Summary

CUSTOMER

Mount Sinai Hospital

CHALLENGE

Identify Medicaid patients eligible for Health Home program when they visit the Emergency Department.

OUTCOME

Time-consuming manual identification process replaced by automated system built on InterSystems HealthShare®.

Mount Sinai Hospital + InterSystems

Using HealthShare, New York City Hospital Builds App to Enroll Chronically Ill Medicaid Patients in Health Homes
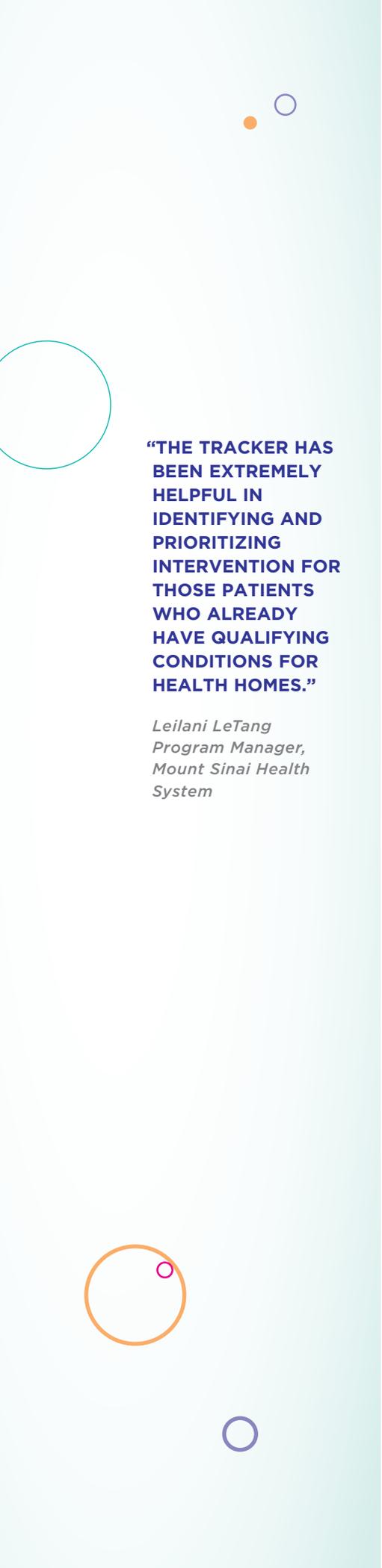
As state and federal agencies strive to reign in healthcare costs, health systems like Mount Sinai Hospital in New York State have become part of a program to improve the care management of chronically ill Medicaid recipients.

Last year the state gave hospitals the responsibility of identifying and referring these patients to Health Home programs, which provide care coordination services.

According to the mandate, New York hospitals must "establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Home providers." Hospitals failing to comply face reduced Medicaid reimbursements.

Created by the Affordable Care Act of 2010 as an optional Medicaid State Plan benefit and embraced by New York State a year later, the Health Homes program ensures that qualifying Medicaid patients get regular care and services with the goal of preventing unnecessary emergency department (ED) visits and hospital admissions.

Mount Sinai Health System is New York City's largest integrated delivery system. With the addition of South Nassau Communities Hospital, it includes eight hospital campuses, a leading medical school, and a vast network of ambulatory practices throughout the

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greater New York region. About 40 percent of patients treated in its seven EDs qualify for the Health Home Program.

The challenge for the Mount Sinai team tasked with meeting the state mandate, under Administrative Director of Care Management Valerie Slater and Program Manager Leilani LeTang, is identifying the ED patients who qualify for the program.

State Mandate Requires Identification of Medicaid Patients with Complex Conditions

The first method was manual. Care coordinators had to review individual health records of ED patients in search of those on Medicaid who met Health Home requirements: two or more chronic conditions or HIV/AIDS, a serious mental illness, or a serious emotional disturbance.

They then had to introduce these patients to the Health Home program, preferably while they were still in the ED, enroll them, or refer them to other members of the team for future follow up. The state requires documentation of the hospital's efforts to meet the mandate, so results of these meetings went into an Excel spreadsheet.

The process was labor-intensive, and administrators wondered whether all or part of it could be automated.

Hospital Builds App to Automate and Expedite Identification Process

The Mount Sinai health information exchange IT team went to work, creating and delivering its ED Health Home Tracker app, built on InterSystems HealthShare®, in just two weeks. LeTang, Program Manager at Mount Sinai, says training to use the application was minimal.

HealthShare pulls the necessary patient data into the app, then flags patients qualified for Health Homes. LeTang and her team know that any patient the Tracker flags as priority one is qualified for Health Homes and triggers an outreach referral.

In addition, the app sends alerts. When a Medicaid patient is registered to any Mount Sinai ED, an admission, discharge, and transfer (ADT) alert triggers email notifications to the appropriate Health Home care coordinators. Depending on the patient's admission location, a filter determines which care coordinator to notify.

These secure emails note patients' Medicaid identification numbers, names, and dates of birth, enough information to locate them in the Tracker. When care coordinators need more information, they can click a link to open the HealthShare Clinical Viewer, a user-friendly window into a patient's unified care record.

Care coordinators now record outcomes of their meetings with patients in the Tracker rather than in an Excel spreadsheet.

"One of the challenges of this mandate is the ED setting," Slater says. "It can be a chaotic environment, not always conducive to patients enrolling on the spot. The goal is to establish some kind of initial rapport or connection with the patient."

Most patients are referred to a call center for follow up.

These referrals appear in a daily report of Health-Home-qualified patients who have not enrolled in Health Homes. The report becomes a call list for a team of outreach staff.
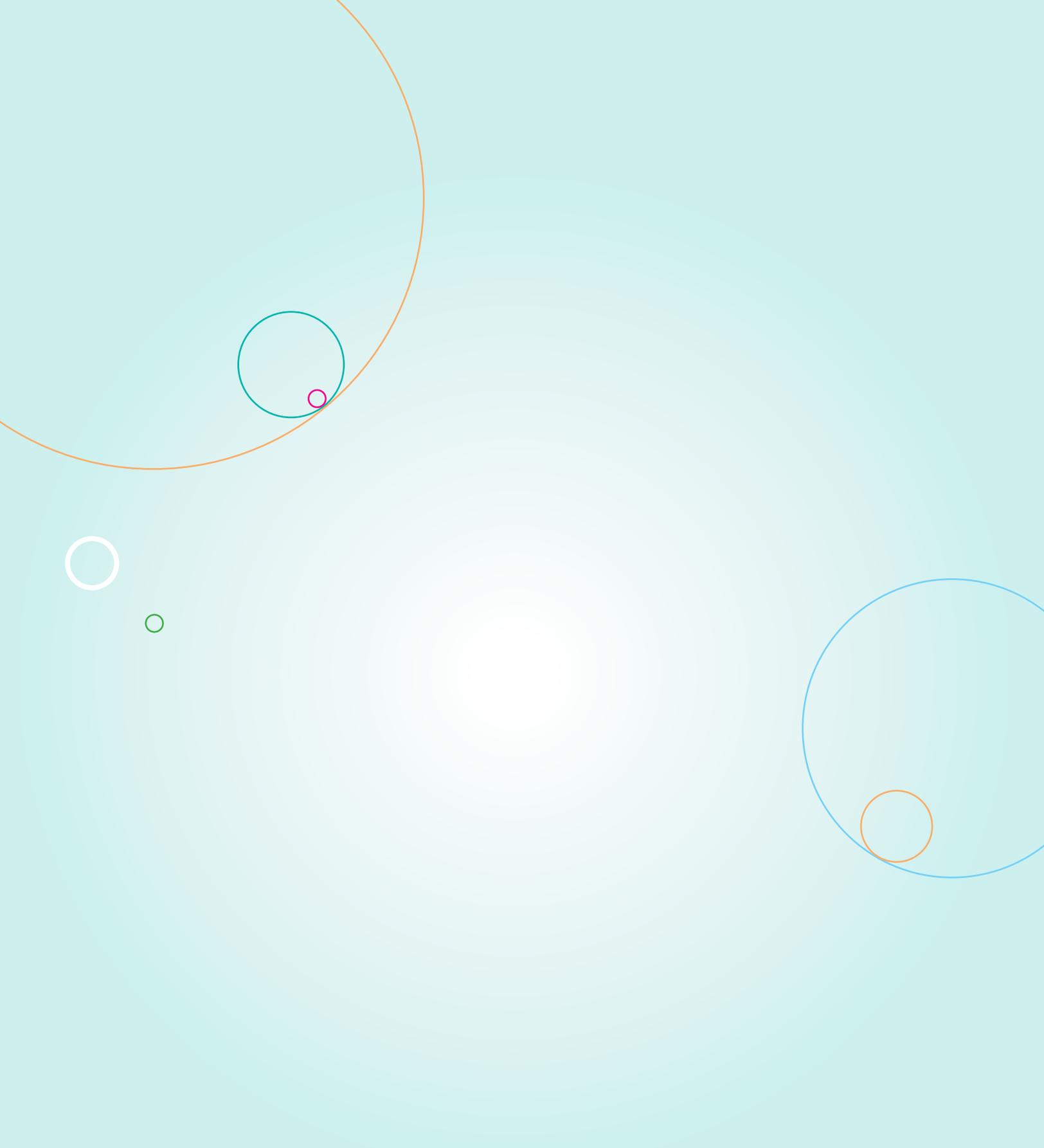
Enhancements Anticipated

Now that Mount Sinai has the team and the process for Health Homes in place, it will shift focus to increasing connectivity and program efficiency. Slater estimates 60 percent fewer records need to be checked manually today, a substantial time savings for her staff.

The call center that follows up on qualifying patients who don't immediately enroll has its own contact management system and downloads the patient names from the Tracker.

Mount Sinai could also soon face another mandate, this one to track Health-Homes-qualified inpatients.

LeTang is confident the Tracker's functionality can be expanded to meet these and other challenges.

"The Tracker has been extremely helpful in identifying and prioritizing intervention for those patients who already have qualifying conditions for Health Homes," LeTang says. "Also, we can track outcomes of our work all in one place."

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