HealthierHere

Clinical Summary
Transitions of Care: Hospital Discharges for High-risk Medicaid Individuals

Goal

Immediate: Implement an integrated whole person model of care that ensures safe and successful transitions from the hospital back into community settings, such as, home or skilled nursing facilities.

Long-term: Reduce avoidable emergency department (ED) visits and hospital readmissions. Ensure continuity of care and redirect resources available to focus on long-term prevention and promotion rather than short-term crisis response.

Focus Populations

Medicaid members transitioning from inpatient hospital stays for chronic or acute conditions, including older adults and people with disabilities who meet a minimum of 3 of the following criteria:

- Age 50 or older
- Two or more chronic conditions
- Four or more prescribed medications
- Two or more hospitalizations and/or four ED visits in the past 12 months
- Active mental health issue and/or substance use disorder
- Low health literacy
- Limited English proficiency
- Limited engagement with primary care (no primary care visit in the last six months)
- Homeless or housing instability
- Limited community supports, ineligible for other programs such as Health Homes.

Alternatively, a clinical provider's determination of high risk for readmission is acceptable without regard to the above criteria.

Key Project Elements

The following interventions are required for participating provider organizations.

HealthierHere is taking a broad, portfolio approach to inform King County's transformation efforts. The evidence-based models identified by the Health Care Authority (e.g., Bree Collaborative Model, Coleman Model, Collaborative Care Model, APIC, and the Chronic Care Model), have congruent underlying principles that are foundational to system and service delivery transformation.

Based on the Coleman model, implementing organizations are encouraged to utilize the following key strategies.

Utilize Population Health Management Tools:

- Use electronic health records and registries to identify individuals and the services that are needed, share transition plans and other Continuity of Care Documents, as appropriate and allowed by law, with primary care providers (PCPs), behavioral health providers, social service providers (such as, supportive housing), individuals, and their caregivers.
- Measure and monitor against a defined set of indicators to track progress.
- Conduct routine quality assurance and improvement reviews of panels of high-risk individuals.

Assess Whole Person Care Needs:

- Whole person care needs include the following: physical health, behavioral health, oral health, and the social determinants of health. Partners will determine their standard assessments and/or adopt HealthierHere's recommended assessments which have yet to be determined.
- Hospital staff will screen individuals before discharge to identify those at high-risk for readmission based on the criteria above.
- Increase the completion of POLST forms and other advanced care planning documents at your organization.

Implement Team-based Care:

- Form a person-centered, multi-disciplinary, integrated care team. Composition of the team should be based on an individual's needs and risk stratification, and members could include a PCP, behavioral health provider, care coordinator, social worker, community support specialist, or other appropriate provider.
- Individuals meeting the appropriate criteria will be assigned to a community support specialist (providing care coordination/transition coaching and capable of making home visits). Matching criteria for the assignment of a community support specialist will include language and cultural competency.

Develop Integrated Care Planning:

- Create individually tailored, culturally appropriate transition plans that support patient engagement with the care team. Transition plans should be based upon an assessment of needed community services and supports and include referral and linkage to culturally appropriate services. Language needs, including interpretation and translation, must be incorporated in the care planning and delivery.
- Ensure that the plan is available to all providers serving the individual's needs.

Provide Self-Management Support:

- All focus population individuals should receive self-management support by a member of the integrated health care team. Establish an individually tailored self-management goal, which should be reviewed at each visit.
- A community support specialist or a member of the integrated health care team will conduct in-person meeting(s) such as home visits and follow-up by phone and/or telehealth options in service of the following goals:
    a. Increase self-management skills
    b. Ensure personal goals are congruent with individual's self-efficacy

c. Improve continuity of care with PCP/specialist follow-up
d. Ensure medication management and reconciliation with PCPs or other providers including pharmacists
e. Practice advocacy by identifying key questions for PCPs/specialists
f. Educate on health system navigation
g. Ensure individual can "teach back" expectations from physical and behavioral health appointments, including what medications are needed and why.

Link to Community Resources:

- As needed or desired, the care team will refer individuals to community resources, including community support specialists.
- To address the social determinants of health, the integrated care team will connect individual with appropriate resources, social services agencies, and community based organizations depending on the individual's needs (e.g. transportation, food, shelter).
- For applicable individuals, the integrated care team will work with the individual and community support specialists to support selected activities. In such cases, the community support specialist will communicate with PCP and/or specialist(s) regarding the individual's treatment and progress.

Pay for Performance Metrics

Incentive payments for ACHs and partnering provider organizations are dependent on improvement in project-specific Pay for Performance metrics selected by the Health Care Authority. Partnering provider organizations participating in the Hospital Transitions project will agree to help HealthierHere improve the following set of metrics.

Metric	Definition
All Cause Readmission Rate	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
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.
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.
Inpatient Hospital Utilization	For members 18 years and older, the risk-adjusted ratio of observed to expected acute inpatient discharges during the measurement year.
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 years, 18-64 years, and 65 years and older.

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References/Guidelines

The Care Transitions Program
https://caretransitions.org/

Roberts, Shauna R, Jane Crigler, Cristina Ramirez, Deborah Sisco, and Gerald L. Early, "Working with Socially and Medically Complex Patients: When Care Transitions Are Circular, Overlapping, and Continual Rather than Liner and Finite," *Journal for Healthcare Quality*, Vol. 37, No. 4, July/August 2015.