Executive Office of
Aging & Independence

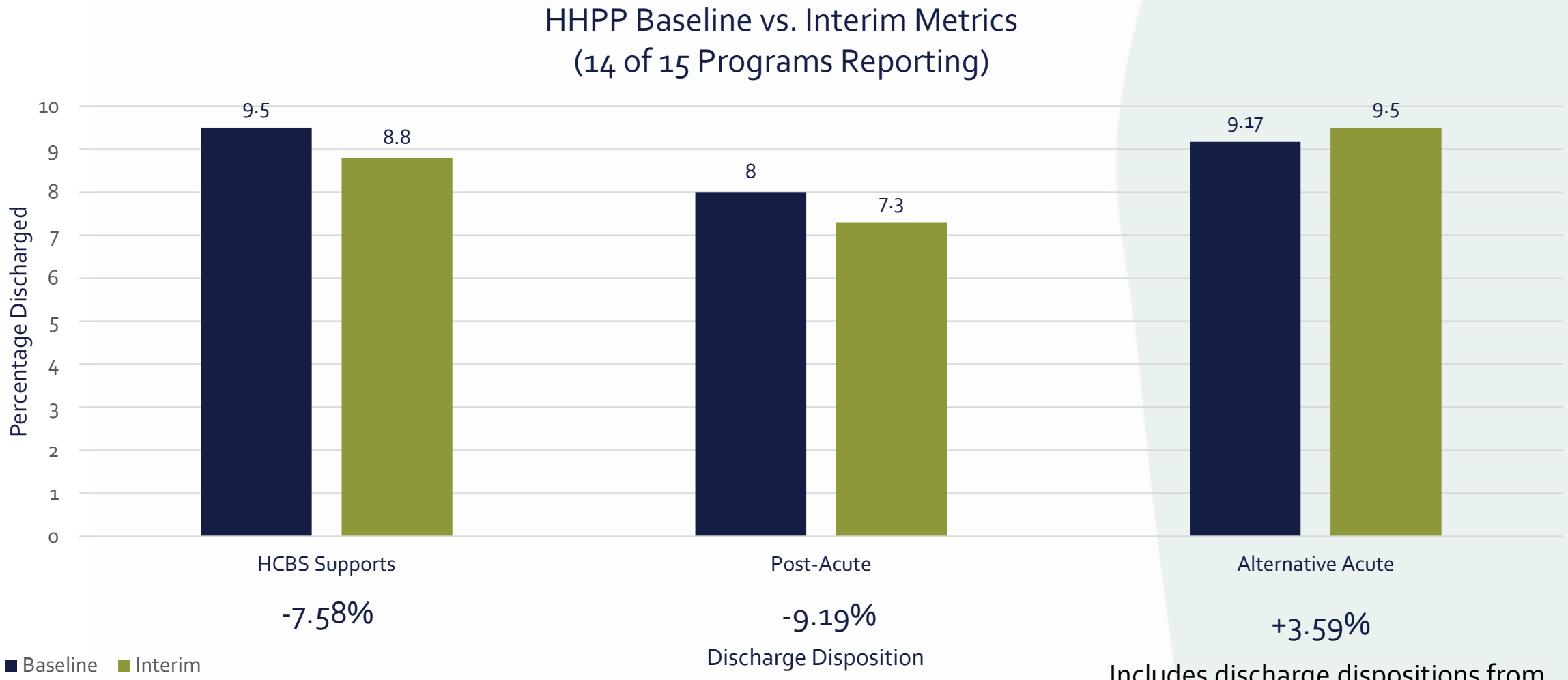
Your Partners in Aging.

Hospital to Home Learning Collaborative
March 26, 2025, 1:30-2:30pm

Agenda

- Review of HHPP Baseline and Interim Reports
- HHPP Presentations
  - Elder Services of Berkshire Country (ESBCI) and Berkshire Healthcare Systems
    - Maureen Tuggey – Client Services Director, ESBCI
    - Breonna Cunningham – Hospital Liaison, ESBCI
    - Lauren Larison, LSW – Client Services Supervisor, ESBCI
    - Allison Kleiner, BSN RN, CCM, ACM - Clinical Manager of Case Management, Berkshire Healthcare Systems
  - Minuteman Senior Services (MSS) and Emerson Hospital
    - Leslie May-Chibani, MBA, LSW - Assistant Director, Compliance and Privacy Officer, MSS
- Discussion Questions
- Wrap Up

Review of HHPP Baseline and Interim Reports



Includes discharge dispositions from one program that were not HCBS Supports or Post-Acute

Berkshire County Hospital to Home Partnership Program

Elder Services of Berkshire County, Inc.

Berkshire Health Systems

A COLLABORATION BETWEEN ELDER SERVICES OF BERKSHIRE COUNTY, INC. & BERKSHIRE HEALTH SYSTEMS

The Berkshire County Hospital to Home Partnership Program: Round Three Grant Program

Elder Services of Berkshire County, Inc. HHPP Team

Breonna Cunningham, CHW, Hospital Liaison

Lauren Larison, LSW, Client Services Supervisor

Maureen Tuggey, Client Services Supervisor

Berkshire Health Systems HHPP Team

Allison Kleiner, BSN RN, CCM, ACM, Clinical Manager of Case Management

Michelle Schnopp, RN, MSN, ACM, Director of Case Management

Roberta Gale, MSN, MBA, RN, Vice President of Community Health

Program Background

- Monthly Project meetings began in June, 2024
- ESBCI identified an internal candidate who transitioned from an AARPA-funded Community Health Worker role to the Hospital Liaison over the summer of 2024.
- While familiar with the Aging & Disability (A&D) database, the Hospital Liaison needed to be trained on the eligibility requirements for the State Home Care Program, and how to complete the required assessments and corresponding paperwork.
- The Hospital Liaison started having a regular presence at Berkshire Medical Center (BMC) towards the end of August 2024.
- ESBCI gave a presentation about the HHPP at the Case Management staff meeting in September 2024.
- The Hospital Liaison was introduced to North Adams Regional Hospital(NARH) in October 2024.
- The Hospital Liaison and other ESBCI staff meet with the Case Management team at Fairview Hospital in Great Barrington in February 2025.
- The Liaison has a presence at the hospitals 3-5 days per week.

Hospital Program Structure

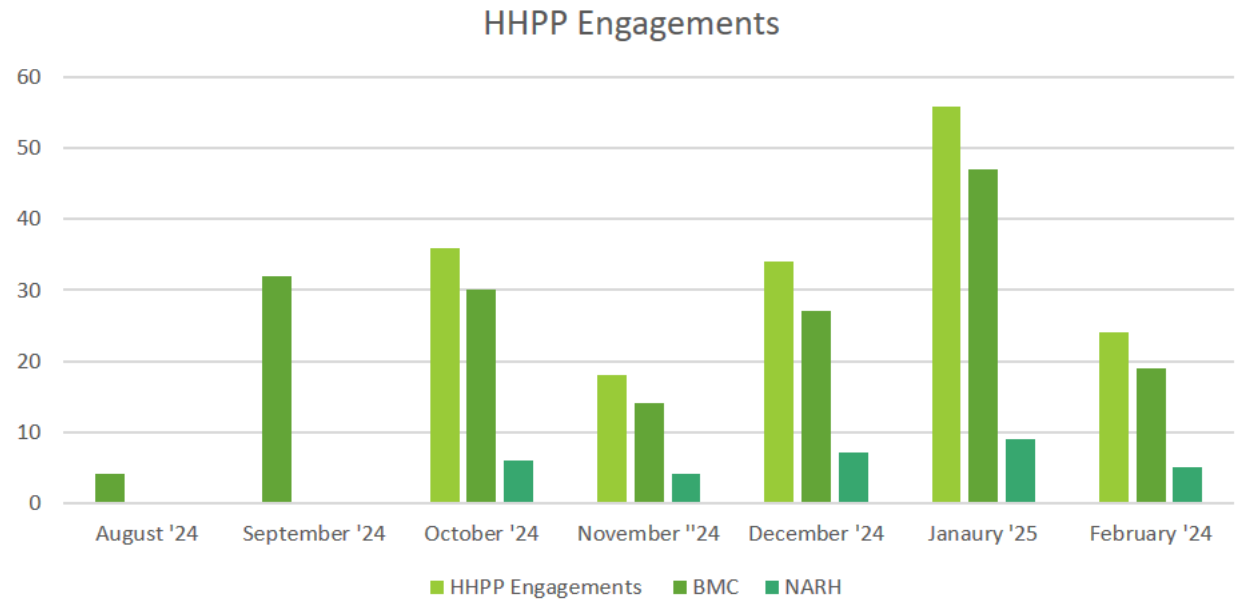
- HHPP referrals focus on patients 60 years of age or older or under 60 with an ADRD diagnosis.
- The Liaison has a dedicated workspace at all three facilities.
- The hospital provided the Liaison with a laptop.
- The Liaison has access to Berkshire Health Systems' electronic medical record, Meditech.
- The Liaison communicates with hospital staff and receives referrals, via the secure app, Tiger Text.
- The Liaison participates in BMC and NARH case management and social work daily morning huddle via TEAMS
- The Liaison also participates in the virtual Medical Director's interdisciplinary daily rounds in reviewing patients with a length of stay greater than 1 day and those who have barriers to discharge.
- The Liaison completes physical rounds at the hospital with individual case management and social work staff.
- The Liaison reports to the Director of Case Management and the Clinical Manager of Case Management while on site.

ESBCI Program Structure

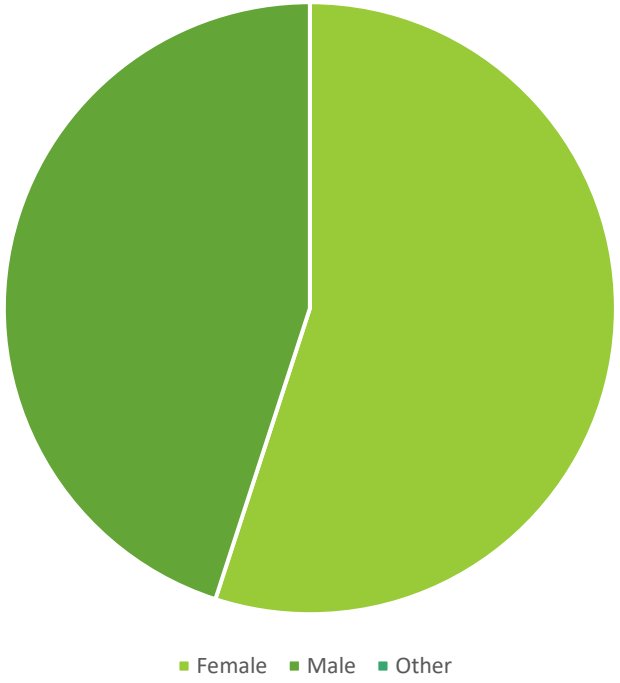
- The Liaison documents in the Aging & Disability (A&D) database.
- When the Liaison receives a new referral, they check A&D to determine if the consumer is an active ESBCI consumer.
- The Liaison can complete a State Home Care (SHC) referral while the consumer remains in-patient.
- In-patient assessments are presented within two business days at the ESBCI's daily IDT meeting for openings, and the assigned SHC case manager is present to allow for a warm hand-off. The assigned SHC case manager will conduct an in-home assessment within 10 business days of the IDT meeting.
- If the SHC assessment cannot be completed before discharge, the Liaison will make the referral via ESBCI's Information and Referral Department.
- The Liaison can initiate referrals for emergency Home Delivered Meals before discharge and other referrals, as appropriate.
- Individuals who do not want or are not eligible for SHC services are provided with a resource folder and are called two business days post-discharge to see if they have any unmet needs.
- Individuals who transition to a SNF are given information about the Community Transition Liaison Program (CTLP) and the names of the CTLP Liaison who covers the facility they will be admitted.
- There are established HHPP dedicated Care Enrollment for each hospital to track engagements.

Berkshire County HHPP Engagements at a Glance

Since the end of August 2024, there have been 204 HHPP engagements. Engagements are defined as case consultation with hospital staff, providing information consumers & their families, State Home Care assessments, tracking current Home Care, SCO, or One Care members, or initiating referrals for services

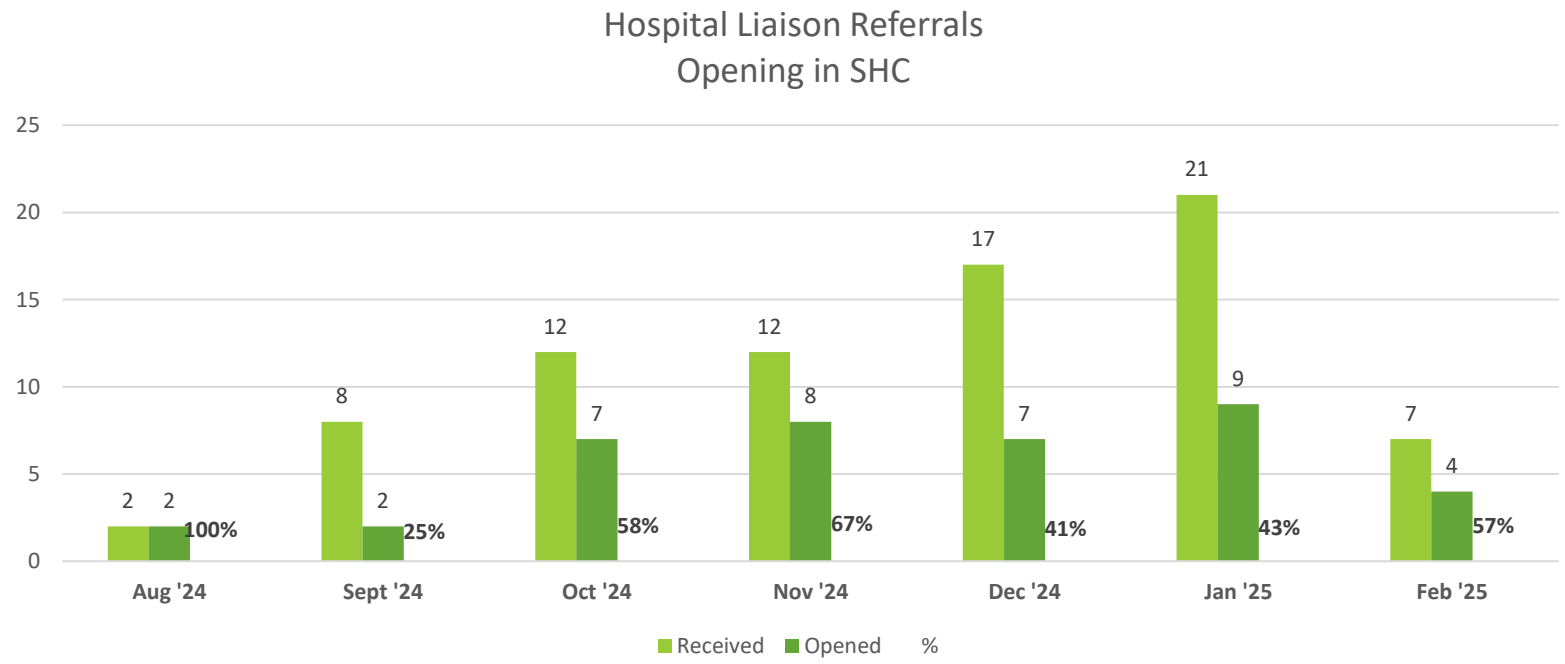


Berkshire County HHPP Engagements at a Glance



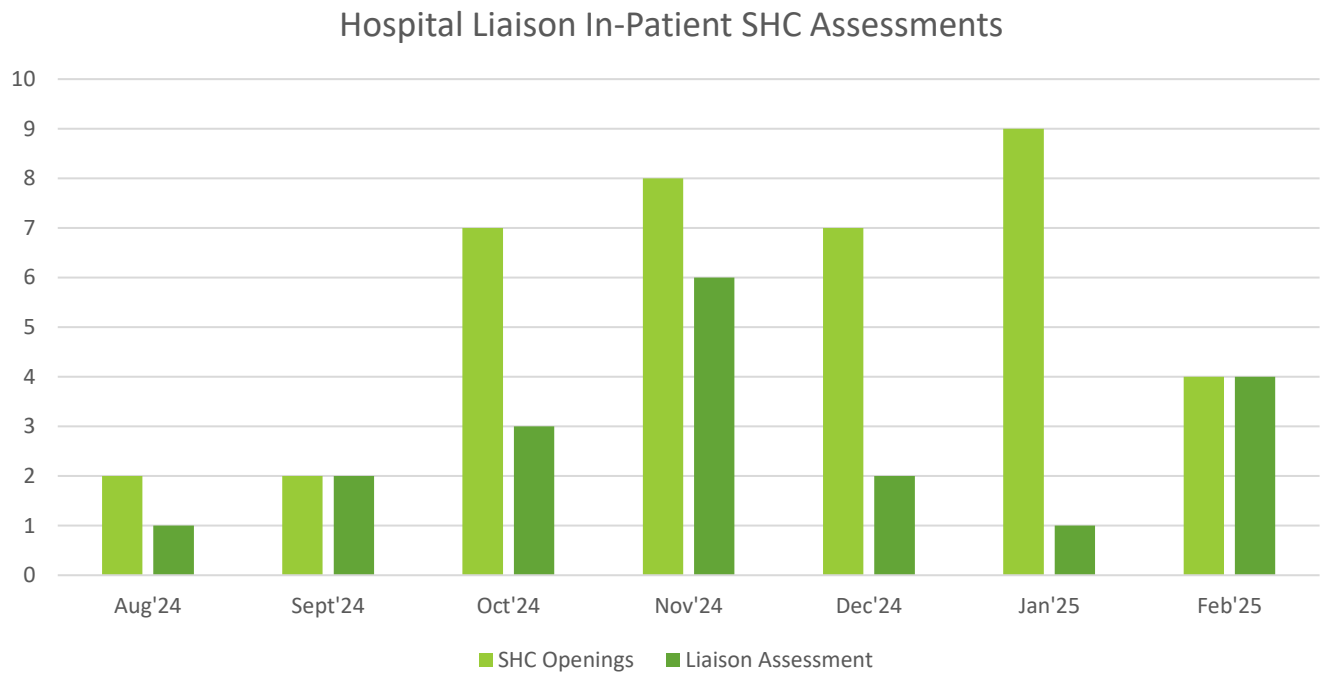
HHPP State Home Care Referrals

In the six months of 2023, 30% of the SHC referrals from local hospitals to ESBCI opened for services. The Hospital Liaison initiated 73 SHC referrals between August'24-February '25. 53% of these referrals resulted in new SHC consumers



HHPP State Home Care Referrals

The Hospital Liaison completed 19 of the 39 State Home Care Assessments that resulted in new ESBCI consumers.



Berkshire County HHPP Case Discussion #1

A 73-year-old woman was admitted to Berkshire Medical Center in November. The hospital Case Manager was referred to the Hospital Liaison to assess for post-discharge services. The Hospital Liaison met with the consumer at the bedside before her surgery to discuss a preliminary discharge plan for the consumer but she requested that an initial State Home Care assessment not be completed until after her surgery.

Due to complications from the surgery, the consumer remained hospitalized until the end of February. The Hospital Liaison monitored her status during that time. As her discharge date neared, the hospital Case Manager made another referral for Hospital Liaison engagement. The Liaison met with her once again at beside. The consumer reported strong informal support to assist her with cleaning and grocery shopping. In addition to regular appointments at the wound center, she would also be receiving weekly in-home wound care from a certified agency. She declined the need for State Home Care services at that time.

Berkshire County HHPP Case Discussion #1

However, she did express concern regarding the cost of the newly prescribed medication, Eliquis, which is approximately $530 a month. Before the consumer's discharge home, the Hospital Liaison submitted a SHINE referral and a request for emergency home-delivered meals to begin within two business days of her discharge.

When the Hospital Liaison called the consumer two business days after her discharge she reported she was doing well but was having difficulty arranging transportation to her medical appointments. The Liaison reviewed the transportation options available to her in Northern Berkshire County. The consumer stated she would be most comfortable utilizing the services of the North Adams Council on Aging.

The Hospital Liaison contacted the COA to arrange the initial ride for the consumer. In addition, the Liaison mailed the consumer a list of Northern Berkshire County medical transportation resources along with a copy of North Adam's COA newsletter.

Berkshire County HHPP Case Discussion #2

In September, a 62-year-old man was admitted to Berkshire Medical Center with dx of Cerebellar Stroke. He was referred to the Hospital Liaison by the hospital case manager as he was not appropriate for a short-term nursing facility stay.

The Liaison met with the consumer bedside at the hospital. The presenting concerns at the initial engagement were:

- He was actively using heroin and cocaine
- He had been issued a 30-day notice to quit for non-payment of rent
- He was without a working phone
- He reported not having any food in the home for himself or his dog
- He was enrolled in a One Care Plan but had no services or support because the Care Partner was unable to contact him because he did not have a phone.

Berkshire Count HHPP Case Discussion #2

The Liaison coordinated with the One Care Plan and arranged for a nursing assessment to be completed while the consumer was still in-patient. Even before the LTSC referral was received, the following actions were taken on his behalf by ESBCI staff:

- ESBCI discretionary funds were used to purchase groceries and a Tracfone and minutes.
- A referral to the Berkshire Humane Society provided food for his dog and regular deliveries were set up.
- An Adult Protective Services report was filed.
- Referrals were made to ESBCI's Options Counseling Program and the local Tenancy Preservation

Berkshire Count HHPP Case Discussion #2

Despite ongoing collaboration between the Long Term Support Coordinator (LTSC), the Protective Services Worker, and the Tenancy Preservation Program, the consumer was evicted from his apartment at the end of February. However, instead of moving into transitional housing secured for him, he finally agreed to in-patient treatment for his substance use disorder.

Two weeks later, the member called the LTSC Supervisor to report he had successfully detoxed, had transitioned to a facility for aftercare treatment, and was planning to move to a sober living house after that. A quote for the journal entry, “The member reports he wanted to let everyone know he is sober and safe. He wanted to thank everyone for all the help that was received - he reports he greatly appreciates it.”

Berkshire Medical Center: Standards of Excellence Star of the Month Program

Each month Berkshire Medical Center recognizes exemplary staff who represent the hospital's Standards of Excellence.

Breonna Cunningham, Hospital Liaison, was nominated by the Case Management department for her excellent representation of January's Standard of Excellence "Ownership".

Minuteman
SENIOR SERVICES

Minuteman and Emerson Hospital's Collaboration

Hospital to Home Liaison Program

Round 3 awardee (8/15/24 to present)

3/26/2025

Our Team

Roles involved:

- MSS- Assistant Director, Liaison, support of Program Managers
- Emerson Hospital – Director of Care Management and Director of Social Work

Intervention Components

Care Transitions Model plus

- Hospital bedside visit
- Home visit 2 days post discharge
- Follow up calls over 90 days
- Identify a personal goal
- Review medication questions, management, and ensuring delivery
- Follow up appointments
- Symptom Management
- Assess for unmet social health needs
- Care Coordination
- Liaison part of rounds and access to EHR

Innovations

- Expedited referrals
- Schedule Calendar
- Frozen meals at discharge
- Liaison home visit scheduled at bedside and added to the patient discharge instructions

Introducing Hospital to Home Liaison to Patients

Here is how it works At times that are convenient for you, a specially trained Hospital to Home Liaison will visit with you in the hospital. Liaison will also visit you at home a few business days after you leave the hospital, and then call you on the phone to follow-up after this visit and check in to see how you are doing and if you need any additional supports. The program is **FREE** and usually ends 90 days after discharge from the hospital.

Minuteman SENIOR SERVICES

For more information, please call Billy DeSimone at 978-912-7926

This program is voluntary and free, as it is funded by the Massachusetts Executive Office of Elder Affairs with ARPA funds, through a 1 year initiative which is aimed at strong recoveries at home. The Hospital to Home Liaison does not replace or make the patient ineligible for other services.

Metrics

Referrals

Goal – 8- 10 referrals a week

Stat- 7 referrals a week

Total – 133

Acceptance Rate

Goal – 80 % accepted program

95 accepted the program

21 withdrawn and 17 declined

85% acceptance rate

% of In Person Home Visits

Goal- 70%

50% in person home visits

50% via phone

% Enrolled in SHC

30% were enrolled in SHC

% New to MSS

70% new to MSS

Enrolled Readmission Rates

Goal- <10% readmitted to hospital during 90-day intervention

Based on MSS data on track to meet goal

TBD- Emerson's IT is pulling this report based upon claims data to confirm.

Strengths and Challenges

Strengths

- Seamless acceptance and integration of MSS Liaison into the Emerson Hospital Care Management Team.
- Liaison part of rounds and access to EHR
- Weekly Check in virtual meetings with team transitioned to bimonthly frequency
- Improved Care Coordination
- Improved understanding of services
  MSS staff joined meetings to showcase lesser-known services and answer staff questions

Challenges

- Staffing issues- extended leave 4 months; engage a second Liaison and get them set up and trained
- Delayed roll out of Schedule Calendar
- Adapted original design of expedited referrals to State Home Care due to staffing issues

Case Story

- Male 82 yrs. and lives alone
- Personal Goal was to regain self-sufficiency
- Patient enrolled at hospital bedside. He was admitted with A-fib with RVR and Covid symptoms.
- Patient completed the intervention over 90 days including home visit and 3 follow up calls and met his goal of being self -sufficient without returning to the hospital.
- Liaison Assessed unmet needs: medication affordability, expedited SHINE referral; transportation to follow up doctor's appointments, confirmed registration with COA TR, additional symptom management concerns, advocated for NP and Medical Care Management

Minuteman
SENIOR SERVICES

Thank you

Contact Leslie May-Chibani at
l.may-chibani@minutemansenior.org
for questions or further information

3/26/2025

Discussion

Discussion

- If you were to build another HHPP, what would you do differently?
  - For ASAPs awarded funding for an additional partnership in round three, did you apply lessons learned from your round one partnership?
- How did you track patients who were referred to or enrolled in a Home Care program as a result of their engagement with HHPP?
- What are some next steps for your HHPPs?
- What are your program successes?
  - What did not work?

Wrap Up