Introduction

Goal
The goal of the program is to reduce readmissions by 20% among patients identified as high risk and to reach a target enrollment of 250 participants per month. To achieve this, the institution created an innovative community-based care program. The quality of the program was reinforced when it was funded by the Center for Medicare and Medicaid Services (CMS) Innovation Forum Project. The Community-based Care Transitions Program (CCTP) test models of care by targeting transitions from the inpatient hospital to other care settings in an effort to improve quality of care, reduce readmissions for high risk beneficiaries, and document measurable savings to the Medicare program, specifically a goal set forth by CMS calling for a 20% reduction in the readmission rates among enrollees. The institution is one of the first participants partnering with community-based organizations (CBOs) to provide care transitions services for high risk Medicare patients. Transition facilitators (TF) work closely with hospital case managers and staff to access patients identified as medically complex at discharge. Under the Coleman model, the TF sees the patient in the hospital, establishes rapport, and visits the patient at home within 48 hours of discharge to coordinate services in the community which were not previously provided. This synergy has led to the positive outcomes of follow-up appointments, medication management, and access to medical equipment and devices.

Methods

Team
Multi disciplinary members from the community based elder services plan in conjunction with acute hospital and visiting nurses form the CCTP team. The acute care nurses review patients that were admitted to the acute care setting at multiple points in time and then collaborate with their community partners. The community team members include the transition facilitator, case manager, nurse practitioner, visiting nurse and the pharmacist.

Process
To initiate the project the first step was to analyze the reasons for admissions. Once analyzed, a plan for care transitions was developed. Implementing a transition facilitator and a community based nurse practitioner role is instrumental to address gaps in care as patient’s transition from the acute care setting to post-acute settings such as home or skilled nursing facilities. Acute care staff completes an assessment of patients on admission that includes a high risk analysis to determine if patients are eligible for enrollment to the Care Transitions Program. If the patient is eligible, the transition facilitator meets with the patient prior to discharge from the hospital to establish rapport and identify potential needs. The transition facilitator then coordinates services in conjunction with the hospital’s case management team. Upon discharge the transition facilitator visits the patient in their home within 3 days of discharge. This is coordinated with the skilled nursing facility or the visiting nurse agency depending on the patient’s discharge destination. The patient is followed for a period of 30 days post discharge. Multiple services and resources are coordinated such as transportation, personal care services, follow up appointments, and medication compliance. Additionally, the patient is assessed by a community based nurse practitioner in the home to assess for additional clinical needs and intervention.

Results

The program has successfully provided services to more than 2,000 total individuals within the high-risk target group (See Table 1 for program enrollment). Measured progress has been made towards the program goal and the CMS prescribed goal of 20% reduction in hospital readmissions in high risk groups (see Table 2 below). Of the 48 CBOs examined, CMS staff did not find any CCTP to have a statistically significant impact on 30-day hospital readmissions at the CMS prescribed goal. However, this CBO is identified as fourth among the 48 CBOs for their 3.74 percentage rate for decreased readmission with a range of 3.47 percentage points to 5.93 percentage points.

Conclusion

Conclusions and Recommendations
In November, 2014 CMS announced that the program was third in the country for performance results including reducing readmissions and enrollment volume. At the annual meeting, the system was invited to present their program as a best practice for the nation. CCTP aims to continue to increase enrollment and participant retention, as well as to work to improve staff recruitment and retention to support consistency in staffing patterns and referral relationships. CCTP staff will also work to disseminate and implement any new approaches and interventions developed by CMS as the result of the ongoing evaluations of program teams nationwide. The CCTP staff specifically plans to increase nurse practitioner visits in the homes of participants as well as reaching out to participants being served in community-based care settings, as well as expanding the availability of its nurse practitioners to triage any anticipated or unexpected patient concerns identified by the transition facilitators or other clinicians. Recommendations for organizations developing a transitions program would be to include a preliminary analysis to determine the root cause of readmissions specific to their population and to include their community based partners as the primary team members.

References

Butterfield, MPH; Susan Lehrman, MPH, PhD; Stefan Gravenstein, MD. The Care Transitions Intervention Translating from Efficacy into effectiveness JAMA Internal Medicine 2011; 171[4]:1232-1237.

Disclosures
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Contact Information
Cheryl Warren, MS, RN, CMAC
Chief Clinical Integration Officer
Halmark Health System
781-306-6402