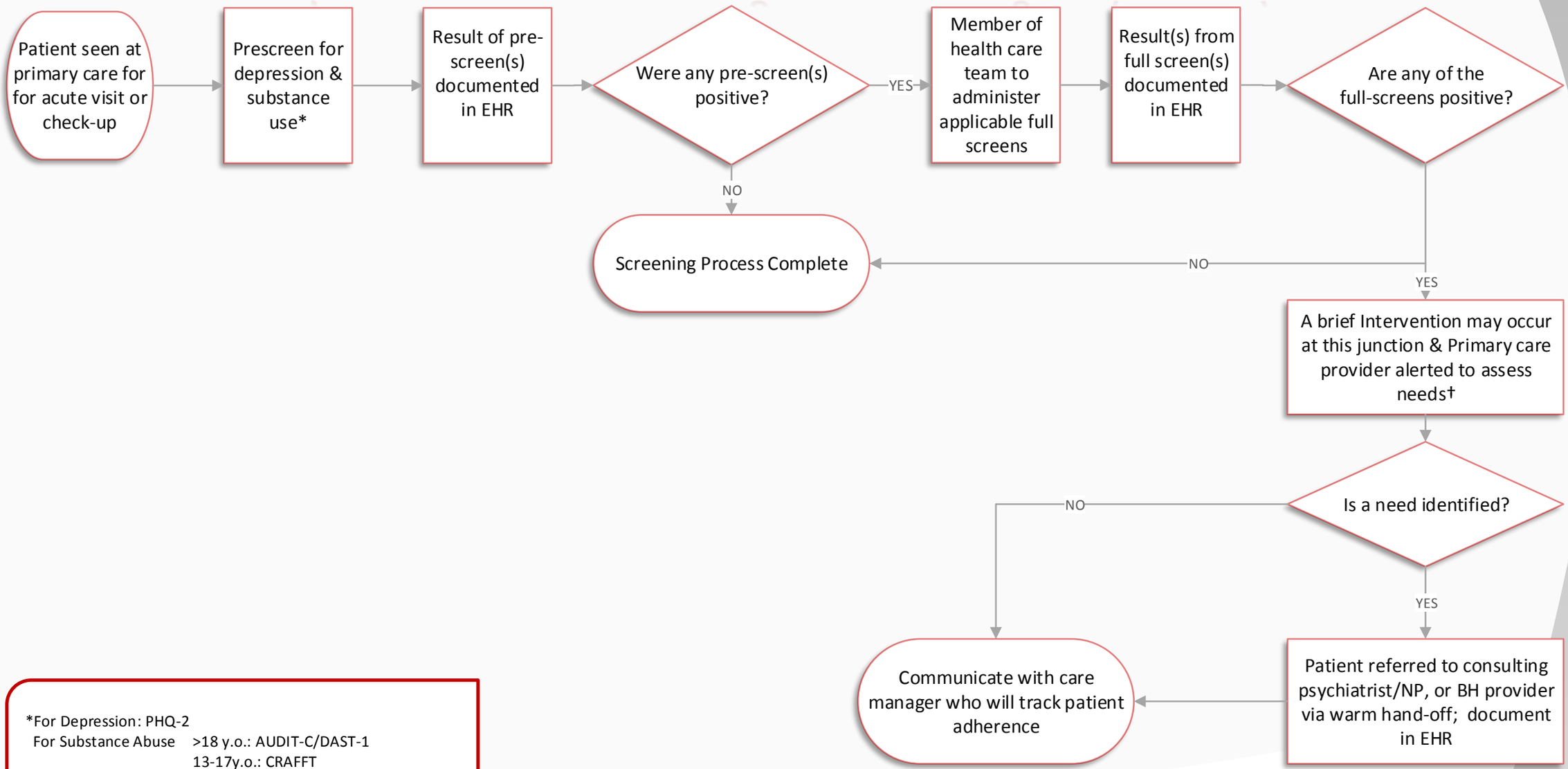
Jail transition: forensic steering committee, intensive case management with LEAD; components of APIC

Hospital transition: care coordination; assertive outreach; Coleman; peers; PACT; REACH; language-specific CM

Barriers for Transitional Care

- Housing
- Communication/collaboration; d/c info sharing
- Timely access to MH/SUD treatment, specialty care, clinics
- Funding – for outreach, CHWs, longer PCP appts.
- Staffing
- SNF and AFH funding models, beds, willingness to accept pts.

Primary & Behavioral Health Integrated Care Program (Model 3) Flow Chart



*For Depression: PHQ-2
For Substance Abuse >18 y.o.: AUDIT-C/DAST-1
13-17y.o.: CRAFFT

†Brief Interventions if performed following a substance use screening may be billable if required criteria met

Suffolk Care Collaborative