



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

## SUCCESS STORY



### Success is Sum of Small Efforts for Care Coordination Patient

Donald was in dire straits. At age 57, he had no stable place to call home, a history of substance abuse, and multiple chronic conditions – including end-stage liver disease, heart failure, diabetes and depression. He wasn't doing well. Further complicating things, Donald had a low literacy level and didn't much follow his care plan.

Enter IHANY which began following Donald in early 2016 when he registered six inpatient hospitalizations and several emergency room visits at various facilities. The complex care manager identified the real social determinants impacting Donald's complex medical condition, including housing and health issues, and his limited support.

The Complex Care Management team intervened, enrolling Donald in a health home in Schenectady, helping him relocate to Albany where he had a more stable home environment, and facilitating his transition to the Eddy Coach Transitions Program.

Donald now has a stable primary care physician and is connected to the SPHPMA (St. Peter's Health Partners Medical Associates) embedded care manager. Additionally, he has been referred to the Capital Region Health Home where he is being followed by Catholic Charities.

The team also helped Donald address his health literacy issues. He now has a complex emergency department care plan, and his hospitalizations and emergency visits have decreased. Donald is more compliant with his medical plan and is no longer actively using alcohol and/or substances.

Assessing and continually reassessing Donald's needs has significantly impacted his utilization.

"Success is the sum of small efforts repeated day in and day out," says Nora Baratto, director of Complex Care Management for IHANY. "The team consistently re-engaged Donald in his care and added community services and supports. The team did the right thing for the patient in the right place, and at the right time."

Thanks to the Integrated Care Coordination System and the coordinated efforts of SPHP care managers and the IHANY Clinically Integrated Network Partners in Schenectady, Donald's quality of life has really improved. And the future is looking brighter.



"OUR ROCK STARS!"

Congratulations to the rock stars: Deb Wurtzel, former director of care central, Ellis Medicine; Julie Layton, embedded case manager, Ellis Medical Group; Brenda Little, Care Central Health Home; Patrick Archambeault, director of clinical nursing services, Eddy Visiting Nurse and Rehab Association; Barbara Rogers, embedded case manager, SPHPMA Primary Care Physician office; Victoria Angert, MD, Riverside Medical Center; David Maurice, LCSW-R, Alliance for Better Health; and Cathy DeSeve, complex care coordinator, IHANY.



**Northeast Home Medical Equipment Offers Equipment, Supplies to Help Patients Remain Safe & Independent at Home**

From wheelchairs, to hospital beds, to oxygen systems, Northeast Home Medical Equipment (NEHME) offers a wide variety of medical equipment and supplies to help patients recuperate and remain in the comfort of their own homes.

The Capital Region’s only not-for-profit durable medical equipment company, NEHME also provides respiratory therapy services and supplies, such as oxygen concentrators and ventilators; plus items such as bed tables, transport chairs, commodes, walkers, lifts; a full line of incontinence and skin care products; and a new line of mom and breast feeding products.

Skilled medical equipment technicians provide free delivery, set-up and instructions. Come check out the spacious retail showroom at 60 Cohoes Avenue in Green Island. For more information, please call **(518) 271-9600**.



**Alerts: Warning... Danger Ahead!**

“Alerts!” They can warn us of imminent threat or danger, and they can mean the difference between life and death. That’s why the Integrated Care Coordination System has focused on alerts as one of its key areas this year.

We're now using system alerts to provide real-time triggers for team members across the network to readily identify "shared" patients and better facilitate care coordination. Our I.T. (information technology) department has been instrumental in their support, embedding alerts over the last six months in the Meditech system for Samaritan, Albany Memorial and Sunnyview. Case managers at those sites can now view on their daily census reports:

- Patients who are members of our Health Home program
- Patients who are on our homecare roster
- Patients who are being followed by a Coach through our homecare program
- Adding a flag if a patient has one of our Medical Associates providers/PCPs
- Patients who have membership in our ACO, IHANY
- Patients who are "high utilizers" of IHANY

We also embedded other alerts in the Homecare Delta reports (i.e. ordering physician name); and we're sending Point Click Care alerts (Electronic Medical Records for our nursing home and housing division) to Athena so PCPs can see discharge summaries.



It's critical that case managers have this type of information to do their jobs, to understand who has been following a patient in the past, and reach out to communicate the acute care status. We're assessing the same alerts to incorporate into St. Peter's Hospital's Allscripts system so that case managers have this vital information at their fingertips. We continue to review value-added alerts monthly.



Additionally, our team is focusing on identifying "high" risk patients who are at risk for hospital readmission, and/or who consume a high level of resources in our health system (i.e. multiple readmissions and/or a high number of emergency room visits, etc.) We're identifying high-risk patients at the acute care setting and then communicating through daily interdisciplinary rounds/snap rounds to post-acute providers and/or communicating through

the discharge summary. The CCN team has outlined a plan for communication and follow-up actions for when a high risk patient is received.

It is truly exciting to be able to have such a positive day-to-day impact on our patients and colleagues! Special thanks to the key IT team members Mike Dunay, Ann Skinner, Kelley Amin and Pat Ahrens for all their efforts. They are as crucial to our success as our care coordinators!

## QUESTIONS?

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

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*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.*