ST PETER'S HEALTH PARTNERS

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

SUCCESS STORY

How care coordination makes a difference

Joe's situation was pretty bad. Only 58 years old, he had end-stage renal disease, congestive heart failure and COPD, plus depression and anxiety disorders. At times, he suffered intense pain...so much so that he couldn't complete his dialysis, which made him even worse. He frequently ended up in emergency rooms, and was often readmitted to hospitals including Samaritan, Albany Memorial and St. Peter's. Those hospitals, along with all of SPHP, participate in IHANY—the Innovative Health Alliance of New York. It's a collaboration of health care providers and health systems, and IHANY had identified Joe as one of our highest utilizers.

IHANY's complex care director Nora Barrato, reached out to Samaritan Hospital staff and they worked together to develop a plan of care that would stabilize Joe, eliminate care barriers and address his unmet needs. They even referred him to a program that helped him find appropriate housing. Then, a consistent team of care managers kept in regular contact, communicating with each other, for example, when he showed up at a hospital. Effectively managing his care across the continuum helped keep Joe out of the hospital for nearly a year and significantly enhanced his quality of life.

"It takes a village," says Nora. "Each member of the team knew what their role was and were ready and willing to help. We were able to be a great comfort to him in his final days and make a difference in his life."

Congratulations to our team of “rock stars” who helped make a difference in Joe’s case, including: Dr. John Krisa, Hospitalist, Samaritan Hospital; Kara Grimmick, former Health Home Coordinator; Cathy DeSeve, IHANY Complex Care Coordinator; Mary LeCoure, Rubin Dialysis Social Worker; Ruth Berkery, Social Worker, Samaritan Hospital; Karen Julian, Manager, Care Coordination, Acute Care Troy; and Christina Yerdon, Director, Care Coordination, Acute Care Troy.

The Infusion Therapy Services team at Albany Memorial, with patient Ruth Reynolds

DID YOU KNOW?

Albany Memorial Hospital offers infusion therapy services.

Infusion therapy, which involves the administration of medication intravenously through a needle or catheter, is usually prescribed when a patient’s condition can’t be treated effectively by oral medications.

Albany Memorial’s Infusion Therapy Services currently treats patients with asthma, arthritis, heart disease, MS, gastrointestinal diseases, and other conditions. Services include blood transfusions, iron therapy, Remicade, Rituxin, Reclast and other osteoporosis medication, Tysabri and steroids, and antibiotics.

Staff members work with Eddy nursing homes to provide transfusions for residents, and also coordinate with Samaritan and St. Peter’s hospitals, and SPHP physician offices. They provide seamless care so patients can be discharged from the hospital and continue to receive infusion therapies on an outpatient basis. (Homebound patients can receive IVs from SPHP’s very own Empire Home Infusion Service.)

For more information about Albany Memorial’s infusion therapy services, contact Darlene Senter **(518) 471-4928.**

Setting Goals…and Winning the Game

In sports, goals can mean the difference between a team winning the game or losing to the competition. Similarly, for the SPHP Care Coordination Network, goals represent the first steps to achieving the highest quality comprehensive integrated care continuum for our patients. Since SPHP launched the CCN a year ago, we've made great progress, setting several goals all aimed at ensuring each person receives the right care, at the right place, and the right time.

We rolled out the Council and Director Group structure to ensure that all SPHP divisions are represented, and we educated the team on various service lines across the system and the barriers they encounter when progressing care across different settings.

Additionally, we have defined key success metrics, including: hospital readmission rates; avoidable delays; financial measures related to how long the patient's hospital stay is vs. the expected time, based on various diagnosis criteria; whether the patient has an assigned primary care physician, which is critical; and if the patient is seen or called by the Primary Care office within 14 days of their hospital discharge.

Looking ahead, we're focusing on these areas of opportunity:

- High Utilizers – identifying those patients who consume a high level of resources in our health system (i.e. having 4 or more hospital admissions in a 12-month period).
- Use of System "Alerts" – the ability to provide real-time alerts for team members across the system to readily identify "shared" patients (i.e. patients enrolled in Health Home or Home Care, are high utilizers, or are active patients of SPHP Medical Associates) to facilitate care coordination.
- Patient Experience Focus – to balance the financial metrics, the Council charged the team to focus on patient experience as he/she moves across the SPHP continuum.

Focusing on these key goals will help bring us that much closer to our ultimate goal of integrated care coordination – providing seamless patient-centered care throughout the continuum.

QUESTIONS?

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

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