

# COMPENDIUM OF STATEWIDE HOSPITAL- HOME CARE COLLABORATIVE MODELS



**Statewide Hospital-Home Care Collaborative  
for COVID-19 and Beyond**

PREPARED IN COLLABORATION WITH THE FOLLOWING PARTNERS



*This collaboration was made possible through the generous support from the Mother Cabrini Health Foundation.*





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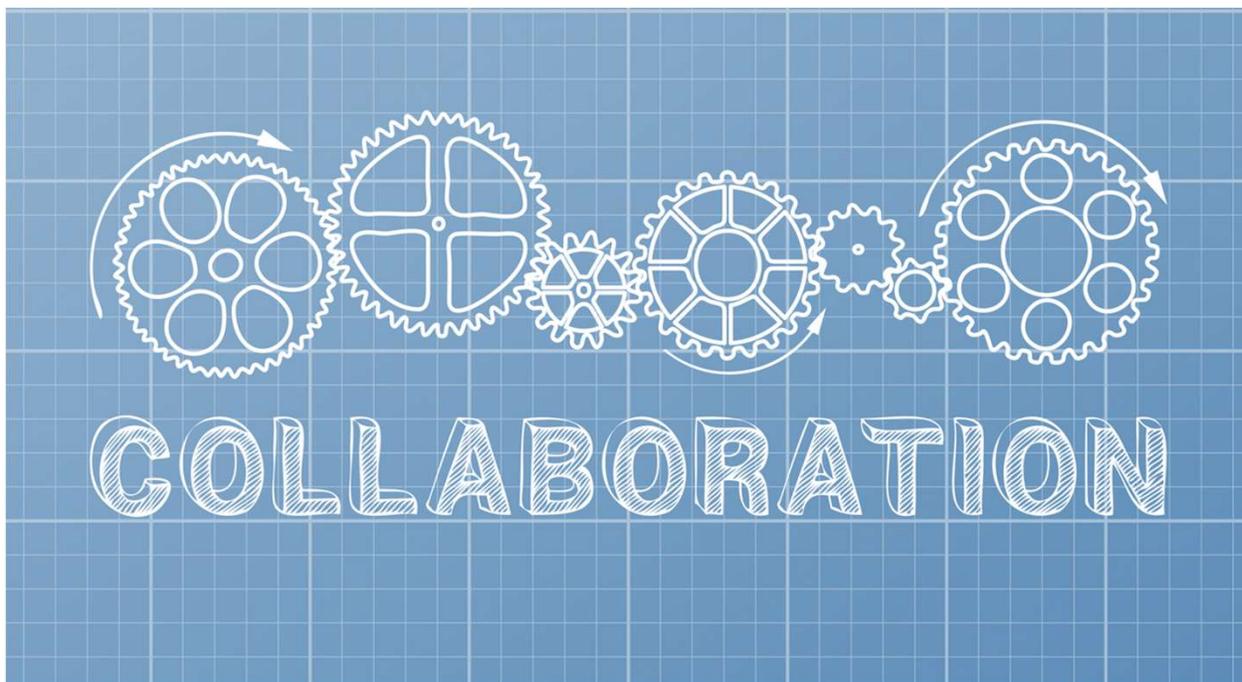
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## EXECUTIVE SUMMARY

Hospitals and home care providers in New York state can build upon the developments made and lessons learned during the COVID-19 pandemic to create an integrated, patient-centered healthcare system that can serve as a blueprint for the nation. New York's hospitals and home care agencies collaborated in new ways to innovate and meet the pressing challenges of the COVID-19 public health emergency. This work has resulted in opportunities to emerge from the pandemic with new solutions to address persistent challenges in improving patient care and outcomes.

Home Care Association of New York State Education & Research (HCA E&R), the Healthcare Association of New York State (HANYS) and Iroquois Healthcare Association (IHA) developed a *Statewide Hospital-Home Care Collaborative* to improve hospital-home care synchronization for front-end, pre-acute hospital care and far-end, post-hospital care, recovery and long-term support.

HCA E&R, HANYS and IHA curated and hosted a series of webinars featuring prototypes of hospital and home care collaboration that can be replicated by other providers statewide — working together, across settings. The associations created an online library of resources and tools to assist hospital-home care collaborative development, offer technical assistance and provide further education.

This initiative was generously supported by the Mother Cabrini Health Foundation.

## KEY TAKEAWAYS

- **Identify Partners and Establish Trust** – Invite community partners to join efforts to meet common goals. Establish personal connections and strengthen community partnerships to build trust.
- **Data Collection and Monitoring** – Determine program evaluation metrics and outcome measures early on. Determine how to monitor and collect outcomes data, utilization data, and any impact i.e., reducing emergency department admissions and hospitalizations.
- **Ongoing Education** – Staff education is imperative to understanding each care settings roles and challenges. Education about physical and behavioral health needs can help to decrease stigma.
- **Protocols and Processes** – Developing a standardized process and protocols for each care setting that span multiple departments, agencies, and community organizations help to serve the shared vision.
- **Effective Communication** – Communication is essential for collaboration. It ensures a coordinated transfer process and allows for all involved to understand each other's roles and responsibilities.

## ABOUT THE HOSPITAL-HOME CARE COLLABORATIVE COMPENDIUM

To spread the learnings from the *Statewide Hospital-Home Care Collaborative*, HCA E&R, HANYS and IHA invited past speakers at *Collaborative* webinars to share their care models and experiences. These case studies should be shared widely to lay the foundation for collaborative efforts to strengthen the capabilities of the system to deliver high-quality services and achieve improved outcomes.

This compendium is a resource for replication, planning and implementation of collaborative efforts. It also serves as a reference for professional, local, state or federal agencies and other organizations seeking to address systematic issues.

# SUMMARY OF COLLABORATIVE MODELS

Hospital and home care partners featured in *Collaborative* webinars have graciously provided summaries of their models for this compendium. These summaries highlight each model’s best practices, key results, successes, challenges, strong partnerships and future plans.

ORGANIZATION PARTICIPANTS	MODEL	PURPOSE AND GOALS	OUTCOMES
<b>Upstate University Medical Center, Nascentia Health and Upstate Home Care</b>	Acute Hospital at Home	This model provides cost-effective treatment for acutely ill older adults while improving patient safety, quality and satisfaction. Older adults can remain in the comfort of their own homes while receiving hospital-level care and avoid common complications associated with stays in traditional acute care settings.	Program results show a cost savings of approximately 30%, better clinical outcomes, shorter lengths of stay and fewer laboratory and diagnostic tests compared with similar patients in hospital acute care.
<b>Mount Sinai South Nassau and South Nassau Home Care</b>	Ambulatory Surgery Total Joint Replacement and Home PT	This initiative promotes improved functional status and a quicker recovery for patients undergoing total joint replacement therapy. This collaboration allows home care to address pre-surgical impairment resulting from progressive pain and dysfunction and post-discharge follow-up visits.	The percentage of patients receiving pre-operative education, initiation of home exercises and mobility training increased. In turn, patient anxiety decreased, which has further decreased post-operative pain and resulted in fewer infections and shorter healing times.
<b>Mount Sinai South Nassau and South Nassau Home Care</b>	Cardiac Surgery and Innovations for Post-Acute Care	This partnership focused on improving care continuity for cardiac surgery patients. The goal is for coordination to occur before a patient’s procedure and to develop a collaborative interdisciplinary plan before discharge.	Launched in 2018, this collaborative strategy prompted a digital patient engagement tool for cardiac surgery patients. This tool allows cardiac patients to engage with providers post-discharge and pushes patient education. Of 11 patients admitted in the first quarter of 2020, 91% were on telehealth or vital sign self-monitoring and 82% of the patients saw their cardiac surgeon within seven to 10 days of discharge from the hospital.
<b>NewYork-Presbyterian Queens and St. Mary’s Home Care</b>	Chronic Disease Home Management Program	The goal of the original model was to target the most at-risk asthma patients, including those living in underserved communities, to help improve their health outcomes and enhance their quality of life. This program has since evolved to include patients with other chronic conditions.	Outcomes to date include improved patient quality of life, a reduction in avoidable emergency department visits and hospitalizations and an improvement in the patient’s ability to self-manage their condition through education.  From April 2021 to August 2022, the program processed 125 referrals. As of August 2022, 48 St. Mary’s Home Care nurses completed 595 home nursing visits, 180 visits were conducted by nutritionists, social work conducted 160 visits and speech therapists conducted 426 visits.

ORGANIZATION PARTICIPANTS	MODEL	PURPOSE AND GOALS	OUTCOMES
<p><b>St. Peter’s Health Partners and Eddy Visiting Nurse and Rehabilitation Association</b></p>	<p>Care Transitions Coach ED COVID-19 Diversion Program</p>	<p>The program was designed to improve patient health and well-being and reduce re-hospitalizations related to the major impact of COVID-19 on their community and hospital system.</p>	<p>Patient feedback scored 100% during the second surge that included the delta variant of the pandemic. During the first surge (December 2020 - July 2021), 285 patients were served and 10% (29 patients) returned to the emergency department/hospital. During the second surge (August - November 2021), 174 patients were served in this program and 2% (four patients), returned to the ED/hospital. During the third surge (November 2021 - January 2022), 142 patients were served and 5% (seven patients) returned to the ED/hospital.</p>
<p><b>Mount Sinai South Nassau and South Nassau Home Care</b></p>	<p>Diabetes Education and Home Care Collaboration</p>	<p>This partnership aims to serve all patients living in the community with diabetes with care and education that is culturally, educationally and linguistically appropriate.</p>	<p>A decrease in hospitalizations for patients with diabetes was measured. The program identified a correlation between decreased readmissions when diabetes supplies are given to patients to have in their homes.</p>
<p><b>New York State eMOLST, University-Langone Hospital and Visiting Nurse Service of New York</b></p>	<p>eMOLST Physician-Hospital-Home Care Collaborative</p>	<p>This collaboration aims to strengthen goals-of-care conversations and promote a model of shared decision-making. This advance care planning is critical at all times, but especially during a public health emergency.</p>	<p>Because of this program, the quality of care improved on many levels. The use of eMOLST improves the intervention of robust goals-of-care conversations at the start of hospice care, prompts skills training and development for best practice end-of-life and goals-of-care conversations, and ensures that patient wishes are consistently documented and easier to honor.</p>
<p><b>Catholic Health System and Catholic Health Long Island Home Care</b></p>	<p>Home Care Behavioral Health Program</p>	<p>The program facilitates interdisciplinary collaboration across the continuum of care and acts as a liaison between physicians, outpatient services and the patient to provide individuals and family members living in the community with support and education on the nature of their illness and available treatments.</p>	<p>Nearly 8,500 patients have been referred to the behavioral health program since 2018.</p> <p>About 50% of patients who were admitted to a home care agency in the past four years were co-managed by the medical and behavioral health team. Patient indicators for specific behavioral health needs were provided with health interventions for their individual care plan.</p>
<p><b>St. Joseph’s Hospital, St. Joseph’s Health at Home and Trinity Health</b></p>	<p>Hospital-Home Care Physician Collaboration</p>	<p>This program was developed to prevent unnecessary hospitalizations, provide reliable, high-quality hospitalizations and lead to efficient post-hospitalizations through collaboration. The collaboration aimed to improve the overall quality of care while decreasing cost.</p>	<p>This model found that the engagement of a provider or executive leader is essential to tackling this problem. The stakeholders also developed shared goals and benefits for all involved to encourage continued participation.</p>

ORGANIZATION PARTICIPANTS	MODEL	PURPOSE AND GOALS	OUTCOMES
<p><b>Nathan Littauer Hospital and Community Health Center of St. Mary's</b></p>	<p>Hospital-Home Care and Primary Care Collaboration</p>	<p>Collaborative partners involved in this initiative aimed to develop effective communication and coordination for optimal patient care. The partners also worked to reduce hospital readmissions and preventable readmissions for high-risk patients.</p>	<p>Communication is clearer and patient satisfaction has increased because of this program's collaboration.</p> <p>In one hospital, readmission rates decreased from 12% to 8% in less than nine months. The rate is currently 6%.</p> <p>The hospital baseline for this pilot included 43 calls. The hospital readmission rate was 12%. The hospital-to-home program year to date included 565 calls and readmission and ED rates went from 8% to 4%.</p> <p>Data elements will be revised in the future, and program growth and outcomes will be measured.</p>
<p><b>Catholic Health System and Catholic Health Buffalo Home Care</b></p>	<p>Managing Patients Through the Continuum of Care</p>	<p>The goal of this model is to ensure patients navigate appropriately and safely throughout the continuum to receive medical services at the correct level of care with the highest level of compassion and quality. Partners used telehealth to reduce readmissions rates for home care patients.</p>	<p>Compared to state and national statistics and a control group of patients, Catholic Health had lower readmission rates as a result of this program.</p> <p>In telehealth patients, readmission rates for Catholic Health were 5.84%, compared to the statewide rate of 21.7% and the national rate of 23.1%.</p> <p>By comparison, Catholic Health's home care patients who did not receive telehealth experienced a readmission rate of 14.7%.</p>
<p><b>Gurwin Health Care System and Stony Brook</b></p>	<p>Telehealth Collaborative</p>	<p>After discovering many isolated seniors living in the community during the pandemic, this collaboration model used telehealth services to reach these patients and prevent emergency room use and hospitalizations. Cutting-edge remote patient monitoring technology was used to better monitor and provide clinical oversight for high-risk patients with COVID-19 or other chronic and/or acute health conditions.</p>	<p>This program increases patient engagement with their care team and their personal responsibility for their care.</p> <p>Because of this program, the census has nearly doubled with an 8% reduction in ED visits and a 12% reduction in preventable hospitalizations.</p> <p>Program results also show 95% of patients' follow-up with their PCP/Specialist by virtual appointment within seven days of facility discharge.</p>

ORGANIZATION PARTICIPANTS	MODEL	PURPOSE AND GOALS	OUTCOMES
<p><b>University of Rochester Medical Center, Strong Memorial Hospital, and UR Medicine Home Care</b></p>	<p>The Critical Illness Recovery Program</p>	<p>The Critical Illness Recovery Program was designed and implemented to accelerate recovery in COVID-19 patients at risk for long-term physical, psychological and neurocognitive sequelae of critical illness.</p>	<p>Beginning in 2020, 77 patients met CIRP program inclusion criteria and 18 COVID-19-positive post-intensive care syndrome patients were referred to the CIRP program. Six patients accepted home care and five accepted and completed 14-day visits. Those who accepted home care and completed their visits were more likely to be discharged from the hospital to home.</p> <p>Future plans include expanding the pilot to include non-COVID-19 intensive care unit survivors.</p>
<p><b>Mohawk Valley Health System and Mohawk Valley Home Care</b></p>	<p>Point of Dispensing Collaborative to Reach Underserved Populations</p>	<p>This partnership aimed to address the COVID-19 vaccination needs in a diverse community (Oneida County), through a collaborative, community approach.</p>	<p>Beginning in 2021, the program helped build trust with community members; 19 community points of dispensing were completed and 1,815 vaccinations were administered to underserved individuals.</p>
<p><b>Mount Sinai South Nassau and South Nassau Home Care</b></p>	<p>Pulmonary Rehabilitation at Home</p>	<p>The Mount Sinai South Nassau outpatient clinic that provided cardio-pulmonary therapy was closed during the COVID-19 pandemic. This program was created to provide a holistic, multidisciplinary approach that aimed to improve how patients with chronic and acute lung conditions could enhance their quality of life. This was achieved through pulmonary-specific education, exercise and behavioral interventions.</p>	<p>Outcomes were positive, with reductions in pulmonary symptoms, dysfunction in ambulation and daily routine management. Many patients were more likely to remain in their homes and avoided re-hospitalization. Patients expressed satisfaction with the development of this home-based pulmonary-specific program as it eased their fears of going out in the community at the height of the pandemic and brought continuity to the therapy they were receiving.</p>
<p><b>Catholic Health System and Catholic Health Long Island Home Care</b></p>	<p>Virtual COVID-19 Home Program</p>	<p>During the COVID-19 pandemic, it was clear that hospital admissions would increase, and patients and families had increased anxiety. The program's goal was to lesson this anxiety and decompress the hospital's COVID-19 volume. Discharges were coordinated with patients and families, discharge planners, Catholic Health Home Care and primary care providers.</p>	<p>Integration of new technology, improved provider access and evidence-based practice guidelines reduced 30-day re-hospitalizations for patients with COVID-19. The program could be expanded to reduce readmissions for other chronic diseases.</p> <p>Initial project implementation occurred April to June 2020, with 372 patients. The 30-day hospital readmission rate was 0% for patients who agreed to all three components of the program (128 patients).</p> <p>The 30-day hospital readmission rate was 2.4% for those electing only home visits and remote patient monitoring (194 patients).</p> <p>During the second surge (December 2020 - April 2021), the 30-day hospital readmission rate was 0% for patients who agreed to all three components of the program (116 patients).</p> <p>The 30-day hospital readmission rate was 3.1% for those electing only home visits and remote patient monitoring (293 patients).</p>

# NEXT STEPS FOR HCANYS, HANYS AND IHA

## *Legislative and Regulatory Efforts that Could Improve the Expansion of these Models*

Hospital, home care, physician and partner associations can advocate on behalf of their membership to promote, develop and expand collaborative efforts. Providers can advocate within their systems, facilities and agencies to promote and increase opportunities for collaboration.

### *Potential opportunities include:*

- Support the inclusion and benefits of hospital-home care and partner collaboration in state and federal reform models, including value-based purchasing, the State's 1115 Medicaid waiver, New York state public health emergency waivers, federal Medicare public health emergency waivers and telehealth policy.
- Advance legislative and budget initiatives that support and build on hospital-home care-physician collaboration in care management and coordination, providing critical investments to enhance communication and achieve better outcomes and lower costs.
- Support the collaborative work by associations to promote successful models and encourage replication of partnerships between hospitals, home care agencies and physicians.
- Providers, state and regional associations, and public officials should work together to promote and support replication in whole, in part and/or in concept of the prototype collaborative models featured in this report, and in HCA-HANYS-IHA *Statewide Hospital-Home Care Collaborative*, along with the creation of similar collaborative models built on these core partners and principles.

The *Collaborative* provides a foundation for accelerated, collaborative work and next steps. These models have reinforced the imperative that home care-hospital collaboration is multilevel and multifaceted. Hospital-home care collaboration and innovation addresses a wide array of healthcare and systemic issues in the state. Ultimately, the commitment to adequate funding and investment in current and future collaborative efforts and innovations must be a priority for all stakeholders.

# COLLABORATIVE MODELS IN DETAIL



**COLLABORATIVE MODEL****Acute Hospital at Home****COLLABORATIVE ORGANIZATIONS***Upstate University Medical Center**Nascentia Health**Upstate Home Care***BACKGROUND AND DEVELOPMENT**

The concept of acute hospital care at home has been tested in a National Demonstration and Evaluation Study at several Medicare managed care sites and a Veterans Affairs Medical Center. This demonstration resulted in a cost savings of approximately 30%, better clinical outcomes, lower average length of stay and fewer laboratory and diagnostic tests compared with similar patients in hospital acute care. The Acute Hospital at Home (ACHAH) program can be a tool to cost-effectively treat acutely ill older adults, while improving patient safety, quality and satisfaction. Older adults can remain in the comfort of their own homes while receiving hospital-level care and avoid common complications associated with stays in traditional acute care settings.

**PATIENT POPULATION**

Seniors are the target population. Although it seems counterintuitive, the hospital is not always the best place for a sick person. It is an unfamiliar environment, there is a lack of restful sleep due to numerous interruptions and — especially with the threat from COVID-19 — family members are often unable to be present the entire time. Elderly patients are especially vulnerable to possible complications, such as hospital-associated infections, pressure ulcers, delirium and disorientation. Long term, there may be cognitive deficits well after the hospital stay has ended. Unfortunately, these individuals may become less able to take care of themselves and are more likely to have longer hospital stays and subsequent readmissions.

**COLLABORATIVE MODEL:***Acute Hospital at Home – continued***GAPS IN CARE**

The COVID-19 pandemic created a serious healthcare crisis, not only because of the illness and death it caused, but also for its assault on the healthcare infrastructure. An already inadequate workforce was reduced, worsening capacity issues during the highest demand. Home care played a significant role in helping to facilitate as many discharges as possible to open hospital beds for more critical patients. In December 2020, CMS expanded the “Hospital Without Walls” initiative to help alleviate COVID-19-driven capacity issues. This waiver paved the way for more patients to receive acute inpatient-level care in their homes.

**DISCIPLINES INVOLVED**

Upstate University Medical Center, Nascenia Health and Upstate Home Care established a comprehensive team including multiple disciplines from both the hospital and home care arena. This included administrative personnel, physicians, nurse practitioners, pharmacists, nurses, therapists and social workers. Each played a significant role in developing a pathway for patients to safely receive acute-level care at home. Transferring patients to their “hospital bed at home” is no small feat and requires buy-in from all involved, including community-based providers.

**KEY RESULTS AND OUTCOMES**

This program is ramping up and expanding to additional populations. On average, 3.4 patient bed days have been saved per patient, with an 8% 30-day hospital readmission rate, and 3% 30 day ED visit rate. Patients and families express high satisfaction with their Hospital at Home experience. Analysis of cost savings is still under review with national programs reporting almost 30% savings. This initiative has also been able to transition several end-of-life patients who were not able to, or were significantly delayed in, receiving hospice services.

**SUCCESSSES**

This collaborative established protocols and processes that span multiple departments, agencies and community organizations to serve a shared vision that creates hospital capacity when resources are extremely limited. It also provides a safe alternative to inpatient care for seniors who are at the highest risk of hospital-associated complications.

**CHALLENGES**

There have been several evolving challenges since the program’s inception. Translating a concept into a contract and then into a working model can almost seem impossible. Everything from medication management to electronic health records and communication presented its own challenges. With executive sponsors in both camps willing to be creative and accommodating to the developing needs of the envisioned program, the collaborative was able to invite community partners to join these efforts and tackle each logistical barrier.

**COLLABORATIVE MODEL:***Acute Hospital at Home – continued***SUSTAINABLE COLLABORATION AND FUTURE OPPORTUNITIES**

As this model evolves, there will be an opportunity to admit patients to ACHAH directly from the emergency room, as this can often become a bottleneck for patients receiving care. As more payers are interested in participating, ACHAH can expand its patient population and pursue value-based contracting.

This model can be complementary to the Hospital-Home Care-Physician Collaborative initiative. With appropriate measures in place, patients could experience an entire episode of care (from primary care provider visit, hospitalization and post-acute care) and not leave their homes. Remote patient monitoring, virtual visits and an array of community resources can make this a reality. Technology and resources need to be optimized so that patients, particularly the most vulnerable, can receive the appropriate level of care at the right time, avoiding escalations that would require lengthy facility-based interventions.



**COLLABORATIVE MODEL**

**Ambulatory Surgery Total Joint Replacement and Home PT**

**COLLABORATIVE ORGANIZATIONS**

*Mount Sinai*

*South Nassau*

*South Nassau Home Care*



**BACKGROUND AND DEVELOPMENT**

This initiative was designed to promote improved functional status and a quicker recovery for patients undergoing total joint replacement surgery. The premise is that providing patients with a select diagnosis with physical therapy prior to surgery will contribute to positive outcomes and improved functional status post-surgery.

Initiating physical therapy prior to surgery has been shown to decrease hospital length of stay by one to two days, allowing patients to recover in the comfort of their own homes within 24 hours of surgery. Pain has decreased and mobility and functional status have improved more quickly.

**PATIENT POPULATION**

This initiative was developed for patients who are undergoing total joint replacement through Mount Sinai South Nassau’s ambulatory surgery center. The targeted patient population is middle-age candidates who are physically healthy with a body mass index lower than 40.

**COLLABORATIVE MODEL:**

*Ambulatory Surgery Total Joint Replacement and Home PT - continued*

**GAPS IN CARE**

Care gaps include delays in obtaining durable medical equipment, and referral and initiation of home care services.

**DISCIPLINE INVOLVED**

The disciplines involved in this collaboration consist of physicians, physician assistants, nurses, care managers/discharge planners, social workers, intake coordinators, physical therapists, home health aides and business service assistants.

- **During an office visit**, the physician identifies the patient for admission to the home care program and a referral is made to Mount Sinai at Home intake staff.
- **After orders and supporting documentation** are obtained and the patient consents to services, a home visit is scheduled. A physical therapist conducts a start-of-care visit, completing the Outcome and Assessment Information Set tool.
- **During the visit**, a home safety assessment and fall risk screening are performed, a home exercise program is initiated and the need for durable medical equipment is assessed.
- **Surgery is performed** at Mount Sinai South Nassau ambulatory surgery center and the patient is discharged back to the care of Mount Sinai at Home staff.
- **A physical therapist visits** the patient post-operatively and performs a complete and thorough physical assessment, including pain assessment and medication reconciliation, and begins home exercises.
- **A skilled nurse** follows up with a call for medication education within 24 hours of admission to the program.
- **Occupational therapy** is provided if indicated for instruction in activities of daily living and assessing any devices needed.
- **Home health aide services** may be provided for assistance with personal care and activities of daily living

**KEY RESULTS AND OUTCOMES**

Preoperative education and early mobilization of post-operative patients have led to a decrease in venous stasis; stimulation of circulation; prevention of deep venous thrombosis/pulmonary embolism; increase in muscle tone, coordination and independence; and improved gastrointestinal, genitourinary and pulmonary functions.

Each patient completes rehabilitation in their own home, eliminating the increased risk of infection in a facility. Visiting clinicians cater to the specific recovery needs of one patient at a time. This customization is difficult to provide in a rehabilitation facility.

**COLLABORATIVE MODEL:***Ambulatory Surgery Total Joint Replacement and Home PT – continued***SUCCESSSES**

This innovation increased the percentage of patients receiving preoperative education and initiation of home exercises and mobility training, which in turn reduced patient anxiety. The collaborative team has also observed a decrease in postoperative pain, infection and healing time.

**CHALLENGES**

Mount Sinai South Nassau and South Nassau Home Care faced several challenges in developing and implementing this initiative, including securing physician and patient buy-in; appropriate patient selection; the anticipation of potential complications; and procedures to optimize anesthetic technique, pain management, blood management, rehabilitation and patient safety. The collaborative team also had to establish effective communication between the physician, hospital and home care staff to ensure coordinated and safe care transitions.

**SUSTAINABLE COLLABORATION AND FUTURE OPPORTUNITIES**

Patients experienced better continuity of care from the hospital to the home care setting with a focus on early mobilization and progression of exercises so that the patient can complete their rehabilitation following surgery. Patients' goals are also considered and documented so the care plan can be individualized for each patient. Access to the hospital orthopedic patient navigator makes the hospital-home care connection seamless.

The program could be expanded to include different diagnoses in the target population. The ability to treat a patient both pre- and post-operatively in their home has the potential to benefit many other patients served by surgical specialties.

Consideration can be given to the care of antepartum hypertensive or preeclamptic patients. Home care visits by a registered nurse supplemented with daily telehealth monitoring both antepartum and postpartum can lead to improved symptoms, blood pressure control and medication management.



## COLLABORATIVE MODEL

### Cardiac Surgery and Innovations for Post-Acute Care

#### COLLABORATIVE ORGANIZATIONS

*Mount Sinai*

*South Nassau*

*South Nassau Home Care*



## BACKGROUND AND DEVELOPMENT

When Mount Sinai South Nassau affiliated with the Mount Sinai Health System in 2018, cardiac surgeons from the Mount Sinai Hospital began seeing patients at Mount Sinai South Nassau. Care coordination and collaboration with the system transfer center were initiated for patients requiring cardiac surgery.

To ensure continuity of care for cardiac surgery patients, the organizations recognized the need to tighten the collaboration with the Mount Sinai at Home staff and the interdisciplinary cardiac team at Mount Sinai Hospital. In March 2020, direct communication was initiated between the leaders of Mount Sinai Hospital and Mount Sinai at Home. The team conducted a review of home health services and telehealth needs, the referral process, post-operative surgical protocols and the concerns of Mount Sinai key stakeholders and their high-risk patients.

## PATIENT POPULATION

This initiative was developed for patients who transferred from Mount Sinai South Nassau to Mount Sinai Hospital for cardiac surgery. The collaborative team identified the opportunity to improve coordination of follow-up care for these patients so that no one “got lost in the system” post-discharge.

**COLLABORATIVE MODEL:***Cardiac Surgery and Innovations for Post-Acute Care – continued***GAPS IN CARE**

Care gaps included:

- Coordination of the cardiac patient pre-operatively;
- Situational awareness to ensure leaders and key stakeholders within Mount Sinai Heart were aware of the arriving transfer;
- Interdisciplinary collaboration to ensure a plan is appropriately developed post-discharge; and
- Referral of the patient to home care with the transfer of information between systems and the monitoring of follow-up with Mount Sinai Hospital discharge instructions post-operatively.

Throughout this initiative, the team worked to support the development of personal connections between the leaders of Mount Sinai at Home and Mount Sinai Heart.

**DISCIPLINES INVOLVED**

This collaboration work included physicians, nurses, medical social workers, business support assistants, physical therapists, occupational therapists, dietitians and home health aides.

- **The cardiac surgeon** who sees the patient at Mount Sinai South Nassau assesses the need for surgery and makes the referral to Mount Sinai Hospital.
- **The Mount Sinai social work staff** refer the patient to Mount Sinai at Home where the Mount Sinai Hospital nurses and the home care intake nurse collaborate and have an RN-to-RN handoff prior to patient discharge.
- **The Mount Sinai at Home intake nurse** contacts the patient/ family and the community physician, who evaluates for telehealth and obtains face-to-face documents and the patient's hospital discharge summary.
- **The business service** assistants schedule the patient for the admission visit the day after hospital discharge.
- **The admitting registered nurse** provides a comprehensive patient assessment and obtains orders for any additional services, durable medical equipment or adaptive equipment required. The nurse also reconciles medications, provides patient/family/caregiver education, reviews the hospital discharge instructions with the patient and facilitates the follow-up visit with the cardiac surgeon.
- **The physical and occupational therapists** assess and further follow up with education staff regarding therapeutic exercise, activity limitations, reducing risk factors, activities of daily living, breathing techniques and pain interventions. They further monitor the signs and symptoms to be reported to the physician and monitor follow-up with appointments and cardiac rehabilitation.
- **Medical social workers** address any psychosocial issues that may impact the patient's recovery, provide education on community resources if needed and offer supportive counseling.
- **The registered dietitian** educates the patient about their prescribed diet and makes recommendations to promote compliance with their dietary needs.
- **Home health aides** assist with personal care if needed.

**COLLABORATIVE MODEL:***Cardiac Surgery and Innovations for Post-Acute Care – continued***KEY RESULTS AND OUTCOMES**

The organizations achieved significant improvements, including:

- Preventing avoidable admissions;
- Better support for acute care management through coordination of referrals and enhanced patient information provided at transfer;
- Optimization of successful discharge and transfer to home;
- Improved clinical outcomes and patient satisfaction; and
- Cost-efficient care at home.

Of 11 patients admitted in the first quarter of 2020:

- 91% of patients referred were on telehealth or self-monitoring vital signs;
- 82% of high-risk for re-hospitalization patients were NOT re-hospitalized; and
- 82% of the patients saw their cardiac surgeon within seven to 10 days of discharge from Mount Sinai Hospital.

**SUCSESSES**

The successes realized were:

- Process developments of the RN-to-RN handoff;
- return of patients to Mount Sinai at Home whenever possible;
- Improved collaboration with the transfer process;
- Timely initiation of home care admissions for the post-op cardiac surgery patient;
- Improved process flow of information through access to the Epic electronic medical record by the community intake home care nurses;
- Development and best practice education to the home care clinical staff;
- Access to telehealth monitoring for any patients evaluated; and
- Improved monitoring of patient compliance with post-op discharge instructions by home care staff.

**COLLABORATIVE MODEL:***Cardiac Surgery and Innovations for Post-Acute Care – continued***CHALLENGES**

Mount Sinai South Nassau and South Nassau Home Care faced several challenges in developing and implementing this initiative. These include:

- Ensuring effective communication between Mount Sinai South Nassau and Mount Sinai Hospital for cardiac surgery patients;
- Coordinating the transfer process so that Mount Sinai Hospital staff were aware of the arriving transfer;
- Ensuring that patients were referred back to Mount Sinai at Home;
- Hardwiring “preferred provider” status with Mount Sinai Hospital social workers;
- Establishing personal connections amid staff changes;
- Obtaining electronic medical record access for the intake and clinical team in order to read and print pertinent patient information; and
- Receiving referrals and discharge notifications early enough in the day so that patients could be scheduled within 24 hours of discharge.

In addition, COVID-19 severely challenged the implementation of this program by disrupting planning meetings, creating staffing shortages and limiting available resources.

**SUSTAINABLE COLLABORATION AND FUTURE OPPORTUNITIES**

These types of collaborations could also be beneficial with DME companies, extended care facilities, pharmacies, community resources, telemonitoring and telehealth vendors, and specialty care providers. Strong partnerships between hospitals and home care agencies help prevent avoidable hospitalizations, assist patients in the recovery process and facilitate the start of treatment faster. This results in better patient care and outcomes through an improved flow of information in the care continuum.

In turn, hospitals can dedicate scarce resources where they are most needed for an emergency — critical care, surgical trauma and other specialty care. This is especially important when critical shortages of resources abound. Clinical and communication collaborations enable home care agencies to access the information they need to improve the quality of care and the overall patient experience. It also helps hospitals reduce operational inefficiencies.

The future of this innovative model includes the expansion of services for patients transferred to Mount Sinai Hospital from Mount Sinai Queens and to additional surgeries such as lung transplants and orthopedic procedures.



**COLLABORATIVE MODEL****Chronic Disease Home Management Program****COLLABORATIVE ORGANIZATIONS***St. Mary's Home Care**New York-Presbyterian Queens***BACKGROUND AND DEVELOPMENT**

The model's early beginnings started with New York State Delivery System Reform Incentive Payment Program. DSRIP was a five-year initiative launched in 2014 to reinvest Medicaid funds to promote community-level collaborations and reduce avoidable hospital use by 25% over five years. New York-Presbyterian Queens (NYP-Q) Hospital was designated as a DSRIP Performing Provider System and chose Project 3.d.11 — Expansion of a Home-Based Asthma Program as a key project.

NYP-Q had already established relationships with both St. Mary's Home Care and the Asthma Coalition. The partners came together to use DSRIP funding to create programs and services specifically targeted to the most at-risk asthma patients, especially those living in underserved communities, to help improve their health outcomes and enhance their quality of life.

The original name of the collaborative was the Home-Based Asthma Management Program, but as it evolved to include other chronic conditions, the team changed the program name to the Chronic Disease Home Management Program. The model is comprised of a three-way partnership between New York-Presbyterian Queens Hospital, St. Mary's Home Care and the Asthma Coalitions of Brooklyn, Queens and Staten Island.

**PATIENT POPULATION**

The initial target population was children at risk for avoidable emergency department visits and/or hospitalizations due to asthma. As the model achieved success, the organizations expanded it to include children and young adults with other chronic diseases such as respiratory non-asthma, feeding difficulties, obesity and newborns discharged from the neonatal intensive care unit.

**COLLABORATIVE MODEL:****Chronic Disease Home Management Program – *continued*****GAPS IN CARE**

The collaborative model provides “eyes and ears” in the community for the physicians in primary and specialty care at NYP-Q. It also fills the need to coordinate care among agencies while providing a direct method to deliver patients’ equipment and supplies, and to evaluate and assist in meeting patients’ social determinants of health needs.

St. Mary’s Home Care clinicians deliver care at patients’ homes. Their visits allow them to conduct thorough environmental home assessments in addition to patient health assessments. Bi-directional communication between the home care nurses and physicians enables seamless coordination of care. The Asthma Coalition provides asthma education and supplies such as mattress covers, pillowcases and spacers for St. Mary’s Home Care nurses to deliver to asthma patients.

**DISCIPLINE INVOLVED**

The model starts with collaboration between the physician, the home care team and the Asthma Coalition.

- **NYP-Q physicians** request St. Mary’s Home Care provide skilled nursing home visits and asthma education for patients in the community.
- **The Asthma Coalition** provides staff education, training and patient supplies.
- **St. Mary’s Home Care nurses** conduct the initial Start of Care visit to evaluate patient needs and continue to conduct home nursing visits as needed; most patients require weekly visits for the first month or two. The SOC visit includes a thorough nursing evaluation for additional services that might benefit the patient. These services might include physical, speech and occupational therapies, and nutrition and social work. The SOC visit also offers the visiting nurse an opportunity to walk with the patient through their home to evaluate environmental conditions that might trigger asthma (e.g., pets, pests, smoking, carpets and mold).
- **Masters-prepared social worker** provides patient and family-supportive counseling. In addition, for patients struggling with weight issues on both ends of the spectrum (obesity or failure-to-thrive), the home care agency provides nutritionists and speech therapists with a specialty in feeding to help patients manage their weight.
- **The use of telehealth and remote patient monitoring** using “smart” Bluetooth devices is another key service. Telehealth enables patients in underserved areas to receive services and provide a connection to home care clinicians for them to reach out to as needed. RPM provides real-time data about the patient’s use of prescribed asthma medications and other measurements such as vital signs and weight measures.
- **Routine touch-base calls between the referring physicians and the home care clinicians** are key to success; this keeps all informed of patient status and enables more timely interventions to be activated as needed.

**COLLABORATIVE MODEL:****Chronic Disease Home Management Program – *continued*****KEY RESULTS AND OUTCOMES**

All partners are impressed with the results to date. Outcomes they are measuring and recording include:

- Improvement in medication adherence to prescribed controller meds for high-risk asthma patients;
- Improvement in high-risk asthma patients' Asthma Control Test scores;
- Improvement in patients' ability to self-manage their condition through education;
- Reduction in patients' social anxiety and development of coping skills;
- Improved eating habits resulting in overall improved vital signs (e.g., blood pressure);
- Reduction in avoidable ED visits and hospitalizations;
- Weight loss for obese patients and weight gain for failure-to-thrive patients; and
- Improvement in the patient's quality of life.

**SUCCESSSES**

The development and implementation of the model are ongoing; therefore, program data continue to be collected through 2023. The team is developing an interactive dashboard to capture specific data regarding the program's impact on reducing ED visits and hospitalizations.

To date (April 2021- August 2022) the Chronic Disease Home Management Program has processed 125 referrals for high-risk asthma and weight management patients. The active census as of August 2022 is 48. St. Mary's Home Care nurses have completed 595 home nursing visits, nutritionists have conducted 180 visits and the social work team has conducted 160 visits. The agency's speech therapists have conducted 426 visits with a combination of patients requiring weight management or specialized feeding assistance.

All of the high-risk asthma patients have a current asthma action plan available in the home (as of August 2022). All 22 patients on RPM for asthma have achieved and maintain an ACT score above 20, putting them in the "asthma well-controlled" zone. Four of nine (44%) active patients on the weight management program in August achieved a goal of losing five or more pounds. The agency continues to work collaboratively with the program physicians to enhance the dashboard to capture additional metrics that will reflect program outcomes.

The collaboration among all three partners further strengthens community relationships and enhances patient trust in the physician and the home care agency clinicians. The patients and families get to know their nurse, the telehealth team members monitoring their care and other team members who visit regularly. The home care clinicians reinforce the importance to their patients of following the physician's plan of care.

Patients' level of trust builds; they more readily adhere to their plan of care and follow through with their physician appointments. They learn to recognize the signs and symptoms of exacerbations related to their conditions, which then helps them self-manage their own care before situations escalate. They know that they now have additional providers whom they can contact when they have questions and are hesitant to ask the physician, especially during non-office hours.

**COLLABORATIVE MODEL:****Chronic Disease Home Management Program – *continued*****CHALLENGES**

Challenges encountered include the fact that not every patient referred follows through with program enrollment. Scheduling conflicts sometimes pose challenges to coordinating and conducting the required visits at the frequency ordered by the physician. Since the majority of the agency's patients attend school during the day, the home care visits must take place after school and school activities.

Obtaining appropriate insurance authorizations often poses a barrier and requires a long lead time and collaboration with the physicians to document and submit appeals to obtain approval for home visits in each discipline.

Lack of access to technology and Wi-Fi are additional barriers for those patients who would benefit from “smart” devices such as Bluetooth inhalers and scales.

**SUSTAINABLE COLLABORATION AND FUTURE OPPORTUNITIES**

With evidence-based outcomes, the vision is for the program to expand to partnerships with other hospital systems and to obtain appropriate reimbursement for all services offered.

The success of this model has led to plans for expanding the partnership to collaborate on treatment and care plans for patients who are seen in NYP-Q's Theresa Lang Children's Center. Physicians at this center/clinic treat children and young adults with a variety of complex chronic conditions and focus on the concept of creating a medical home for patients.

Eventually, the partners will scale the model to other providers in the broader NYP network, recruit staff with specialized skillsets, define disease-specific outcomes for other chronic illnesses and identify an evidence-based tool to evaluate and measure the program's impact on patient quality of life and experience.

Project expansion to provide care and monitoring for other chronic conditions (e.g., diabetes, seizures, cardiac and other respiratory issues) may be beneficial.



**COLLABORATIVE MODEL**

**Care Transitions Coach ED COVID-19 Diversion Program**

**COLLABORATIVE ORGANIZATIONS**

*St. Peter’s Health Partners  
Eddy Visiting Nurse and Rehab Association*



**BACKGROUND AND DEVELOPMENTS**

During COVID-19 surges, St. Peter’s Health Partners hospitals were reaching capacity and needed a community-based program to support COVID-19-positive patients who presented to the emergency department. Patients/families were rightfully scared and required close support and monitoring. This program allowed the health system to avoid admitting all COVID-19-positive patients to inpatient beds, so that hospital capacity could be maintained for acutely ill patients.

**PATIENT POPULATION**

The target population was COVID-19-positive patients visiting the EDs at St. Peter’s Health Partners hospitals who could be safely monitored at home with the home health agency’s Care Transition Coach Program.

**COLLABORATIVE MODEL:****Care Transitions Coach ED COVID-19 Diversion Program – *continued*****GAPS IN CARE**

In December 2020, the COVID-19 pandemic was having a major impact on the communities St. Peter's serves and its hospitals were reaching surge capacity. They saw fewer "regular" hospital patients, more COVID-19 patients, more in the intensive care unit and more on ventilators, with long lengths of stay. The care team continued to ask: How do we discharge COVID-19 patients from the ED and keep them home? Historically, EDs have not discharged patients on oxygen.

Patients with COVID-19 were highly anxious as there were many unknowns in the early surges of the pandemic. COVID-19-positive patients gravitated to the ER for care — both those acutely ill who required admission and those who were symptomatic and required close monitoring but did not need inpatient admission if an alternative existed.

St. Peter's home health agency, Eddy Visiting Nurse & rehab Association's Care Transitions Program was modified to meet the needs of COVID-19-positive patients, working in close collaboration with the patient's primary care provider, to support and monitor them at home and avert admission. The model is a clinical telephonic support service that educates patients/families on symptom management and where and when to get medical follow-up care. A pulse oximeter was provided.

Patients reported less anxiety and greatly appreciated the one-to-one follow-up and knowing someone was a phone call away if they had questions or worsening symptoms.

**DISCIPLINES INVOLVED**

All disciplines involved worked together to develop the algorithm for patient identification, the communication process for care transitions seven days a week and evaluation and continuous improvement.

- **Hospital physician leaders** provided leadership support to establish the program, ongoing evaluation and process improvements.
- **Hospital ED teams and case management** handled patient identification and referral.
- **Eddy Visiting Nurse and Rehab Association** modified the existing care transition program for this COVID-19 ED diversion program; received referrals and connected with patients/families at home; and conducted data tracking and reporting, program evaluation and process improvement.
- **Primary care providers** (St. Peter's medical group and other primary care providers in the community) assisted with medication reconciliation and were available to the Eddy VNRA RN coaches and patients/families if symptoms worsened to prescribe treatment.
- **Northeast Home Medical Equipment** (the system's durable medical equipment/respiratory therapist program): provided pulse oximeters and oxygen.

**COLLABORATIVE MODEL:**

Care Transitions Coach ED COVID-19 Diversion Program – *continued*

**KEY RESULTS AND OUTCOMES**

Patients' anxiety levels were lessened by having trusted nurses communicating with them frequently. Patient satisfaction survey responses were overwhelmingly positive.

During the first surge, 285 patients were enrolled in the Coach ED COVID-19 Diversion Program. Only 29 patients returned to the ED. Therefore 90% of patients were able to recuperate in the comfort of their own homes.

**SUCCESSSES**

This intervention was able to support successful management of COVID-19-positive patients at home, keeping beds available for the more acutely ill patients needing access to the hospital.

**CHALLENGES**

The chief medical officer for the hospitals worked to address concerns shared by ED physicians regarding safely caring for COVID-19-positive patients at home with the coach RN intervention. The ED had not previously discharged patients requiring oxygen; therefore, it was important to define the support and monitoring that would be provided.

During the first surge, the coach RNs sometimes found it difficult to connect with patients at home as they were sleeping. In response, the coach RNs called twice daily to connect with patients sooner. In the second surge, symptoms were less severe and some patients did not engage with the coach RNs; however, they had their contact information if questions arose or if symptoms worsened.

**COLLABORATIVE MODEL:**Care Transitions Coach ED COVID-19 Diversion Program – *continued***SUSTAINABLE COLLABORATION AND FUTURE OPPORTUNITIES**

Eddy VNRA's Coach ED COVID-19 Diversion Program is an ideal example of the importance and benefits of continuous collaboration between the hospital and home health agency. Because of close collaboration using this intervention to reduce readmissions of chronically ill patients and DRSIP patients with behavioral health and substance abuse needs, the hospital immediately recognized the capabilities of and potential for using this program during the COVID-19 pandemic.

By working together on the coach program, readmission avoidance workgroups, progression of care and more, the hospital and home health teams know each other well, understand the talents and resources available in the community and have the relationships in place to act quickly.

Eddy VNRA's Coach ED COVID-19 Diversion Program began by serving seniors with chronic illnesses on discharge from an inpatient stay (heart failure, chronic obstructive pulmonary disease, etc.). During DSRIP funding, the program was adapted for people with behavioral health and substance abuse needs. Later, the program was adapted to care for high-risk maternity patients, upon request by a payer. During the pandemic, the program was adapted for COVID-19-positive patients presenting in the ED who could be safely monitored at home.

While this intervention focused on patients presenting to the ER with COVID-19, there are other diagnoses/symptoms that patients present to the ED with which could also be cared for at home and avoid inpatient admission, if a community-based resource like this coach program were available to reconcile medications at home and provide disease-related education and monitoring.



**COLLABORATIVE MODEL****Diabetes Education and Home Care Collaboration****COLLABORATIVE ORGANIZATIONS***Mount Sinai**South Nassau**South Nassau Home Care***BACKGROUND AND DEVELOPMENT**

More than 30 million Americans live with diabetes — about 9.4% of the population. The staff of Mount Sinai at Home are dedicated to serving all patients in the community living with diabetes; ensuring appropriate care and education that is culturally, educationally and linguistically appropriate. Mount Sinai at Home strives for effective and specific individually based communication to achieve desirable outcomes.

A Diabetes Education and Home Care Collaboration model was developed to aid in these efforts. This teamwork-driven model is based on the knowledge that all parts of the team will achieve greater success if they work as a whole. The physical therapist at Mount Sinai at Home collaborated with the diabetes educators at Mount Sinai South Nassau. The home care leaders suggested the use of a diabetes assessment tool to identify all patients with diabetes who are admitted to home care.

Once identified, a blue circle sticker is placed on the front of the patient’s admission folder. The blue circle is the universal symbol for diabetes. It was introduced in 2006 to give diabetes a common identity. The symbol aims to support all existing efforts to raise awareness about diabetes, inspire new activities, bring diabetes to the attention of the public, brand diabetes and provide a means to show support for the fight against this disease. The stickers allow clinicians to quickly recognize episodes of hypo/hyperglycemia and opportunities for education.

Each clinician documents blood sugar readings and foot checks on every visit. By initiating the conversation on each visit, patients and clinicians can educate, discuss and answer questions regarding diabetes.

Free meters were offered to patients to increase point-of-care monitoring and diabetes control. The patient’s primary physician or hospitalist provides patient-specific blood sugar parameters. After parameters are set, clinicians are instructed to call the physician when readings fall outside the range. Through this circle of care and education, individuals living with diabetes can feel supported and part of a team — and avoid hospitalization due to hypo/hyperglycemia.

Finally, a team of home care staff who have completed the “diabetes champions classes” meet monthly to evaluate the needs of the population living with diabetes.

**COLLABORATIVE MODEL:**Diabetes Education and Home Care Collaboration – *continued***PATIENT POPULATION**

This model included all patients with type 1, type 2, gestational and pre-diabetes.

**GAPS IN CARE**

The assessment tool was used during the initial start of care assessment when patients were admitted to home care. This tool aided the early identification of areas in which the patient might need more education, allowing appropriate resources to be offered to the patient.

This collaborative was filling a need. People who had diabetes and required more support and education were identified and provided with valuable resources.

**DISCIPLINES INVOLVED**

The team is multidisciplinary, including physical therapists, occupational therapists and registered nurses. Each discipline provides education specific to their area of expertise.

**KEY RESULTS AND OUTCOMES**

Key outcomes included a decrease in hospitalizations for patients with diabetes. The organizations also identified a correlation between providing meters to patients and ensuring diabetes supplies were in the home with a decrease in readmissions.

**SUCCESSSES**

Keeping the tool to less than 10 specific questions ensured clinician compliance and comprehensive information. Effectiveness was determined by measuring a decrease in hospitalizations. The home care diabetes team also analyzed the correlation between blood sugar monitoring and fewer hospitalizations.

**CHALLENGES**

The diabetes assessment tool went through several revisions. The original tool was a lengthy flow chart before a specific, short questionnaire was suggested.

**COLLABORATIVE MODEL:**Diabetes Education and Home Care Collaboration – *continued***SUSTAINABLE COLLABORATION AND FUTURE OPPORTUNITIES**

Like the blue circle sticker placed on admission folders, the home care staff surrounds patients with the support they need to be successful. The hospital lays down the groundwork, alerting the home care staff of appropriate measures that should be in place. This is ensured by members of the intake team, who document the parameters that are needed. The home care clinicians strive to continue the education and offer materials such as meters, if needed. Clinicians also inform patients of the beneficial classes that are offered at the Mount Sinai South Nassau Diabetes Center.

The teams are always looking to the future. Part of the assessment includes acknowledging the use of continuous glucose monitors in the diabetes population. Education is being improved to help continuous glucose monitoring users and their families understand this remarkable technology.

The team is also working with the Mount Sinai South Nassau hospital staff on methods to decrease hypoglycemia rates and improve outcomes.

The collaborative team hopes that healthcare organizations will model similar programs based on this collaboration to help those with diabetes. Greatness can be achieved by working together as a team.



**COLLABORATIVE MODEL****eMOLST Physician-Hospital-Home Care Collaboration****COLLABORATIVE ORGANIZATIONS**

*New York State eMOLST*  
*New York University Hospital*  
*Visiting Nurse Service of New York*

**BACKGROUND AND DEVELOPMENT**

Medical Orders for Life Sustaining Treatment became part of New York State Public Health Law in 2008 after a successful three-year legislated community pilot. MOLST is an end-of-life care transitions program designed to improve the quality of care end-of-life that seriously ill patients with advanced illness, including advanced frailty, receive.

MOLST is a set of medical orders for life-sustaining treatment, based on the patient's current health status, prognosis and goals for care. The MOLST may also be used for individuals who wish to avoid and/or receive specific life-sustaining treatments now and is not designed for future preferences. MOLST is not for healthy people; MOLST is not an advance directive.

MOLST is the only alternative to the non-hospital Do Not Resuscitate form that emergency medical services can follow. After reviewing data from a 3-year study, the DOH Commissioner of Health approved MOLST as the form to follow both Do Not Resuscitate and Do Not Intubate medical orders. As a result, New York State Public Health Law was amended to include MOLST.

**PATIENT POPULATION**

MOLST is generally for patients with advanced illness who require long-term care services and/or might die within one to two years. Examples of advanced illness include end-stage heart failure, metastatic cancer unresponsive to therapy, and advanced lung, renal, liver, neurodegenerative disease (e.g., Dementia, Parkinson's Disease, ALS), and advanced frailty.

Advanced chronic conditions coupled with frailty put people at the highest risk for recurrent hospitalizations, worsening frailty, diminished functional status in everyday life and mortality. These individuals deserve to be identified early and offered the opportunity to learn about and complete a MOLST with their physician, nurse practitioner or physician assistant. Screening and identification of individuals appropriate for MOLST prior to hospitalization provides the patient the opportunity to make their values, beliefs, goals and medical preferences known while they retain the capacity to make complex medical decisions and ensure the right healthcare agent is chosen and a healthcare proxy is properly executed.

**COLLABORATIVE MODEL:****eMOLST Physician-Hospital-Home Care Collaboration – *continued*****DISCIPLINES INVOLVED**

Physicians, nurse practitioners and other clinicians who practiced in different care settings participated in eMOLST development and testing in 2008-2009. When the Family Health Care Decisions Act went into effect and MOLST became a DOH form on June 1, 2010, eMOLST required a significant redesign to accommodate the complexity of NYSPHL changes, particularly regarding surrogate decision makers and the mandatory role of ethics committee use in some settings.

DOH became an active partner in reviewing the online system, recognizing the value both in patient care as well as to healthcare systems.

**KEY RESULTS AND OUTCOMES**

Key successes that organizations, including VNSNY and NYU Langone Health, have cited regarding eMOLST implementation include:

- Patients are offered robust care goals and end-of-life discussions every time eMOLST is used, even when clinicians have very little experience working in New York state and may have relatively little knowledge of relevant NYSPHL, such as during the height of the COVID-19 emergency disaster when clinicians from across the country came to help in New York.
- eMOLST implementation has encouraged organizations to improve their staff skills training and development for offering best practice discussions to their patients.
- When conversations and wishes are consistently documented and readily available in eMOLST they have become easier to honor.
- Pre-existing eMOLST orders from prior settings allow for improved care transitions, especially when multiple organizations are using eMOLST to guide the same end-of-life goals for care discussion. Consistency in the process and messaging with patients and families has also been helpful.
- eMOLST has helped care teams initiate appropriate early end-of-life discussions and allows for easy revision and updates as changes occur in real-time.
- eMOLST has allowed for a team-based approach to these discussions, leveraging team members' strengths while enforcing scope-of-practice limitations where they are applicable.
- As more organizations find success with eMOLST, other organizations are encouraged to use eMOLST, which furthers its benefits – both to patients and the organizations that serve them, as more individuals' end-of-life preferences are documented in a standardized format and accessible across care settings.

**COLLABORATIVE MODEL:****eMOLST Physician-Hospital-Home Care Collaboration – *continued*****CHALLENGES**

Some of the greatest challenges observed in developing and implementing eMOLST have been:

- The inertia of moving away from paper because it is what many organizations and clinicians knew and were comfortable with;
- The need to adhere to the correct standardized process when using eMOLST and resisting workarounds;
- The need to integrate eMOLST deeply into EMRs to satisfy EMR-centered workflows that organizations have developed; while eMOLST can be integrated in EMRs, organizations must make investments to accomplish this; and
- The complexity of implementing any statewide tool on a voluntary basis. eMOLST works best when many organizations use it because data on a patient are created and retrieved by multiple organizations through care transitions, but convincing organizations to take the leap can be challenging.

**SUSTAINABLE COLLABORATION AND FUTURE OPPORTUNITIES**

The eMOLST Physician-Hospital-Home Care Collaborative can be strengthened by expanding eMOLST use among key physicians, nurse practitioners, physician assistants and other clinicians in a health system. Successful models can share lessons learned and advocate for eMOLST expansion.

When engaging primary care and/or specialist physician(s) and/or palliative care teams and hospitalists in collaborative discussions using eMOLST and telemedicine, keep these key points in mind:

- Trust is important in a therapeutic relationship between the patient and their physician and medical team. Establishing trust takes time.
- The healthcare system has changed dramatically over time. The patient's primary care physician no longer sees the patient in all care settings. As a result, the physician, nurse practitioner or physician assistant who knows them best and can share their values, beliefs, goals and previous discussions is often not engaged in the MOLST discussion.
- Telemedicine offers the opportunity to engage the PCP, NP or PA they trust with the team who is actively involved in their care.
- Unfortunately, many patients with advanced illness do not have a PCP and may be seen by multiple specialists who have never developed an understanding of what matters most to the patient.
- It's best to ask the patient whom they trust. If they lack capacity, engaging the PCP and/or specialist physician engaged in their care may help clarify what matters most.



**COLLABORATIVE MODEL****Home Care Behavioral Health Program****COLLABORATIVE ORGANIZATIONS**

*Catholic Health System – Long Island*  
*Catholic Health Long Island Home Care*

**BACKGROUND AND DEVELOPMENT**

Behavioral health describes the connection between behaviors and the health and well-being of the body, mind and spirit, and how behaviors impact someone's health — physical and mental. It focuses on how your habits, emotions, biology and behaviors impact your overall health. Current evidence-based literature shows that early intervention in patients with behavioral disorders has resulted in a decrease in hospital recidivism, and an overall decrease in yearly costs for the care of the individual.

**PATIENT POPULATION**

All patients admitted to Catholic Health Home Care are screened for behavioral needs using the PHQ-2 (Patient Health Questionnaire). Patients who score a three or above on the PHQ-2 assessment are referred to the behavioral health team for further exploration using specific mental health assessments that assess for anxiety and depression.

**GAPS IN CARE**

Using the PHQ-2 assessment to screen patients admitted to the home care agency, Catholic Health can readily identify any mental or emotional needs the patients may be experiencing that could potentially impact their recovery, including depression, anxiety or feeling overwhelmed about a complicated treatment plan. Catholic Health Home Care acts as a bridge from acute care to home for patients and families in the community until they have successfully connected with community-based outpatient programs.

**COLLABORATIVE MODEL:****Home Care Behavioral Health Program – *continued*****DISCIPLINES INVOLVED**

Admitting clinicians (registered nurses, physical therapists and occupational therapists) administer the PHQ-2 assessment at the start of care. Patients scoring a three or above are referred to the behavioral health team and a psychiatric nurse evaluates the patient further using evidence-based tools to assess for depression, anxiety or other behavior-associated issues.

The goal of this program is:

- Assessment and supportive treatment of individuals within the community;
- Education of family members and patients concerning the nature of their illness and available treatments;
- Provision of “bridge” services to individuals and follow-up in the community;
- Facilitation of interdisciplinary collaboration across the continuum of care; and
- Liaison between physician, outpatient services and patient.

**KEY RESULTS AND OUTCOMES**

The number of patients referred to the behavioral health program increased. Approximately 50% of patients admitted to home care agencies in the past four years were co-managed by medical and behavioral health teams, indicating patient needs for specific behavioral health interventions within their individual plans of care.

**SUCCESSSES**

The agency began to see an increase in the number of patients that needed to be evaluated by the behavioral health team either to re-evaluate due to a PHQ-2 score of three or above or for co-management with the medical staff due to unresolved behavior issues. From 2018 to 2021, 8,491 patients were referred to the behavioral health program and 4,000+ were co-managed with the medical team, which showed the agency how important the behavioral health service was to the patient’s recovery.

**CHALLENGES**

The biggest challenge was educating home care staff about the correlation between physical and mental health and how one affects the other. Changing the name of the program from “psychiatric team” to “behavioral health program” helped decrease stigma. Educating staff on the benefits for patients, families and agencies in addressing behavioral health needs early in the patient’s illness episode was also a challenge.

**COLLABORATIVE MODEL:**Home Care Behavioral Health Program – *continued***SUSTAINABLE COLLABORATION AND FUTURE OPPORTUNITIES**

Catholic Health recognizes the importance of hospital and home care collaboration. The health system has six acute care hospitals, two of which have psychiatric units, three nursing homes, a home nursing service, a hospice, a community-based agency for persons with special needs, outpatient mental health services and addiction recovery services. Patients can move across the continuum of care within the health system. Telehealth would be an opportunity to be able to check in with patients in the event they are not able to be physically seen and/or if another pandemic were to occur.

Current behavioral health collaborative projects within Catholic Health’s home care agency include:

- *Better Breathing Now Program-COPD* — assists with decreasing hospitalizations and anxiety-related symptoms.
- *Mother and Baby* — screens for postpartum depression; provides counseling related to preeclampsia diagnosis.
- *COVID program* — provides supportive therapy related to COVID-19 diagnosis and inpatient stay; provides counseling related to COVID-19 expiration.



**COLLABORATIVE MODEL**

**Hospital-Home Care Physician Collaboration**

**COLLABORATIVE ORGANIZATIONS**

*St. Joseph’s Hospital*  
*St. Joseph’s Health at Home*  
*Trinity Health*



**BACKGROUND AND DEVELOPMENT**

St. Joseph’s Health led development of this model as payers move toward alternative payment models. The team identified the benefits of taking advantage of multiple health system components that span the continuum. Collaborative efforts aimed to improve the overall quality of care while decreasing cost.

To meet the Triple Aim objectives of better health, better care and lower costs, St. Joseph’s Health expanded Certified Home Health Agency services by improving access to home care services across its nine-county, clinically integrated network. This will promote care coordination and high-value care in the community.

**PATIENT POPULATION**

The target population includes patients enrolled in an alternative payment model where St. Joseph’s Health is “at risk” for the cost of care. These models include Medicare Bundled Payments for Care Improvement, Medicare Accountable Care Organization, a commercial contract with Blue Cross Blue Shield and a value-based purchasing agreement with Fidelis.

**GAPS IN CARE**

The model aims to address multiple gaps in the system. The goal is to prevent unnecessary hospitalizations, avoid unnecessary ER visits and admissions, and manage chronic diseases and conditions. The model will ensure reliable, high-quality hospitalizations and improve care coordination. Efficient post-hospitalizations will be executed to control readmissions.

**COLLABORATIVE MODEL:****Hospital-Home Care Physician Collaboration – *continued*****DISCIPLINES INVOLVED**

This cross-continuum model required the involvement of staff from many levels, including primary care, specialists, acute care hospital providers, skilled nursing facility and rehabilitation. Registered nurses provide the biggest lift in the workflow. Health Home program care managers, physicians and ancillary staff provide great contributions to the work that is being done.

**SUCCESSSES**

This initiative showed that if post-acute care is provided safely in the least restrictive environment, then avoidable all-cause readmissions and ED utilization will be reduced, primary care engagement and patient satisfaction will improve, and shared savings within value-based agreements can be achieved.

**CHALLENGES**

The healthcare system is widely based on transactional care. Care management was a barrier for this program to navigate. RN staffing shortages limited the availability of home care services. The global COVID-19 pandemic limited many resources and in-person interactions with patients. The acuity of patients was also a barrier.

**SUSTAINABLE COLLABORATION AND FUTURE OPPORTUNITIES**

Engaging a provider and/or an executive leader is essential in developing a collaborative model. Making clear objectives and holding accountability for preferred networks is important. Developing shared goals and expressing the benefits for all involved in the project is necessary to see the value of participation.

The future of this model includes improving the understanding of regulatory and best-practice priorities, and care expectations across the continuum. The program plans to leverage EMRs to improve coordination and communication. Data sharing on total care management work, inpatient readmissions and skilled nursing facility days will be improved for reporting outcomes. Leadership members across settings will set goals together.



**COLLABORATIVE MODEL****Hospital-Home Care and Primary Care Collaboration****COLLABORATIVE ORGANIZATIONS**

*Nathan Littauer Hospital  
Community Health Care Center of St. Mary's*

**BACKGROUND AND DEVELOPMENT**

Nathan Littauer Hospital's discharge planners recognized a sizable number of repeat patients. By collaborating with team members and doing a root cause analysis, the hospital identified an opportunity to improve the simplicity and timeliness of communication between primary care and home care. In addition, the team learned that patients did not understand their discharge plan information.

This hospital-to-home care collaboration project increases bidirectional communication between the hospital, physician and home care.

This program was created as part of New York's \$8 billion Delivery System Reform Incentive Payment waiver, which had the goal of reducing avoidable hospitalizations 25% over five years.

**PATIENT POPULATION**

The targeted population was high-risk patients based on diagnosis including congestive heart failure, chronic obstructive pulmonary disease, pneumonia, urinary tract infections and diabetes. All information was based on hospital and agency quality measures.

This initiative aims to identify, target and treat high-risk patients. Data from the electronic medical record system, billing information, CMS, DOH and the hospital were used to determine a population of high-risk patients. The data showed that some patients had more than 12 ER visits or readmissions. This program aimed to focus on and help educate this group of high utilizers.

**COLLABORATIVE MODEL:****Hospital-Home Care and Primary Care Collaboration – *continued*****GAPS IN CARE**

Primary care and home care are central to this collaborative care management approach for complex patients. The model includes effective communication, coordination of care and services provided between hospital and home care for optimal patient care and cost effectiveness.

Communication coordination was a challenge before implementing this model. Changes in patient conditions that need a quick response and cases of emergent care that need fast coordination have presented difficulties. This program intends to fill these gaps, including the consistency of care between providers, emergent care, changes in patient conditions for quick response and closing the loop between discharge planners, home care and the primary care physician.

**DISCIPLINE INVOLVED**

Communication between providers that is consistent and coordinated with discharge planners, home care providers and primary care providers aims to close the loop.

**KEY RESULTS AND OUTCOMES**

This collaborative effort achieved lower readmission rates, improved patient outcomes, clearer communication, patients following up with their PCP within five to seven days after discharge, cost reductions and home care agency documentation received within five days.

Many positive outcomes were observed for patients, including improvements in their quality of life, increased patient and family engagement and better communication.

Home care management works. In the initial hospital-to-home pilot, 43 calls were made and the readmission and ED visit rate was 12%. The hospital-to-home program year-to-date totaled 565 calls and the readmission and ED visit rate was 8%. A 4% decrease was observed.

**COLLABORATIVE MODEL:****Hospital-Home Care and Primary Care Collaboration – *continued*****SUCCESSSES**

The team achieved a large hospital readmission reduction, from a little over 12%, to 8% in less than nine months. The current hospital readmission rate is now just 6%.

Through this project, Nathan Littauer gained a better understanding and appreciation of each care setting's challenges. Most importantly, patient satisfaction improved.

**CHALLENGES**

One of the most significant challenges was drilling down to the “real” root cause of readmissions and identifying high-risk patients.

Patient and family education on the escalation tool and protocol presented difficulties. Ongoing education to home care and primary care staff was also challenging.

Other challenges included COVID-19 restrictions, managing different communication styles, developing protocols for each care setting, training the “rapid response team” and setting up data tracking in multiple EMR systems.

**SUSTAINABLE COLLABORATION AND FUTURE OPPORTUNITIES**

Home care case management works because Nathan Littauer Hospital is the central point in this model. The team is proactive, rather than reactive, and has actionable data to report to the primary care provider and discharge planner. The team knows that it needs to communicate with every provider that touches the patient.

Coordinating care with primary care and home care in the community to improve patient care and outcomes results in many benefits for the healthcare system and the patients. Results include improved patient outcomes, improved patient satisfaction, controlling acute care and emergent episodes, and efficient costs of care.

This program focused on the ED. Expanding the program to address social determinants of health and health equity is a goal. The next steps include further revision of data elements and outcomes monitoring. Measures of patient satisfaction program growth will be collected further.



**COLLABORATIVE MODEL**

**Managing Patients Through the Continuum of Care**

**COLLABORATIVE ORGANIZATIONS**

*Catholic Health System – Buffalo*  
*Catholic Health Buffalo Home Care*



**BACKGROUND AND DEVELOPMENT**

The development of this collaborative model is truly embedded in the day-to-day work of Catholic Health System. However, during the pandemic, there was a heightened need to ensure robust, coordinated communication and collaboration at all levels of care to manage capacity and workforce challenges and ensure patients were navigating through the healthcare system safely and appropriately.

The pandemic gave Catholic Health System a platform to collectively engage in daily dialogue to ensure it was transitioning patients appropriately and discussing strategies to overcome barriers to patients moving to the next level of care in a coordinated and cohesive manner.

**PATIENT POPULATION**

The target population was individuals admitted into the system with a primary diagnosis of COVID-19. In response to the challenges of the COVID-19 pandemic, CHS collaborated at all levels of care to ensure patients navigated appropriately and safely through the continuum to receive medical services at the correct level of care and with the highest level of compassion and quality.

**COLLABORATIVE MODEL:****Managing Patients Through the Continuum of Care – *continued*****GAPS IN CARE**

This model ensured patients were treated in the appropriate setting and the barriers to moving the patient to the appropriate level of care were mitigated. This model was a critical component for the health system's ability to manage capacity surges and ensure care access to patients that required lifesaving interventions during a heightened time of community medical needs.

CHS addressed patient needs and barriers, not only through the collective engagement of its leadership but by leveraging important community partnerships. The establishment of the one and only centralized COVID-19 hospital in Western New York was a result of collaborative efforts to meet a community need. The development of a post-acute COVID-19 facility was the result of community partners coming together to share a vision and resources to offer the Western New York community a skilled nursing facility solely for patients with COVID-19 that could not go directly home and required a higher level of post-acute care.

**DISCIPLINES INVOLVED**

This model was truly a multidisciplinary approach to patient care and involved clinical and operational leadership from all levels of care, physicians, nurses, physical therapists, occupational therapists, speech therapists, social workers, registered dietitians, home health aides and certified nurse assistants from the hospitals, home care and sub-acute rehabilitation.

It was a combination of collaborative engagement to transition patients to the right level of care with direct patient care providers delivering the hands-on patient care.

**KEY RESULTS AND OUTCOMES**

- Among 980 patients receiving non-telehealth services, approximately 14.7% were readmitted to the hospital.
- By comparison, among 568 patients receiving telehealth services, approximately 5.8% were readmitted to the hospital.

**COLLABORATIVE MODEL:****Managing Patients Through the Continuum of Care – *continued*****SUCCESSSES**

This model brought to light the successful management of a patient population through consistent representation, communication and collaboration from all levels of care. The daily dialogue allowed for the development and implementation of creative patient care solutions, increased collective partnering and facilitated the breakdown of barriers.

CHS discovered the significant impact telehealth had on managing patient care and the positive outcomes attainable when this care delivery model is deployed in conjunction with hands-on patients and the use of clinical care pathways.

The development and implementation of the St. Joseph Post-Acute Center site was the most impactful and successful endeavor performed during this initiative. The ability to overcome barriers and resurrect this facility in such a short time was remarkable. The SJPAC ensured that patients in need of post-acute care following a COVID-19 diagnosis did not remain in a hospital bed once they were no longer acutely ill. This freed up those beds for others in need of medical care — whether it was COVID-19 or other diagnoses.

Additionally, SJPAC provided an alternate care site for nursing home residents who contracted COVID-19 to reduce the possibility of spread throughout the facility. This provided residents and families with peace of mind when a facility was experiencing COVID-19 outbreaks.

**CHALLENGES**

The challenges encountered during the delivery of this model during the COVID-19 pandemic included the implementation of the SJPAC site. As time has gone on and CHS learned more about COVID-19 and obtained vaccines and standard treatments, the urgency for establishing programs like this has waned, so the model is no longer needed.

The whole process, however, was an excellent learning experience. CHS' associates learned a great deal from the programs, policies and procedures the team developed for SJPAC and are comfortable with care for COVID-19 patients. They are able to safely care for them within their own facility and confidently accept COVID-19-positive patients from hospitals who still need isolation, knowing they can ensure their safety and that of other residents.

Another challenge was the immediate and quick institution of a telehealth task force and operation command center to help coordinate the deployment and distribution of telehealth equipment to patients in need. This challenging endeavor was a huge success in helping manage workforce challenges, mitigate clinical staff exposure to COVID-19, and safely and appropriately manage patient care needs.

**COLLABORATIVE MODEL:**Managing Patients Through the Continuum of Care – *continued***SUSTAINABLE COLLABORATION AND FUTURE OPPORTUNITIES**

CHS collaborated both internally along the care continuum and externally with community partners to operationalize an exceptional COVID-19 care delivery model. This model promoted the highest level of patient care and helped to mitigate readmissions by placing the patient at the right level of care with comprehensive, clinically detailed handoffs.

Throughout the pandemic, CHS' successful patient management was attributed to the consistent, frequent and engaged collaboration and communication that occurred among care managers, discharge planners, severe acute respiratory syndrome admissions teams, home care providers and community service providers. All levels of care worked collectively to assist with capacity management challenges, COVID-19 isolation protocols and ensuring patients were advanced to the appropriate level of care.

This model can be the best practice standard for all levels of healthcare transition and communication. This type of collaboration breaks down barriers, places patients where they need to be and ensures robust, patient-centered handoffs occur, promoting the highest standards of patient care delivery.

The model deployed during the COVID-19 pandemic reflected the expected level of care coordination and collaboration that should occur on a daily basis to ensure appropriate care transitions and patient management occur each time a patient moves from one level of care to another. While many organizations have streamlined workflows and care transitions, others have not made this a priority. This model is a reflective analysis of how a true continuum of care should function on a day-to-day basis.

Health systems are challenged in so many ways from staffing to finances, but at the center of what they do is care delivery. This model exemplifies best practice transitions of care at the highest standards.



## COLLABORATIVE MODEL

### Telemedicine Collaborative

#### COLLABORATIVE ORGANIZATIONS

*Gurwin Home Care*  
*Stony Brook Medicine*



## BACKGROUND AND DEVELOPMENT

For COVID-19 patients to continue their recovery back to health, Gurwin's Clinical Team provided specialized care utilizing cutting-edge remote patient monitoring (RPM) technology to better monitor and provide clinical oversight for high-risk patients with COVID-19 or other chronic and/or acute health conditions. The technology platform includes active remote patient monitoring of the patient's daily blood pressure, heart rate, temperature, pulse oximetry, glucose, and weight readings. RPM includes a virtual platform, which allows the clinician to communicate with the physician the changes in the patient's health condition. The technology provided advanced cardiac and respiratory care at home, using Bluetooth - enabled stethoscopes, that captured, analyzed, and transmitted heart and lung sounds in real-time to physicians. The user-friendly virtual platform feature also allows patient/physician and patient/nurse virtual visits to take place.

## PATIENT POPULATION

At the start of the COVID-19 pandemic in the United States, Gurwin Certified Home Health Agency (CHHA) launched a transitional telehealth program treating COVID-19 patients as they transitioned home from the hospital or a rehabilitation facility, and those patients at home experiencing signs and symptoms of COVID-19, but fearful of entering the emergency room or hospital. Often, patients were opting to leave the hospital or rehabilitation facility early so that they could be reunited with their family and receive essential health care services in order to continue recovery in their homes.

**COLLABORATIVE MODEL:****Telemedicine Collaborative – *continued*****GAPS IN CARE**

Our transitional telehealth program expanded to create access to critical health care services within our community. Gurwin's team of clinical specialists provided outreach to at-risk seniors in the community who were experiencing signs of decline in their health and/or possible signs of COVID-19 but who were afraid to leave their homes to seek medical attention. Partnership with primary care physician practices was key to our success. Unique to Gurwin's Telehealth Program is the ability to provide advanced cardiac care monitoring using state-of-the-art stethoscopes equipped to record, analyze, and transmit heart and lung sounds and electrocardiogram (ECG) recordings. This technology, once only available in the physician's office, was now able to be implemented in the patient's home, providing physicians with the critical patient health information they need to care for patients at home, helping to avoid unnecessary hospitalizations and emergency room visits.

**DISCIPLINES INVOLVED**

A COVID-19 Primary Care Clinical Evaluation Algorithm was developed to identify high-risk patients for the telehealth program. Stony Brook Medicine collaborated with Gurwin CHHA clinical leaders to develop a seamless referral process to ensure timely telehealth services for high-risk patients.

Clinical education for specialized Bluetooth-enabled stethoscopes was conducted to inform and train physicians, hospital physician residents, and CHHA clinical staff. Interdisciplinary education took place virtually. Physicians and the CHHA nurses learned innovative technology together which further cultivated collegial and collaborative teams across healthcare settings.

The CHHA clinical team was provided with competency-based education which required quality monitoring, home visits and coordinating virtual physician visits, and getting real-time feedback from patients and caregivers on using technology in the home to stay connected to their healthcare team.

**KEY RESULTS AND OUTCOMES**

- Doubled census
- 8% reduction of ED visits
- 12% reduction of preventable hospitalization
- 95% of patients' follow-up with their PCP/Specialist by virtual appointment within 7 days of facility discharge
- Implementation of best practice for chronic illness self-management

**COLLABORATIVE MODEL:**Telemedicine Collaborative – *continued***SUCCESSSES**

The most visual measure of how the program contributes to the success of our organization is in our census: within two months, our census doubled. But this is not the full picture of the program's success. Increased collaboration with primary physician practices is another measure of the success of the Telehealth Program. When the COVID-19 crisis began, physicians were concerned about managing their patients. They reached out to us to ask for help in caring for patients with chronic conditions who were unable or unwilling to go to a physician's office due to the pandemic. Patients were experiencing symptoms of an exacerbation of their chronic conditions and/or potential signs of COVID-19, and were fearful of leaving their homes. Many home-bound elderly are socially isolated, without smart phones, camera-equipped laptops or tablets. These patients traditionally can only be reached by phone. For high-risk older patients with medical comorbidities, particularly coronary artery disease, CHF and COPD, the addition of a Telehealth Program enables physicians and nurses to manage a patient's care in the home. Weekly Telehealth patient rounds include not only the Gurwin clinical team, but also the clinical team from the physician's office. At monthly meetings, we meet with vendors and physicians, focused on strengthening transitional IT workflows, risk stratification and targeted outreach to high-risk patients and families, as well as improved processes to effectively scale our collaborative Transitional Telehealth program.

There is a cost savings in that our Transitional Telehealth Program reduces the number of in-home nursing visits required and replaces the in-home nursing visits with virtual patient/nurse visits.

The program also:

- reduces the number of patient contacts, thereby reducing or mitigating the spread of COVID-19;
- increases access to primary care and specialist services for patients at home; increases patient engagement with their care team and their personal responsibility for their care; and
- supports aging in place and quality of life by maximizing patient health and wellness goals by managing the patient's acute health needs at home – where they want to be!

**COLLABORATIVE MODEL:****Telemedicine Collaborative – *continued*****CHALLENGES**

Assessing older seniors' and/or their caregiver's learning needs is potentially challenging, as many have little exposure to technology. Remote patient technology requires that patients and/or caregivers take daily telehealth readings of blood pressure, heart rate, temperature, pulse oximetry and weight. In addition, after the initial training, our telehealth vendor conducts a second training call to ensure the patient/caregiver is comfortable using the platform and all questions are answered.

Because of the feedback we have received, we conducted a detailed patient/caregiver survey on their experience using the technology: what worked, what didn't work, and any lessons they would like to share with other seniors who are learning to use remote patient monitoring. We created a very clear, very detailed, step-by-step telehealth guide for seniors using this feedback.

When COVID-19 hit, residents with Alzheimer's disease and dementia living in assisted living facilities were especially vulnerable. We created a Telehealth Support Specialist position to conduct telehealth readings within our assisted living community when the patient requires assistance and when there is no caregiver available.

**SUSTAINABLE COLLABORATION AND FUTURE OPPORTUNITIES**

To foster this relationship with the physicians, we created standardized transitional telehealth physician referral workflows and physician communication alerts for changes in the patient's clinical condition. These transitional workflows ensured that all patient referral information was complete and accurate, allowing for remote patient monitoring to be installed in the patient's home within 48 hours. Physicians have access to a cloud-based Telehealth Dashboard, allowing for real-time access to patient clinical information. Unique to our workflow is that it occurs across healthcare sites – from home care to assisted living to the physician's office, providing a true integration of care.



## COLLABORATIVE MODEL

### The Critical Illness Recovery Program (CRIP)

#### COLLABORATIVE ORGANIZATIONS

*University of Rochester Medical Center  
Strong Memorial Hospital  
UR Medicine Home Care*



## BACKGROUND AND DEVELOPMENT

Early interdisciplinary post-discharge care assessment and coordination can help patients who have been critically ill come to terms with their experience and return more quickly to their baseline cognitive, emotional and physical functioning. Previously, some of these interventions were provided in an outpatient pulmonary clinic setting at the hospital. But barriers to engagement and patient follow-up were identified, with a number of patients unable or unwilling to come to the clinic.

With the onset of the COVID-19 pandemic and the increasing number of patients recovering from critical illnesses, in an effort to improve accessibility and continuity, the new program was designed to reach out to patients at home to connect them with the care they need to accelerate recovery.

An interdisciplinary team of leaders and clinicians at Strong Memorial Hospital and UR Medicine Home care designed the CRIP as an innovative transition of care model for recovering critically ill patients with COVID-19.

The model merges traditional home care services with synchronous telemedicine visits by partnering social workers, home care nurses and therapists, physicians and pharmacists to address physical, cognitive and mental health impairments that may arise after critical illness. The program provides timely screening and collaborative interventions in the patient's home, removing logistical barriers and thereby optimizing both patient participation and social distancing during the COVID-19 pandemic. CRIP incorporates hospital identification of patients at high risk for post-intensive care syndrome and the development of a post-discharge home care plan and telemedicine follow-up visit to provide comprehensive, interdisciplinary home visits to patients recovering from severe COVID-19 illness.

**COLLABORATIVE MODEL:****The Critical Illness Recovery Program – *continued*****PATIENT POPULATION**

The COVID-19 pandemic resulted in an increase in patients with acute respiratory distress syndrome, many requiring ventilator support in the intensive care unit. The majority of these critically ill patients were at risk for post-intensive care syndrome, which includes physical, cognitive and mental health impairments after critical illness. These symptoms can last for months or even years. CIRP was designed to address the needs of patients recovering from severe COVID-19 illness and at risk for Post Intensive Care Syndrome (PICS) and support them in their recovery at home.

**GAPS IN CARE**

Patients recovering from critical illness and experiencing PICS were unable to benefit from the specialized pulmonary medicine services provided by the outpatient clinic at the hospital due to the clinic closure during the COVID-19 pandemic. Before suspending its consultative visits, the clinic experienced difficulties with patient access and attendance similar to those experienced by frail COPD patients (patient illness-related factors and scheduling limitations), which would delay the delivery of beneficial interventions.

Home care was already beginning to receive referrals for patients being discharged to home following a prolonged period of hospitalization, which included time in the intensive care unit, ventilator support, severe sepsis and ongoing functional loss due to COVID-19.

These “survivors” of severe COVID-19 illness continued to have ongoing significant deficits consistent with PICS that were best addressed through a multidisciplinary approach at home, including nursing and rehabilitation services to support their recovery and return to a functional baseline.

The opportunity realized was an early identification of these high-risk patients prior to discharge and the integration of the outpatient pulmonary clinic team (previously seeing this patient population in person) with the home care team members through a synchronous telemedicine visit with the patient and caregivers at home.

**DISCIPLINES INVOLVED**

CIRP was a new collaborative effort between SMH and URMHC to provide supportive care and consultation to address the needs of patients recovering from severe COVID-19 illnesses at risk for PICS following hospital discharge.

- **Critical care pharmacists** screen patients for specific criteria while in the intensive care unit.
- **An ICU acute care coordinator and home care coordinators** collaborate to facilitate referrals to the program.

**COLLABORATIVE MODEL:****The Critical Illness Recovery Program – *continued***

- **UR Medicine Home Care nurses, physical therapists, occupational therapists, speech therapists and social workers** provide services in the home and patients then receive telemedicine visits with the home care nurse, team pharmacist and pulmonary/critical care physician or another provider.
- Additional referrals are made as needed to psychiatry/mental health, physical medicine/rehabilitation, otolaryngology or cognitive rehabilitation services depending on the problems identified.

**KEY RESULTS AND OUTCOMES**

In the pre-existing, facility-based PICS clinic, less than 10% of eligible patients presented for follow-up care. In the CIRP pilot, bringing care to patients at home and via telemedicine drastically increased patient engagement, with about 80% of patients accepting home care services and completing the initial telemedicine visit.

In the first six months of the pilot, average 30-day hospital readmission rates among CIRP-enrolled patients were less than 10%.

**SUCCESSSES**

- There was a substantial increase in patient engagement compared to the pre-existing facility-based model and lower hospital readmission rates among pilot patients than control and benchmark.
- The organization saw positive functional improvement on home care Outcome and Assessment Information Set metrics at discharge.
- There was positive qualitative feedback about the program from the project team — select comments:
  - At a time when burnout among clinicians is high, one CIRP provider documented that seeing a particular patient after a prolonged and tenuous ICU stay, was “among the highlights of [her] career.”
  - Another CIRP provider has described the program as “transformative.”
  - URMHC nurses describe the close collaboration with providers a “home care nurse’s dream come true.”
  - “This project was a bright spot in the pandemic.”

During the pilot phase, a sample of CIRP patients were contacted by telephone for feedback about their experience in the program. The feedback was overwhelmingly positive, and that information was used to optimize the program and generate additional ideas for improvement.

**COLLABORATIVE MODEL:****The Critical Illness Recovery Program – *continued*****CHALLENGES**

- Collaboration and buy-in across disciplines and locations were key.
- More frequent evaluations of the resource capacity of staff (both time and ability to meet challenges) were experienced in the workforce due to illness and attrition.
- Early incorporation of workflows across two different electronic health records necessitated “workarounds” to ensure smooth hand-offs of information and to lay the foundation for sustaining the program.
- Data were critical for program evaluation and can take a long time to gather. Earlier outlining of outcome measures could have facilitated more timely data acquisition.

**SUSTAINABLE COLLABORATION AND FUTURE OPPORTUNITIES**

Leadership support at both the hospital and home care settings, along with creative problem-solving, contributed to this program's success. The patient focus was the driver for collaboration, workflow development and team engagement. During the stressful time of the pandemic, this program emerged as a rallying point for very different clinical teams, working in different locations, to focus on the shared commitment to assisting critically ill patients on the road to recovery.

It “met patients where they are” in their own homes and gave a sense of closure for the critical care teams at the hospital to have a longitudinal follow-up with patient “survivors” of COVID-19 illness and see how things improved.

It validated efforts in the ICU that many of the clinicians had witnessed when patients were dying during the first wave of the pandemic. It also elevated the role of home care professionals providing services in the homes post-discharge from the hospital and created an innovative link to have real-time conversations with members of the home care team and inpatient providers to collectively work together to best assist patients.

As a pilot program, the intervention was initially limited to patients positive for COVID-19 who met PICS inclusion criteria (located in any hospital ICU) and were discharged with UR Medicine Home Care services. The pilot was temporarily expanded to non-COVID-19 ICU patients between May and December 2021, but was scaled back in mid-December 2021 due to a surge in COVID-19 cases and resource considerations.

Ongoing plans for CIRP include expansion to ICU patients without COVID-19 illness but at risk for PICS. The organization is also looking at the adaptation of the transitional model of care involving home care and hospital collaboration to other patient populations including home pulmonary rehabilitation and longitudinal disease management programs (such as conditions including stroke, sepsis and lung disease).

Similar types of transitions of care models or longitudinal/chronic disease management programs could be adapted to models of collaboration similar to CIRP. Especially with the usefulness of video telehealth/telemedicine visits in the patient’s home, integrating team members from the hospital and home care gives a more comprehensive picture of a patient’s unique circumstances and helps define the best way to approach a care plan with the patient at the center.



**COLLABORATIVE MODEL****Point of Dispensing Collaborative to Reach Underserved Populations****COLLABORATIVE ORGANIZATIONS***Mohawk Valley Health System**Mohawk Valley Home Care***BACKGROUND AND DEVELOPMENT**

For two years, Mohawk Valley Health System has facilitated a Health Equity Task Force and related workgroups to ensure access to and equitable distribution of COVID-19 vaccines to vulnerable populations, with an emphasis on people of color. This task force and its related minority/refugee workgroup brought together a variety of community organizations to initially focus on educating vulnerable populations and making vaccines available in neighborhoods and community locales that make vaccination both accessible and convenient. The task force has largely been successful because of the commitment and innovation of the organizational leaders engaged in this initiative and a mutual desire to build on this infrastructure to address public health issues in communities of color.

As a hub hospital for COVID-19 vaccine distribution, MVHS was tasked with identifying target populations for vaccine distribution, educating the patient population and breaking down barriers of vaccine hesitancy. By brainstorming, MVHS' point of dispensing staff determined that the best approach for distribution would be to develop a partnership with the community.

**PATIENT POPULATION**

The purpose of the MVHS Mobile POD was to make the vaccine readily available to members of the community in a location that was easily accessible, convenient and not intimidating. Substantial thought went into locations where the Mobile POD was deployed — churches, missions/shelters, home visits, refugee centers, the YMCA and other community sites (libraries, public schools, etc.).

MVHS developed partnerships with “point people” employed at targeted locations. These staff not only shared the information about upcoming vaccine PODs but were onsite the day of the PODs and were familiar faces for those who attended. They were a very valuable and trusted source of recruiting members of the community to come and receive vaccinations.

**COLLABORATIVE MODEL:****Point of Dispensing Collaborative to Reach Underserved Populations — *continued*****GAPS IN CARE**

An initial gap was the need to identify staff to manage PODs and ensuring they had the appropriate training and tools to perform their assigned tasks. Many staff were cross-trained in multiple roles.

Education regarding vaccines was provided onsite. Language assistance/interpretation services were also readily available at each POD. Follow-up appointments for subsequent vaccines were scheduled on the same day (if indicated). Patient demographic information was obtained upon registration so that electronic appointment reminders could be sent.

An MVHS provider agreed to order vaccines for whoever was willing to receive them. If at the time of a second vaccine clinic some of the scheduled patients were absent, staff reached out to each one directly to invite them to come into the mobile POD for follow-up.

**DISCIPLINES INVOLVED**

An “all-hands-on-deck” approach was taken in groundbreaking efforts for this project. Staff from the hospital, home care and community partners all took active roles in identifying target/underserved populations and demographic areas and participated in the vaccine PODs themselves.

Staff involved in vaccine PODs were diverse, including administration, clinicians, infection prevention specialists, pharmacists, information technology specialists, electronic health records experts/trainers, registration/scheduling staff, emergency medical services and a Federally Qualified Health Center.

**KEY RESULTS AND OUTCOMES**

A total of 19 PODs were held in community locations, with 1,815 vaccines administered.

**COLLABORATIVE MODEL:****Point of Dispensing Collaborative to Reach Underserved Populations – *continued*****SUCCESSSES**

This was a positive experience for the MVHS team and built trust within the communities the health system serves.

**CHALLENGES**

The team faced the following challenges identifying:

- Areas where POD deployment was expected to have good attendance;
- How to best communicate POD locations and times to the community; and
- How to best educate the community on the benefits of the vaccine.

**SUSTAINABLE COLLABORATION AND FUTURE OPPORTUNITIES**

Each partner entity is equipped to complete tasks and provide specific care that the other cannot. Each has valuable resources and expertise that in a pandemic were essential to success. With collaborative efforts, MVHS truly accomplished great things.

When mobile PODs began, the COVID-19 vaccine was not readily accessible at provider offices or pharmacies. Expansion of this model could include the distribution of vaccines/treatments not otherwise readily available during rapidly emerging infectious diseases or public health emergencies.



**COLLABORATIVE MODEL****Pulmonary Rehabilitation at Home****COLLABORATIVE ORGANIZATIONS**

*Mount Sinai South Nassau  
South Nassau Home Care*

**BACKGROUND AND DEVELOPMENTS**

During the COVID-19 pandemic, the Mount Sinai South Nassau outpatient clinic providing cardio-pulmonary therapy had to be closed. Home care clinicians were still able to access patients in their homes to provide necessary treatment while reducing the risk of contracting and transmitting disease in a community setting.

The pulmonary at-home rehabilitation program was created to provide a holistic, multidisciplinary approach aimed at improving how patients with chronic and acute lung conditions could enhance their quality of life. This is achieved through pulmonary-specific education, exercise and behavioral interventions.

To create the most effective program, it was designed using a collaborative model involving members of the organization from areas including Mount Sinai South Nassau physicians and clinical staff, community physicians, outpatient therapy representatives and the Mount Sinai at Home managers and clinicians.

**PATIENT POPULATION**

This program targeted patients who had any pulmonary diagnosis, including pneumonia, COVID-19, chronic obstructive pulmonary disease and congestive heart failure. There was a severe need for this care, especially with patients impacted by COVID-19 and the pulmonary-based symptoms it triggered. Evidence-based practice establishes improvement in the quality of lives of people with these diagnoses who participate in pulmonary-based rehabilitation programs.

**COLLABORATIVE MODEL:****Pulmonary Rehabilitation at Home** – *continued***GAPS IN CARE**

This initiative was created to bridge the care gap for those patients who were no longer able to attend the outpatient program. It ensured patients would not lapse in their healthcare needs and therapy pursuits.

**DISCIPLINES INVOLVED**

- **Nursing** was vital in assessing pulmonary needs and educating patients on new medicines, the disease process, the appropriateness of the telehealth monitoring system placement, breathing techniques and any nutritional concerns.
- **Physical therapy** provided specific cardio-pulmonary-based home exercises, reinforced breathing methods and monitoring of vital signs, in addition to providing appropriate education to ensure optimal functional mobility and strength.
- **Occupational therapy** focused on training patients on energy conservation techniques, recommending adaptive equipment and activities of daily living training to allow patients to remain as independent as possible in their home.
- **Home health aides** helped in bathing, dressing and light home management to alleviate any challenges in the home as patient progressed to a more independent level.
- **Social workers** managed any depression/anxiety related to pulmonary disorders, counseling as needed and connecting patients to community-based resources.
- **Dietitian services** provided patients with dietary interventions and encouraged healthy eating habits.
- **Therapy and nursing** visits required objective testing measures at evaluation and discharge to assess the program's effectiveness and outcomes.

**KEY RESULTS AND OUTCOMES**

In general, the outcome measurements were positive, with reductions in pulmonary symptoms and dysfunction in ambulation and daily routine management. Many patients were more likely to remain in their homes and avoided re-hospitalization.

**COLLABORATIVE MODEL:****Pulmonary Rehabilitation at Home** – *continued***SUCCESSSES**

Patients expressed satisfaction with this program because it was sensitive to their fear of going out in the community at the height of the pandemic and limited the discontinuity of therapy they were receiving prior to the outpatient level.

**CHALLENGES**

Challenges included statistics related to the occasional omission of necessary objective measures; these patients were unable to be included in the data. Re-education was provided to staff to minimize these errors and through ongoing examination, the inclusion of statistics improved with time. The pulmonary committee will continue to meet for ongoing monitoring of the program and to pursue any necessary improvements and opportunities for development.

This home care initiative remains in place even though the outpatient therapy clinic has reopened to serve pulmonary patients who are homebound and need these comprehensive services in their home.

**SUSTAINABLE COLLABORATION AND FUTURE OPPORTUNITIES**

The pulmonary at home rehabilitation initiative has benefited patients and the agency will continue to provide this needed level of care. Establishing strong partnerships between hospitals and home healthcare is imperative for continuity of care, patient satisfaction and preventing re-hospitalization. Follow-up and carry-over after hospitalization is essential to ensure the patient can manage their illness appropriately and live as independently as possible in their community.

The future of this initiative looks bright as patients continue to benefit based on objective testing measures and subjective reports. Mount Sinai South Nassau looks forward to expanding the program through any opportunity provided.



**COLLABORATIVE MODEL****Virtual COVID-19 Home Program****COLLABORATIVE ORGANIZATIONS**

*Catholic Health System – Long Island*  
*Catholic Health Long Island Home Care*

**BACKGROUND AND DEVELOPMENTS**

The rising incidence of COVID-19 required consideration of a unique and modifiable approach to care delivery to ensure the greatest impact with the best possible outcomes. Catholic Health developed an innovative, cross-continuum program to care for and manage patients at home during the COVID-19 surge. Employing a patient-centric model, a collaborative partnership was expediently implemented among entities across the care continuum. The primary goal was to decompress the patient volume within system hospitals to manage the most acutely ill individuals, while not compromising patient care and outcomes.

**TARGET POPULATION**

The target population was individuals with a primary diagnosis of COVID-19 who were oxygen-dependent with residual respiratory effects but who could otherwise be safely discharged from the hospital with careful clinical oversight.

**GAPS IN CARE**

This collaborative care model can be applied to other diagnoses by adapting and translating the knowledge gained. Evidence demonstrates early intervention and the combination of provider access, home health services, and remote patient monitoring can significantly reduce readmissions and improve patient satisfaction. Hospital readmission rates remained similar between waves of the pandemic. This collaborative care model can be expanded to reduce readmissions for chronic diseases, particularly those which fall within CMS penalty diagnosis groups.

**COLLABORATIVE MODEL:****Virtual COVID-19 Home Program** – *continued***DISCIPLINES INVOLVED**

This model is based on a truly cohesive approach beginning at the hospital level. Hospital physicians, discharge planners and home care transition nurses collaborate to identify and facilitate discharge, order equipment and coordinate prompt and efficient care provision in the home. Once the patient is home, the home healthcare team, telehealth team and physician encounters assumed oversight. The Catholic Health physician performing virtual visits documents care and at the end of their involvement, providing the patient's primary care physician with a warm handoff.

**KEY RESULTS AND OUTCOMES****April 10, 2020, through June 10, 2020**

- A total of 372 patients were the recipients of this innovative approach to care, with an overall 30-day hospital readmission rate of 0% among patients agreeable to all three care components and 2.4% for those electing only home visits and remote patient monitoring. The close collaboration between physicians and nurses, along with three-times-a-day remote monitoring of vital signs supported the ongoing recovery of this medically fragile population.

**Dec. 14, 2020, through April 14, 2021**

- This model served 409 patients during this timeframe. The number of individuals agreeable to the virtual physician encounter decreased, which was attributed to the growing number of primary care providers relying on virtual encounters to assess their patients. The 30-day re-hospitalization rates were 0% for those receiving all three care components and 3.1% for patients receiving skilled nursing home visits and remote patient monitoring. These results correlated with the initial surge results.

**CHALLENGES**

Supporting individuals who are not technologically savvy to encourage the use of telehealth equipment and scheduling virtual physician appointments was a challenge. By training and coaching staff, the early adopters of the initiative were able to influence additional staff buy-in and motivation.

**COLLABORATIVE MODEL:****Virtual COVID-19 Home Program** – *continued***SUSTAINABLE COLLABORATION AND FUTURE OPPORTUNITIES**

Establishing strong partnerships between hospitals and home healthcare established the following:

- Integration of new technology, improved provider access and evidence-based practice guidelines can reduce 30-day re-hospitalizations for patients with COVID-19;
- The innovative use of shared resources can create an efficient healthcare delivery model;
- Employing an interactive approach to care results in high patient satisfaction;
- A true transition of care process review;
- 24/7 availability of the Catholic Health Care Team;
- Training of primary care providers on the management of COVID-19 patients;
- 24/7 remote patient monitoring;
- Performance of eVisit videoconference with a provider within 24 hours of discharge;
- Continued follow-up with patients through tele-visits until discharge from the program;
- Engagement of patients' families to participate in care;
- Ability to address families' concerns about COVID-19; and
- Warm handoffs from the program back to the primary care provider.

A pilot project is currently underway using this framework with an insurance provider. The insurance provider is identifying high utilizer/high-risk beneficiaries for referral to the pilot program to monitor outcomes. Additionally, this framework is being adapted for Medicare beneficiaries hospitalized at system hospitals with a “penalty” diagnosis.



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