Care Transitions Coach
COVID ED Diversion Program

Eddy Visiting Nurse and Rehab Association
St. Peter’s Health Partners Acute Care
St. Peter's Health Partners Medical Group

February 3, 2022
Acknowledgement

Support for this statewide initiative is provided through a grant by the Mother Cabrini Health Foundation. Thank you to the Foundation for its generous support.
Overall Goal and Components of Grant

Creation of a Hospital-Home Care Collaborative to advance statewide systemic collaboration in pre-acute and post-acute care for COVID and beyond.

- Live webinars
  - Recorded for on demand access
  - Additional recorded technical webinars
  - Statewide summit

- Reporting to Cabrini
  - State Communication
  - Policies needed around new models of collaboration

- Technical
  - Operational
  - Educational
  - Workforce

- Case Studies
  - Collaboration Models
  - Implementable Tools including Adaptable Blueprints

E-Learning Series
Provider Assistance
Results
Resources & Tool Kits

Statewide Hospital-Home Care Collaborative for COVID-19 and Beyond
HCANYS, HANYS & Iroquois Healthcare Association
Hospital & Home Care Collaboration
February 3, 2022
Care Transitions Coach
COVID ED DIVERSION PROGRAM

EDDY VISITING NURSE & REHAB ASSOCIATION
ST. PETER’S HEALTH PARTNERS ACUTE CARE
ST. PETER’S HEALTH PARTNERS MEDICAL GROUP
Introductions

• Dr. Dalfino is board certified in Internal Medicine and was the Chief of Hospital Medicine at SPHP from 2008-April 2021, at which time she became Chief Medical Officer for the Acute Care Hospitals (St. Peter’s, Samaritan, Albany Memorial Hospitals).
Introductions

Michelle Mazzacco, MBA, Interim President, SPHP
Continuing Care Network (home health, hospice, PACE, DME, Infusion, Coach, telehomecare, PERS, home based primary care, palliative care (inpatient & community based), ALS Center, 7 skilled nursing facilities (4 with subacute rehab, 1 greenhouse model), 5 independent senior living communities, 2 memory care residences, 3 adult homes/enriched housing, and Eddy Alzheimer’s Services
Introductions

Susan Warren, RN
Supervisor, Eddy VNRA Coach Program
Several years’ experience as a hospital care coordinator and management of an internal medicine practice.

(Credits to Suzanne Defruscio, RN Supervisor of the Coach Program when this hospital/home care collaboration occurred)
St. Peter’s Health Partners Overview

St. Peter’s Health Partners Promise

St. Peter’s Health Partners is a health organization that provides coordinated ease of access and ease of use across a full continuum of health providers, services and facilities for the Capital Region and northeastern New York.

We do this because we provide care for all in body, mind and spirit, demonstrating that:

We Listen
We Partner in Achieving Health Goals
We Make It Easy
About St. Peter’s Health Partners

People-centered, integrated care is at the heart of St. Peter’s Health Partners (SPHP). Our breadth of services across the continuum of care uniquely positions us to be the region’s leader for quality, efficiency, and innovation in delivering compassionate health care and senior services.

OUR SERVICES

- Advanced Medical Care
- Inpatient Acute Care and Rehabilitation
- Outpatient Rehabilitation
- Urgent Care
- Primary and Specialty Physician Practices
- Adult Day Programs
- Alzheimer’s Services

- Enriched Housing/Adult Homes
- Home Care
- Hospice
- Independent Senior Living
- Nursing Homes
- PACE (Program of All-Inclusive Care for the Elderly)
In December of 2020, the COVID-19 pandemic was having a major impact on our communities, and our hospitals were reaching surge capacity.

Less “regular” hospital patients, more COVID patients, more in the ICU, more on vents, long LOS.

How do we discharge COVID patients from the ED and keep them home?

- Emergency Departments have not historically discharged patients on oxygen.
Dr. Eric Coleman’s Care Transition Model
(modified w/RN trained by a Certified Chronic Disease Self-Management Trainer)

Goal
To improve the patient’s health and well being and reduce rehospitalizations.

The Care Transitions Model is a four-week program that encourages and supports the patient to take a more active role in his/her health needs.

Focusing on the 4 pillars of care:
1. Medication reconciliation (sent to PCP);
2. Primary care provider and Specialist follow-up in a timely manner;
3. Use of patient centered health record that helps guide the patient through the care process;
4. Patient understanding of “red flag” indicators of worsening condition and appropriate next steps.

And:
• Ensures patient has transportation to appointments
• Assess for other needs e.g. food insecurities, inability to afford or obtain medications, etc.

NOTE: THIS IS NOT A CHHA Service. No hands-on care provided. No OASIS.
Care Transitions Coach Program History

• Started in 2010 – funding from Eddy Foundation.
  – Later value-based contracts with BSNENY, MVP and CDPHP
• Serving 2,000 a year.
• Targeting chronically ill patients (HF, COPD, Pneumonia, Diabetes, etc.) at high risk for readmission.
• Readmissions previously ranged 20-30%, now 5-10%.
• Adapted during DSRIP for Medicaid patients, including those with behavioral health / substance abuse needs.
• In 2020, adapted for high-risk OB patients for BSNENY.
• In 2021, adapted for high-risk ortho patients (MC FFS).
Collaboration and Approach

The Coach Team Redefined - Stepped up to meet the challenge!

For this presentation we have divided our process and results into the
- December 2020 - July 2021, alpha Covid surge
- August 2021 – November, delta Covid surge
- December 2021 – present, omicron Covid surge

The ED team developed criteria for who would be referred and how they would be referred.
ASSESS FOR HYPOXIA
1 min walk in place: Patient walks in place briskly for 1 min continuously.

1 min sit to stand: Patient continuously performs a sit to stand at the bedside for 1 min. Inability to perform is failure.

ADMISSION/DISCHARGE PLAN
- Exertional SpO2 < 90% → Admit
- Exertional SpO2 90-92% and COVID symptoms > 7 days → Admit

- Exertional SpO2 90-92% and COVID symptoms days 1-6 or
- Exertional SpO2 92-94% →
  - D/C with PCP follow-up (Teams spreadsheet)
  - Oximeter & thermometer
  - Coach program
1st Surge (Alpha)

Criteria for Eligibility

- Ages 18 yo and over
- High risk for readmission
- Comorbidity
- Oxygen saturation less than 94% while in ED
- Patients must have a Primary Care Provider
Different Referral Process

**Original Coach Program:**
- Screeners in each hospital
- Proactively identify patients who can benefit
- Hospital staff also refer
- Screener obtains patient agreement

**Coach COVID ED Diversion:**
- ED team identifies patients
- ED team adds to Teams spreadsheet
- Coach Team monitors the Teams spreadsheet (7 days a week) and follows up with patients
- Medical Group also monitors Teams spreadsheet for other follow-up
<table>
<thead>
<tr>
<th>Today's Date</th>
<th>Site of Admit</th>
<th>Unit Only Entered By</th>
<th>Patient Name</th>
<th>COVID Status</th>
<th>Risk Score</th>
<th>Medical Group - Do Not Complete - Automatically Populated</th>
<th>Eligible for COVID Coach Program</th>
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**The Eddy**

St Peter's Health Partners
A Member of Trinity Health
Coach Intervention: 1st Surge (Alpha)

- **Hospital:** Discharged from ED on oxygen, with pulse ox and thermometer, zone sheet, educational material
- **In-Home Visit Replaced** with telehealth or phone call encounter; same day as discharge or next morning
- **Call Frequency Increased** from weekly for 4 weeks to daily for 14 days, including weekends
- **24/7 On Call RN added** (NEW: patients were scared)
  - Review of oximeter use and when to report.
  - Educate patient/family on COVID zone sheet and CDC general information
  - Ensure f/u PCP/Specialist visit/telemedicine encounter is scheduled timely
  - PCP Interventions: Same day telehealth PCP visit. Might start on dexamethasone or AB, coordinate MAB treatment.
SPHP
Primary Care Provider Algorithm

SPHP Ambulatory COVID + /PUI Decision Tree

**Primary Care Provider Algorithm**

- **SPHP ED**
- **Algorithm Used**
- **TSPHP ED**
- **Primary Care Provider Algorithm**

**SPHP Ambulatory COVID + /PUI**

- **Decision Tree**

**Covid + Clinic**
- Already tested positive
- Dyspnea or worsening symptoms

**Urgent Care**
- Moderate symptoms
- Has not been tested
- >3 days symptoms

**Emergency Room**
- Severe symptoms
- Respiratory Distress

**Ambulatory Lab testing**
- Covid 19
- Rapid Strip
- Rapid Flu

**400 Patton Creek**
**1 Tallow Wood Drive**

**Clinical improvement?**

- **Yes**
- **Follow up with PPO**

- **No**
- **Direct Admission**
- Continued worsening symptoms
- >5-7 days of illness
  - Call 518-252-REDS (2357)

**Coach Program, Home O2 monitor and PCP appointment**

- Engage Case Management to set up COACH program or use Teams; text COACH with patient information
- COVID discharge, quarantine, & follow-up instructions
- Referral for Antibody infusion @ AMH per criteria (see back)
- May consider dDA Ribon PO only for 2+eks no contraindication or allergy

**Frequent Factors that Increase MACE**
- Age >50 years, HTN, CHF, CAD, DVT, ESRD-20, pulmonary disease, immunosuppression, HIV, intravenous, transplant, pregnancy

- Inter-MI: ACL <15, ALT >100, CRP >300,
- LUS <2500mg/L, BUN >20, CK >2x upper limit of normal, D-Dimer >500ng/mL

- Elevated triglycerides

- Vital: RR >24, HT >134, SBP >90, Eventual D: decrease, Hb<10, Po2<200mmHg
Only one payer declined coverage (health plan case managers were calling members). However, due to our hospital workforce shortages, and the need to assure our ED physicians of a safe discharge plan, we continued to provide the service at no cost to the patient.
COVID-19

**Every Day**
- Wash hands often.
- Take your temperature.
- Avoid touching your eyes, nose, and mouth.
- Stay 6 feet away from others whenever possible.
- Avoid sharing household items.
- Clean household surfaces that are touched often.
- Avoid contact with a person positive for COVID-19 or with someone who is waiting for test results.

**Green Zone**
- No fever
- No cough or sore throat
- Easy breathing
- No contact with a person positive for COVID-19 or with someone who is waiting for test results.

**Yellow Zone**
- Call your home care nurse at ____________ , or call your doctor at ____________
- Temperature more than 99.5°F (37.5°C)
- New cough or sore throat
- Contact with a person positive for COVID-19 or with someone who is waiting for test results

**Red Zone**
- Call your doctor at ____________ for direction.
- Temperature of 101°F (38.3°C) or greater
- Shortness of breath
- Worsening cough or sore throat
Steps to help prevent the spread of COVID-19 if you are sick

Follow the steps below if you are sick with COVID-19 or think you might have it, follow the steps below to help protect other people in your home and community.
10 Ways to Manage Respiratory Symptoms at Home

If you have fever, cough, or shortness of breath, call your healthcare provider. They may tell you to manage your care from home. Follow these tips:

1. Stay home from work, school, and away from other public places. If you must go out, avoid using any kind of public transportation, ride sharing, or taxis.
2. Monitor your symptoms carefully. If your symptoms get worse, call your healthcare provider immediately.
3. If you have a medical appointment, arrange a time ahead of time and tell them that you have or may have COVID-19.
4. For medical emergencies, call 911 and notify the dispatch personnel that you have or may have COVID-19.
5. Get rest and stay hydrated.

6. Wash your hands often with soap and water for at least 20 seconds or clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol.
7. As much as possible, stay in a specific room and away from other people in your home. Also, you should use a separate bathroom, if available. If you need to be around other people in or outside of the home, wear a face mask.
8. Avoid sharing personal items with other people in your household, like dishes, towels, and bedding.
9. Clean all surfaces that are touched often, like counters, doorknobs, and electronic devices. Use household cleaning sprays or wipes according to the label instructions.
10. Cover your cough and sneezes.
Prone Positioning

PHOTOS BELOW TO DEMONSTRATE THIS:

LAS FOTOS DEBAJO DEMUESTRAN ESTO:

1. 30 minutes – 2 hours: laying on your belly
1. 30 minutos – 2 horas: acostado sobre su estómago (boca abajo)

2. 30 minutes – 2 hours: laying on your right side
2. 30 minutos – 2 horas: acostado sobre su lado derecho

3. 30 minutes – 2 hours: sitting up
3. 30 minutos – 2 horas: sentado

4. 30 minutes – 2 hours: lying on your left side
4. 30 minutos – 2 horas: acostado sobre su lado izquierdo

Then back to Position 1. Lying on your belly!
Luego, vuelva a la posición 1. (Acostado sobre su estómago [boca abajo])

Self Positioning Guide, Elmhurst Hospital, SB
Satisfaction Survey

SATISFACTION SURVEY

COVID EMERGENCY ROOM COACH PROGRAM

Our records indicate that you were recently in the Emergency Room and were referred to our Covid Coach Program. Please fill out our brief Patient Satisfaction Survey so that we may continue to strive to provide the best care possible.

Were you provided information on the Coach program during your Emergency room visit?
Yes______ No______

Were you provided with an oximeter (to check your oxygen level at home) and a thermometer during your ER visit?
Yes______ No______

Did you find the daily follow up calls from the nurse helpful?
Yes______ No______

Did the nurse provide education on Covid? E.g. Quarantine, ways to prevent spread of infection, use of the oximeter and when to call the MD?
Yes______ No______

Did the nurse review the importance of following up with your primary care physician?
Yes______ No______

Overall were you pleased with the follow up care you received after your ER visit?
Yes______ No______

Please provide any additional comments below so that we may better serve you in the future.

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

433 River Street, Suite 3000
Troy, New York 12180
Ph 518.274.6200

Sphp.com
1st Surge Outcomes (Alpha)

• Timeframe: December ‘20 through July ‘21
• 285 Patients Served

• 29 (10%) returned to the ED/hospital
• 94% overall satisfaction rating
Patient Feedback

- I found the daily calls helpful and reassuring. She answered my questions, and I had many. She offered helpful advice to recover daily. It was good to know that I had someone checking on me daily. She was wonderful and this is a great service. Covid is scary and she calmed my fears.
- Having a coach was a great thing. I am very happy to have a nurse checking in. Every day was different with the virus and I had questions and concerns when she did call. She was very helpful.
- We were very happy with the follow up from nurse Cathy. She was very helpful with medical information and also helped with our anxiety over what to do and what to expect with the recovery from Covid. We are very grateful for her calls.
- We couldn't have a better coach. We had a lot of questions and Ellen answered all of them.
- I can't answer number 1 because I don't remember. Our contact, Amy, could not have been more caring and informative. I greatly appreciated her input and compassion.
- The coach program was very nice and helpful. I recommend it to all that need it. Thank you for your help.
- I welcomed my daily phone calls from Carolyn. Knowing that she would call made me feel comfortable being home. I spoke highly of this service and of her to many.
- Nurse Ellen was amazing and genuinely concerned. When I wasn't provided with an oximeter, she made sure one was mailed to me.
- Elizabeth was excellent!!! Very informative and very pleasant and caring. I looked forward to her calls every day. Please give her a big thank you!!!!
- ER nurse and doctor were the best!!
2nd Covid surge Delta variant August 2021 to present

- Our ED referrals decreased in May-July but in August 2021 we saw a sudden increase in our referrals which was the beginning of the second surge.

- This was different:
  - Workforce shortage
  - Patients were vaccinated
  - MAB treatments available
  - Less severity of illness for those vaccinated
  - Limited ICU and medical/surgical beds
2\textsuperscript{nd} Surge (Delta)

- Many COVID positive patients were not as ill and did not want or need the 14-day follow up.

- The Coach team was also finding it difficult to cover all of the ED referrals due to our RN shortage.

- Coach, ED and Medical Group met to develop new criteria for eligibility for the program.
Program Changes 2\textsuperscript{nd} Surge (Delta)

- Eliminated On Call RN mid-way thru the 2\textsuperscript{nd} surge (no need)
- Continued refinement of the Teams spreadsheet
2nd Surge Outcomes (Delta)

- Timeframe: August 2021 through November 2021
- 174 served
- 4 (2%) returned to the ED/hospital
- 100% overall patient satisfaction
3rd Surge Outcomes (Omicron)

- Timeframe: November 2021 through present (1/25/2022)
- 142 Served
- 7 (5%) returned to the ED/hospital
- Kelly was awesome!
- Thank you so much!
- Thank you for the concern and follow up care!
- Elizabeth was great. She called every day and followed up with me.
- It was nice knowing someone would call and check on me daily. Especially with my husband being out of town. I think this program is important and critical for patients without medical experience.
- They did a great job. I don’t think they need to change anything!
- I think they did a great job. Nothing further is needed to improve.
- Thank you for all the follow ups.
Special Thanks

• Dr. Christopher Guzda
• Suzanne Defruscio, RN
• Matthew Van Pelt, Medical Group
• Cailin Burke
• Dr. Katrina Kardos
Questions?

Please feel free to reach out to us for more information:

- Michelle.Mazzacco@sphp.com
- Susan.Warren@sphp.com
- Thea.Dalfino@sphp.com
## Next Scheduled Webinar Series

<table>
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<th>Name of Session</th>
<th>Collaborating Organizations</th>
<th>Date**</th>
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<td>February 24</td>
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<td>Montefiore Home Care</td>
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<tr>
<td>Innovations in Care and Management through Hospital-Home Care Collaboration</td>
<td>Catholic Health System</td>
<td>March 10</td>
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<td>Catholic Home Care</td>
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<tr>
<td>Collaboration of Care for Patients with Mental Illness Across the Health System</td>
<td>Catholic Health Mercy Hospital</td>
<td>April 7</td>
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<td>Catholic Health Home Care</td>
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**All events are from noon to 1pm**
Important Links

RESOURCE PAGE

https://hca-nys.org/statewide-hospital-home-care-collaborative

https://www.iroquois.org/hospital-homecarecollaboration/

https://www.hanys.org/quality/patient_safety/
Contacts

**HCA/HCA E&R**

Al Cardillo  
President and CEO, acardillo@hcanys.org
Rebecca Fuller Gray  
Executive Vice President, rgray@hcanys.org
Lauren Ford  
Director for Research, Program Development and Policy, lford@hcanys.org

**HANYS/HERF**

Dora Fisher  
Director for Post-Acute and Continuing Care, dfisher@hanys.org
Christina Miller-Foster  
Senior Director, Quality Advocacy, Research, and Innovation, cfoster@hanys.org

**IHA**

Eileen Murphy  
Senior Director, Special Projects, emurphy@iroquois.org
Kathy Kirvin  
Director, Marketing and Communications, kkirvin@Iroquois.org