Staten Island Primary Care Symposium

Panel Discussion: Avoiding Hospitalization through Care Coordination

DECEMBER 2, 2017
Panel Discussion: Avoiding Hospitalization through Care Coordination

- This session will cover the role and impact of urgent care centers, care coordination programs, managed care organizations and community health workers in connecting patients to primary care and educating them on appropriate use of emergency departments.

- **Moderator:**
  - Victoria Njoku-Anokam, MPH, Director of Behavioral Health Initiatives, Staten Island PPS

- **Panelists:**
  - Dr. David Shih, MD, FACEP, CityMD
  - Susan O'Connor, BSN, MBA, Empire Blue Cross Blue Shield HealthPlus
  - Deeana Dobrer, MSc, Coordinated Behavioral Care (CBC
  - Becca Telzak, MPA, Make the Road New York
CITYMD AT A GLANCE
Who We Are: Trusted, Patient-Focused Partner

- Serve 90% of population with commercial and managed Medicaid plans
- Trusted Brand with Net Promoter Score ("NPS") of 72 vs. Industry Average of 17
- Dynamic Network Referral Management
- Emphasis on Quality and High Reliability
- 7 Integrated Health System Partnerships
- 328 Employed Board Certified Physicians and Extenders (1)
- Aftercare Team to Manage and Coordinate Care
- 1.5MM Annual Patient Visits (1)
- 82 (1) Facilities

(1) Facilities and patient visits are estimates as of 11/15/17; Number of physicians and extenders are actuals as of 11/30/16.
(2) For facilities open 2 years or more.
PARTNERSHIP AT A GLANCE
Staten Island PPS and CityMD Initiative Alignment

Follow-Up Care:
Assisting patients to obtain appropriate follow-up care with their primary care physicians and physician specialists as their condition and needs require. Patient medical summary sent to receiving provider on every referral.

Inappropriate ER Usage Avoidance:
Offering a lower cost alternative to patients who do not require emergency room care in a more appropriate urgent care setting, when clinically appropriate.

Care Management:
Opportunities to create policies and protocols with primary care providers to help tackle population health and social determinants of health issues.
CITYMD FACILITY BASICS

- Hours of operation are 8a-8p weekdays, 9am-6pm weekends
- Supersites open 8am-midnight, 9am-9pm weekends
- Open 365 days a year
- Accept all commercial plans and most Managed Medicaid (Healthfirst, Healthplus, HIP, UHC-Community Plan, Affinity, etc.)
- On-site pharmaceuticals and intravenous therapy for early dosing and treatment
- On-site x-ray, POC testing, and stat lab capabilities
- Stat advanced imaging and referrals arranged
CURRENT NEARBY SITES

STATEN ISLAND
New Dorp
2710 Hylan Boulevard

Richmond
2187 Richmond Avenue

BROOKLYN
Bay Ridge
8712 4th Avenue

Bensonhurst
2175 86th Street

NEW JERSEY
Bayonne
904 Bayonne Crossing Way
CITYMD PHYSICIANS
Great Care Begins With The Best Practitioners

- All our physicians are either board-certified or board-eligible (EM, IM, or FP)
- There is a physician at every site, at all times
- Our screening process includes a skills evaluation at the time of hire. Nearly 4/5 of providers who apply for a position with us are turned down
- We have a robust QA/PI process
- We have a formal orientation and training program, even for our clinicians
- Our secret sauce, Aftercare, reviews all tests and referrals, and catches errors in real time
AFTERCARE: ADDING VALUE TO VISITS
Aftercare Programs and Services

AVERT
- Inappropriate ER usage avoidance program
- Real time high-acuity case management
- Remote site and clinical patient support
- Patient resolution in under 60 minutes
- ER send rate of 2.6%

Navigate
Patient Referral System
- Streamlined referral management experience
- Ensures patients stay within network/network tier
- Facilitates clinical data exchange
- 85% acceptance of referral

CareCheck
Coordination Team
- Follow-up for lab results, tests, and care plans
- Advanced imaging coordination
- Clinical performance and key quality measure audits

Partner PCP Support
- PCP notification for all patients
- Surveillance program for patients with care gaps
- Identifying incidental chronic disease to coordinate care with PCPs
- Physician Access Line program as an extension to PCP hours and scope
MOST COMMONLY SENT REFERRALS SINCE 01.01.17

1. Primary Care
2. Orthopedics – Hand
3. Dermatology
4. Neurology
5. Cardiology
6. Ophthalmology
7. Podiatry
8. ENT
9. Orthopedics
10. OB/GYN

184,807 referrals matched
Total number of list, routine, urgent, and stat referrals thus far in 2017 where a provider was matched based on patient insurance, distance from patient’s preferred address, the availability of the provider, and additional patient preference criteria.

95,290 managed referrals matched
Number of routine, urgent, and stat referrals thus far in 2017 where a provider was matched based on patient insurance, distance from patient’s preferred address, the availability of the provider, and additional patient preference criteria.
EXTENDED CARE FOR YOUR PATIENTS

The CityMD Care Partnership Program is designed to provide extended medical care for your patients. When they require services you may not provide, or need immediate medical care outside of your office hours, CityMD is there to help.

- X-RAY
- LAB TESTING
- ORTHOPEDIC
- WOUND CARE
- STD TESTING
Our AfterCare team will ensure that all test results, imaging and chart summaries will be communicated back to the referring provider.
RANGE OF SERVICES

TYPICAL URGENT CARE PROCEDURES:

- Laceration Repair
- Wound Care/Abscess Drainage
- Orthopedic Fracture/Sprains/Strains (X-ray + Splint)
- Foreign Body Removal/Cerumen Removal
- Nosebleed (Epistaxis Control)
- Corneal Ulcer/Abrasion (Fluorescein)
- STD Workup
- GYN Complaints

POTENTIALLY AVOIDABLE ER VISITS:

- Asthma
- Abdominal Pain
- Cellulitis
- Pneumonia
- Dehydration/Vomiting
- Minor Head Injury/Concussion
- Atypical Chest Pain
- Dyspnea

DEPARTMENT OF HEALTH REPORTABLE ILLNESSES:

- Measles, Mumps, Rubella
- Hepatitis A/B/C
- HIV testing, and PEP
- Zika
- Animal Bites
- Travel Vaccines (Yellow Fever, Typhoid, Tetanus, etc.)
ONE CALL DOES IT ALL

833 (CITYMD-1)

CITYMD Physician Access Line
Monday–Friday 8am to 10pm
Weekends 9am to 8pm
Thank You!

Q&A
Avoiding Hospitalization through Care Coordination

Susan O’Connor, BSN, MBA
Director of Clinical Operations, Empire Blue Cross Blue Shield HealthPlus
Staten Island Hospital Primary Care Symposium
12/2/2017
Inpatient Overview

Inpatient starts with:
- Request for emergent services
- Notification received by National Customer Care Center (NCC)
  - Phone
  - Fax
- Local Plan Census Review
- Request for clinical documentation

Inpatient goals are:
- Review request for medical necessity and benefit
- Meet compliance requirements
- Timely discharge planning
- Refer to CM, Long Term Care per protocol
- Review for PCS/CDPAS and complete M11Q
- Timely assessment of transportation needs
- Ensuring pharmacy fulfillment prior to d/c

Inpatient Team composed of:
- Clinical Reviewer
- Administrative team
- Medical Director
- Social Worker Team
- External: facility UR team

Inpatient UM responsibility:
- Initial and concurrent review
- Retrospective Reviews
- Acute inpatient
- SNF/ Rehab
- Engage Long term care, if needed
Care Transition

- IP admission
- D/C planning
  - Field Visit – clinician or peer
  - Coordination with CM or HH
  - Coordination with OP Clinic
  - Bridge Visit
- Reminder calls
  - F/U with provider
  - Case Management
- Relapse Prevention visit and follow up
Case Management Overview

Case Management starts with:
- Identifying members in need for case management based on a predictive model developed by the plan.
- Initiating member outreach via telephonic or face-to-face contact
- Ongoing follow up per NCQA requirement

Case Management goals are:
- Identify, reduce or remove barriers to care- help the members get to the doctor and get their medications
- Prevent or prolong relapse or recurrence of issues, disease, and health impairments
- Assist member support systems to improve health outcomes
- Improve member and provider satisfaction

Case Managers assist members with:
- Optimizing the use of health plan benefits and community resources
- Ensuring that members receive high quality health care
- Engaging members to improve self-management skills (esp. in managing a chronic condition)

Case Management Programs:
- Complex Case Management
- Post Discharge
- HIV Program
- High Risk Maternity and NICU CM
- Carve-in populations
- Special Initiatives
- Health Homes
Discharge Planning Program

➢ Integrated program acts as a bridge between the hospital team (SW, DC planner, MD) and the facility or home that member is being discharged to

➢ Team of social workers with background in behavioral and physical health and inpatient discharge planning

➢ Collaborate with internal and external providers as well as multiple health plan departments

➢ Oversee ALL aspects of member’s discharge care

➢ Participate in multiple interdisciplinary rounds
➢ Focus interventions on behaviors that can help prevent readmissions

➢ Improve the quality of transition from acute care to lower level of care or home and reduce hospital readmissions

➢ **Four program components:**
  • Medication reconciliation
  • “Red Flag” recognition (i.e. lack of education, inadequate treatment, ineffective OP treatment, social issues, and no d/c instructions)
  • Follow up care including access to transportation and medical record review
  • CM and member create a mutually agreed upon care plan with identified barriers and goals
Key Contacts

➢ Inpatient UM Nurse:
   Diana Gaffney, RN (212) 563-5570 x66503
   Fax: (866) 494-5703

➢ Social Worker/Discharge Planner:
   Veronica Bond, SW (212) 563-5570 x 66542

➢ M11Q Fax:  (844) 528-3685

➢ DME Requests: Integra (718) 287-1229

➢ Pharmacy Prior Auth: (800) 359-5781
SI CARES
Staten Island Community At-Risk Engagement Services
A DSRIP Partnership
Presented by Deeana Dobrer, MSc
SI CARES: Program Overview

- Short-term **Care Management program** designed to assist community members with Medicaid to become linked and engaged with community based providers in order to **better manage their health care needs**.
  - **Health Coaches** identify and address barriers to receiving treatment, including cultural and language factors.
  - **Health Coaches** partner with community members to develop a personalized Care Plan that addresses health and social needs.

**SI CARES** services are provided through a network of local organizations on Staten Island.
SI CARES: Snapshot

- **DSRIP Year 1**
  - April 1, 2015 – March 31, 2016
  - Total Staten Island Residents Served: 436

- **DSRIP Year 2**
  - April 1, 2016 – March 31, 2017
  - Total Staten Island Residents Served:
    - 1668

- **DSRIP Year 3 (as of 11/24/2017)**
  - April 1, 2017 – March 31, 2018
  - Total Staten Island Residents Served:
    - 911

- Total Unique Clients Served: 2,770
SI CARES: Primary Health Conditions

- Other: Physical Health 26%
- Other: Developmental 2%
- Other: Mental Health 29%
- Asthma 9%
- Depression 7%
- Diabetes 6%
- Substance Use 6%
- Unknown 15%
SI CARES: Social Determinants of Health

- Housing & Utility Needs
- Food
- Clothing
- Transportation
- Entitlements/Benefits
- Safety Needs
- Medication Issues
- Childcare Needs

October 1, 2016 to September 30, 2017
SI CARES: Hospital Utilization

- SI CARES Health Coaches **assist community members** in navigating health care resources.
  - Health Coaches recognize that sometimes going to the ED is necessary, and we continue to work with community members to **educate and empower** them of their options.

- SI CARES **unique placement in the community** means that we can respond swiftly when a client is hospitalized and begin to coordinate services.
  - SI CARES Health Coaches receive Healthix alerts daily and **respond to every alert** by reaching out to both the client and hospital staff.

- SI CARES Health Coaches work with clients to **determine the appropriate level of care** based on needs, including hospital utilization.
  - Health Coaches assist clients with **moving into higher level care coordination services**, including Health Home.
SI CARES: Demographics

Zip Codes Served

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<th>Zip Code</th>
<th>10301</th>
<th>10302</th>
<th>10303</th>
<th>10304</th>
<th>10305</th>
<th>10306</th>
<th>10307</th>
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<td>389</td>
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<td>254</td>
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<td>27</td>
<td>23</td>
<td>202</td>
<td>38</td>
<td>142</td>
<td>143</td>
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</tr>
</tbody>
</table>

Staten Island Zip Codes
SI CARES: Demographics

**Gender Distribution:**
- M (Male): 49%
- F (Female): 51%

**Age Distribution:**
- Under 18: 30%
- 19-30: 17%
- 31-45: 21%
- 46-60: 21%
- 61-80: 10%
- 81 and over: 1%

The data shows a slight majority of females over males and a significant portion of the population is concentrated in the 31-45 age range.
SI CARES: Encounters and Services

- Rate of Client Encounter: 84%
- Average Encounters Per Care Planned Client: 6

Visit Type:
- CARECOORD: 79%
- OUTREACH: 17%
- OTHER: 4%

Core Services:
- Community and Social Coordination: 305
- Comprehensive Care Coordination: 6116
- Individual and Family Coordination: 4339
- Searching: 264
- Other: 936
SI CARES: Referral Process

If you are working with SI residents that have:

- Medicaid (managed care or fee-for-service) AND
- One chronic condition and at risk for another condition AND/OR
- Risk factors may be medical or related to social service needs

Please complete the Referral and Consent Form and send it via fax to 877-572-2220

For more questions, please contact SI CARES at 718-556-7340
SI CARES: Thank you!

Deeana Dobrer
Project Coordinator | Staten Island CARES
Coordinated Behavioral Care, Inc.

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Fax: 877-572-2220
Care Coordination: Health Advocates, Community Health Workers and Promotoras

Rebecca Telzak, MPA
Director of Health Programs, Make the Road New York
December 2, 2017
Make the Road New York (MRNY) builds the power of Latino and working class communities to achieve dignity and justice through organizing, policy innovation, transformative education and survival services.
Health Advocates

- Assist families in navigating the health system: negotiating between insurance companies and providers, lowering hospital bills, accessing low cost care, etc.
Promotoras

- Conduct outreach, assist families in connecting to benefits and social services
Community Health Workers

FREE HEALTH CAREER TRAINING FOR NYC IMMIGRANTS

Offerings include:
- Community Health Worker Certification Training
- "Bridge to Health Career" Training for Immigrant Learners
- Language, Computer, & Professional Training
- Health-Related Internships
- Health Career Counseling & Job Placement
- Connections to Further Healthcare Training

REGISTER NOW for classes starting in September!
Contact 718-418-7600 ext. 1271 for more information
Example: Asthma Home Visiting Program
Asthma Home Visit Program Process

- CHW receives referral from provider or school nurse or CHW does outreach and refers clients
- CHW calls client to schedule home visit
- Conducts home visit
- Intake, environmental assessment, Asthma Control Test, review of Asthma Action Plan, help contact provider/apt, Rx refills, provide asthma education
- Referral for pest remediation
- Referrals to MRNY for social services: Food Stamps, health insurance, legal
- Regular case conferences with CHW and providers
- Follow up with support phone calls and 2-3 home visits in the year
Results over the past year

- Opened 1,414 food stamp cases (over 2,200 individuals) helping families access over $1.1M a year in food stamp benefits.
- Helped 5,595 families obtain health insurance or navigate the health system.
- CHWs conducted home visits with over 300 families to help them manage their children’s asthma and oral health.
- Advocates reduced medical debt by $160,828 for immigration families.
Preliminary results from evaluation of CHW oral health project

- Increased parents knowledge of caries-related risks
- Increased parents understanding of seriousness and susceptibility of childhood caries as a disease
- Increased parents self-reported capacity to overcome barriers to caries management
- Increased parent satisfaction with CHW intervention
  - >97% agree/ strongly agree that CHWs listened, explained, spent sufficient time, did everything possible to help, were respectful/friendly and helped families reach their goals
  - 98% of parents agree/ strongly agree that they would recommend the program to others
- Parents welcomed CHW’s additional help with food, housing, income insecurities, and access to non-dental educational and social service resources
- Parents reported a drastic improvement in their child’s oral health after this program
Thanks!

Contact info:
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Q&A
THANK YOU!