



The latest update on our efforts to provide world class “care coordination” across the SPHP system

SUCCESS STORY



Lansingburgh
Rensselaer County

The best place for this patient: home

Celeste lived in a quaint, tree-lined Lansingburgh neighborhood, right next door to her grandkids. But now she found herself at Samaritan Hospital, with doctors telling her that because her cancer had spread so extensively, a cure wasn't possible. She told the chaplains she was scared of dying, and it was clear she had an aversion to even the word “hospice.” In addition, she initially had no interest in speaking to the hospital's palliative care social worker. Ultimately, Samaritan's case management department succeeded in getting Celeste to focus on her goals, which in her case were to spend as much of her remaining time as possible back in her Lansingburgh home, with family nearby, and to not keep going to the hospital.

“We were able to say, ‘if that’s really your goal, then let’s talk about hospice, and—forgetting about the word for a moment—let’s just focus on the services provided,’” says Christina Yerdon, director of care coordination for Acute Care Troy. “There was a lot of talking and planning and helping the patient focus on what’s best for her, and when she was finally ready to go home with hospice, it was late on a Friday afternoon.” A few urgent phone calls later, arrangements were made to expedite her discharge and have a hospice admissions nurse meet Celeste at home for a Sunday morning admission. “A lot of times we want to put patients on our timetable, versus their own. This was really about meeting her at where she was on her journey, and helping her attain her goals,” says Christina. “A lot of times patients know what they want, but don’t know how to get there.”



"OUR ROCK STARS!"

Janet Enfield, Samaritan case manager; Charleen Pascariello, Samaritan Case Manager; Aloysius Kabunga, Samaritan chaplain; Chris Webber, Samaritan palliative care team social worker; Dr. Scott Newton, Samaritan hospitalist; Christina Yerdon, director of care coordination, Acute Care Troy; Lisa Covington, Community Hospice RN; Jessica Wiley, Community Hospice RN; Alice Benfey, Community Hospice admissions nurse; Nori Giacchetta, Community Hospice clinical director.



Members of SPHP's
Capital Region Health Connections team

DID YOU KNOW?

Medicaid patients in Albany and Rensselaer Counties, who have two or more chronic conditions—like obesity, diabetes, heart disease, COPD or a behavioral health disorder to name a few—can be referred to Capital Region Health Connections to see if they qualify for care coordination which is part of this area's SPHP-led "Health Home" program. "We work with complex, vulnerable patients who use acute care the most, matching them with programs and services that support their ultimate health and wellness," says Janelle Shults, the program's director. The SPHP team oversees and supports the operations of ten other community-based agencies that deliver care coordination. Referrals are matched with the agency that's best able to handle a specific patient's needs. Referrals can come from anyone: nurses, social workers, community agencies or even patients or their family members. Call **(518) 271-3301** or go to: www.sphp.com/healthhome for a referral form.

490 Number of referrals
received in 2015.

1,199 Number of referrals
received in 2017.

ICCS UPDATE



Hand-offs and the 72-hour goal

In a relay race, hand-offs are key to the next transition and if the baton is dropped, it really doesn't matter if each runner ran their best leg of the race. This is true in healthcare as well and is a major goal of the care coordination work across SPHP. As an example, even if we provide the best care and service to a patient in a hospital setting, if the hand-off to homecare or rehab isn't clear and comprehensive, we could be doing a disservice to our colleagues and the patient, raising the risk of readmission. Hand-offs are where the "rubber meets the road". Sometimes they're referred to as hand-overs or hand-ins or care transitions. Care transitions occur both within facilities and between facilities and service lines. The primary objective of a transition of care is to provide accurate information about a patient's care, current condition and any recent or anticipated changes. Initially, our care coordination efforts are focusing on safe care transitions for our high-risk patients through some of the following interventions:

- Utilizing technology to relay information and alerts.
- Discussing key information at interdisciplinary rounds/SNAP rounds, where our post-acute liaisons may be present.
- For example, our acute clinical care coordinators (C3s) reaching out to the SPHP Medical Associates' embedded case manager RNs at the practice sites at time of discharge.
- Communication between providers where necessary. For example, an emergency department MD texting the hospitalist regarding an admission.
- Primary Care sites calling the patient within two business days of discharge to check-in.

- Most importantly, ensuring high-risk patients have a follow-up visit with a doctor, nurse practitioner or physician's assistant within 72 hours of acute discharge (and having an escalation protocol if there is difficulty in getting that appointment scheduled, tapping into our homecare nurses or coaches to visit that patient in the interim period if warranted).

We have much work to do, but have been meeting with clinicians and providers to improve our hand-off processes and overall communication. We know if it were your loved one, you wouldn't want the baton to be dropped!

QUESTIONS?

If you have questions about care coordination, how it works or what we hope to accomplish, we're here to help. Please contact:

Kim Baker M.A. CCC-SLP, President, Continuing Care Network;
Executive Sponsor, SPHP Integrated Care Coordination System
Kim.Baker@sphp.com | 518-525-5513

Tricia Brown, Director, Continuous Performance Improvement
PatriciaA.Brown@sphp.com | 518-525-6044

Please consider submitting patient stories that cross care transitions and/or service lines to be highlighted in the "Did You Know?" section of the newsletter. Your input is welcomed.