Care Transitions Program

Decreasing 30 Day Readmissions Using the Bridge Care Model

What is Care Transitions

- Transitions of Care: The movement of patients from one health care practitioner or setting to another as their conditions and care needs change. Occurs within settings, between settings and across health states. (National Transitions of Care Coalition, NTOCC)
- Care Transitions: A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. (American Geriatrics Society)

History

2003

- American Geriatrics Society recognized that patients and caregivers were not adequately prepared when transitioning from one point of care to another, which risked patient safety and increased the possibility of service duplication.

2007

- American College of Physicians, Society of Hospital Medicine, and Society of General Internal Medicine convened a multi-stakeholder consensus conference to address transitions between inpatient and outpatient settings with a goal to address quality and develop standards for these transitions.

2009

- Study was conducted which showed nearly 20% of Medicare beneficiaries are re-hospitalized within 30 days after discharge, at an annual cost of $17 billion dollars. N Engl J Med 2009; 360:1418-1428. DOI: 10.1056/NEJMsa0803563

Community-based Care Transitions Program

- The Community-based Care Transitions Program (CCTP) was created by Section 3026 of the Affordable Care Act.
- An initiative to test models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
- The goals of the CCTP were: improve transitions of beneficiaries from the inpatient hospital setting to other care settings; improve quality of care; reduce readmissions for high-risk beneficiaries; and document measurable savings to the Medicare program.
- This initiative charged hospitals to work with community based organizations, and gave special consideration to hospitals that joined with Area Agencies on Aging in their Care Transitions Program.

CCTP in Lansing

- In 2013, Tri-County Office on Aging through the Capital Area Collaborative for Care Transitions, along with Sparrow and McLaren Hospitals received funding from CMS to initiate a Community-based Care Transitions Program.
- One of 200 sites across the country.
- A root cause analysis was conducted and a social based model was chosen.
- Operated for two years until funding ended.
- The last 12 months of the program saw over 2,300 clients with an average re-admission rate of 11.7%. (baseline 25%, goal 20%)
- The Bridge Care model was chosen, which is an evidenced-based social worker led model developed at Rush Hospital in Chicago, addressing the socio-economic barriers to discharge.

Bridge Care Model

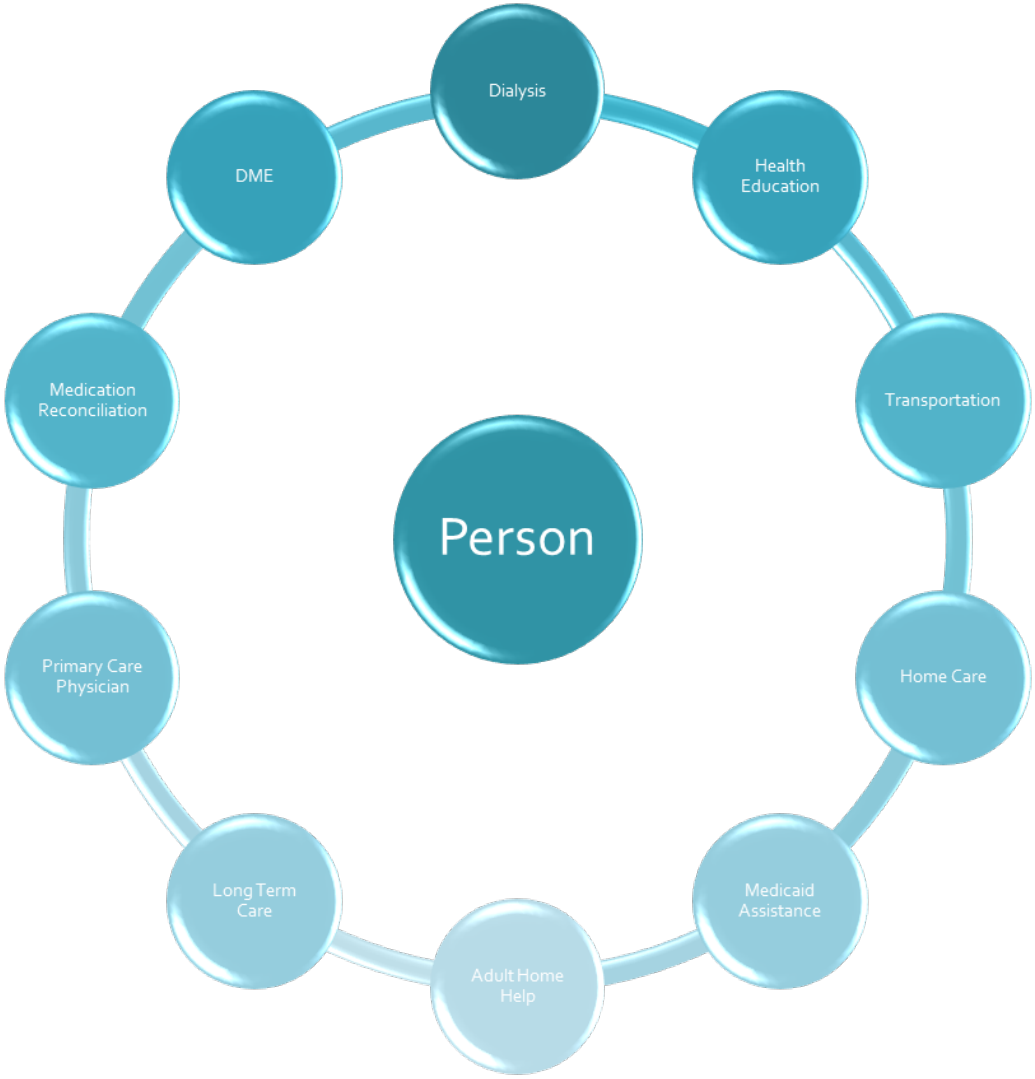
Why a Social Work Model?

- 40-50% of readmissions are related to psychosocial problems and a lack of community support resources. (E.K. Proctor et al, "Adequacy of home care and hospital readmission for elderly congestive heart failure patients," Health & Social Work, 25 (2000): 87–96.)
- 83.3% of intervention group participants experienced significant barriers to care. For 73.3% of this group, problems did not emerge until after discharge. Patients were more likely than usual care patients to have scheduled and completed physician visits by 30 days post discharge. (The Gerontologist. (2013) 53 (3): 430-440. doi: 10.1093/geront/gns109)

Why the Bridge Care Model?

- 24.7% reduction in readmission in 1,390 patients served at Rush University Medical Center from May 2012 through July 2013. (Monitoring report published by Mathematica on behalf of CMS)
- Proven benefits include lower readmission rates, greater understanding of the discharge plan of care, increased understanding of the purpose of taking prescribed medications, increased attendance of post-discharge physician appointments, greater understanding of patient understanding of their responsibilities of managing their own health, decreased patient stress, and decreased caregiver stress. (Randomized controlled trial- Rush University Medical Center)

Care Transitions Program



Care Transitions Program

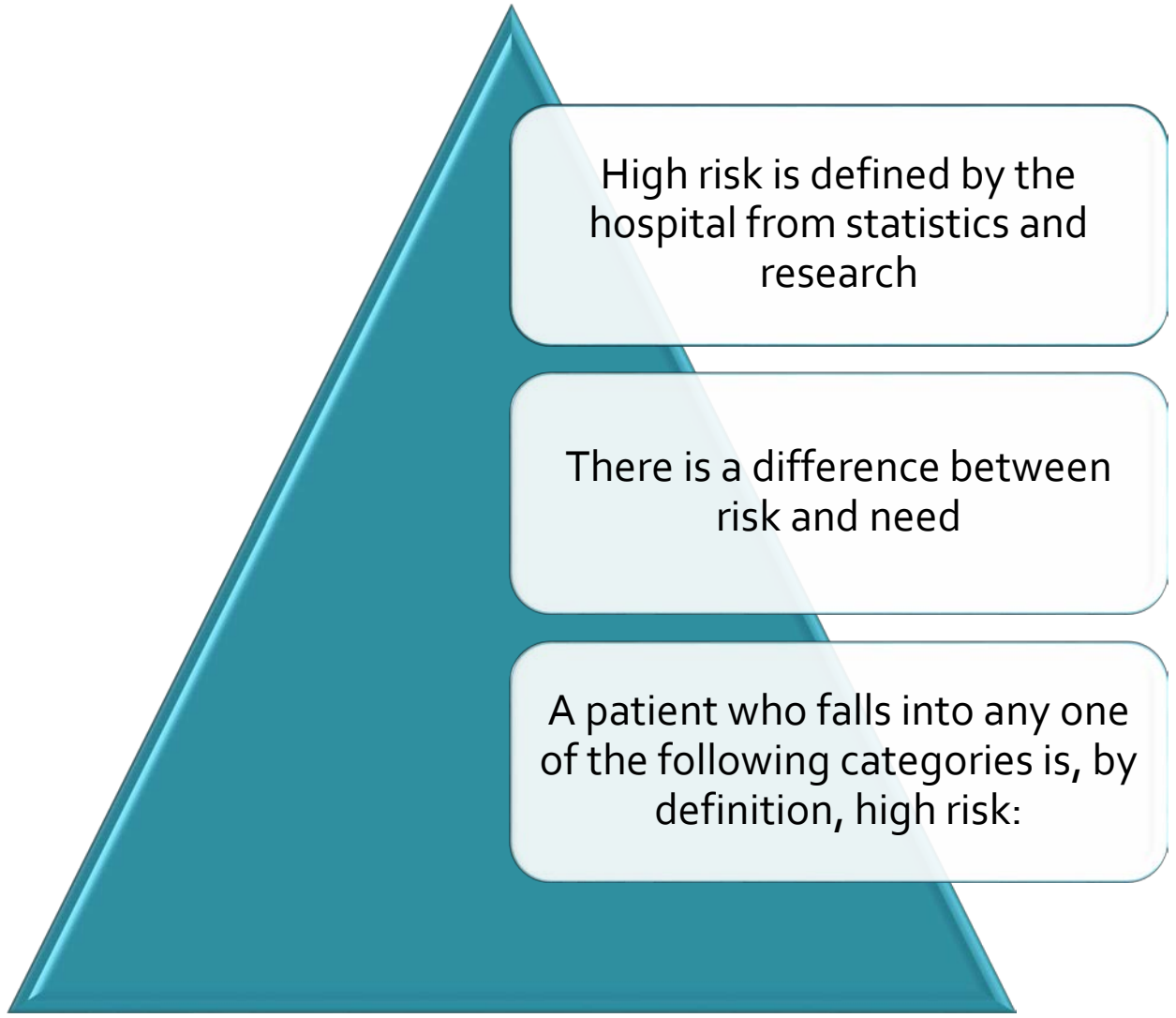
Care Transitions Program

- Currently have a contract with Sparrow to provide Care Transitions services to 200 high risk patients a month.
- Using the Bridge Care model.
- All Care Transitions Social Workers are Masters level social workers.
- Primary care location is the clients home. (community based)
- Program duration is 30 days.

Eligibility

- 18 years or older
- No insurance restrictions
- Ingham, Eaton, Clinton Counties
- Identified as High Risk

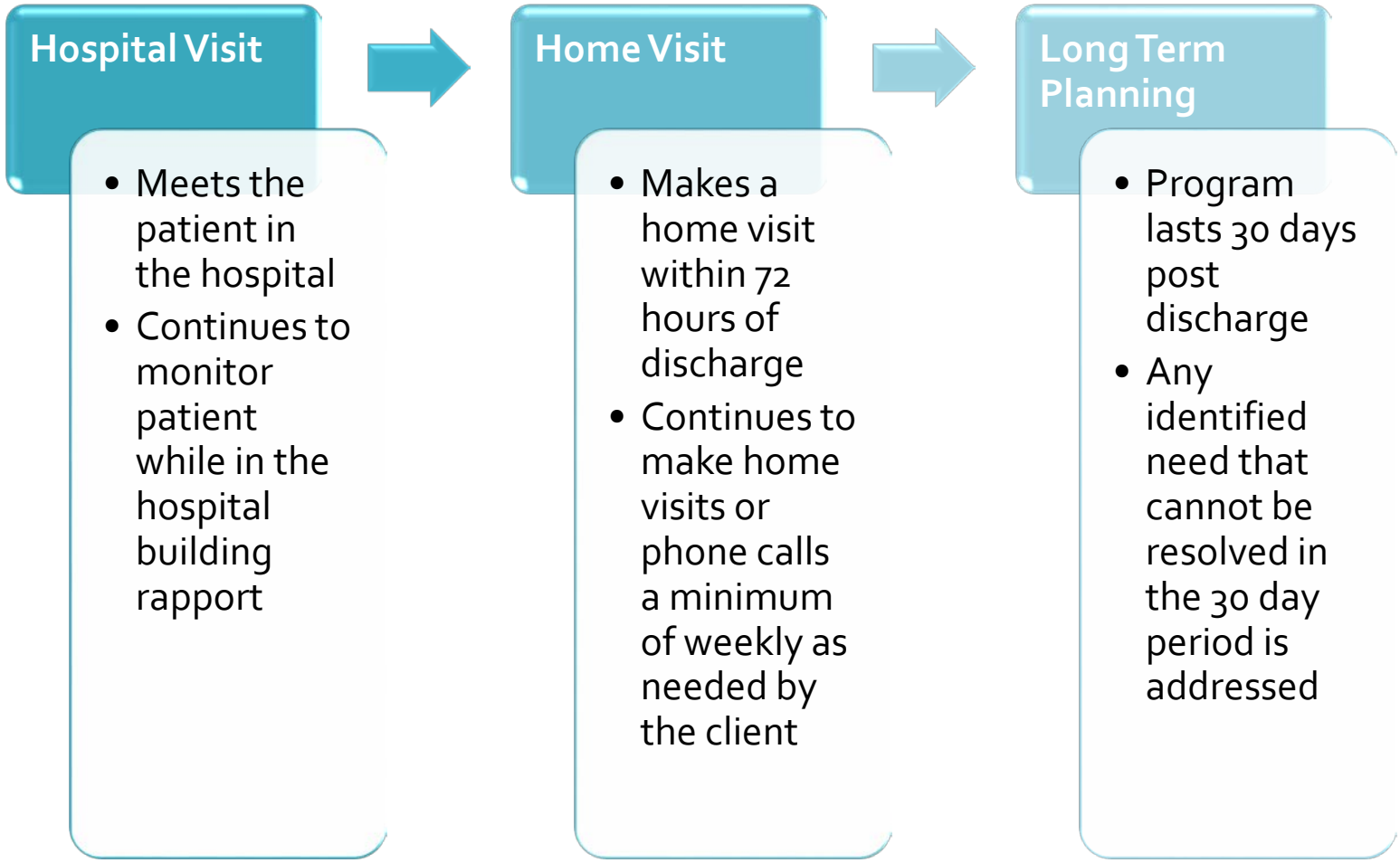
Risk vs. Need


High risk is defined by the hospital from statistics and research
There is a difference between risk and need
A patient who falls into any one of the following categories is, by definition, high risk:

High Risk Categories

- Could include:
- Acute Myocardial Infarction (AMI)
- Congestive Heart Failure (CHF)
- Coronary Artery By-Pass Graft (CABG)
- Chronic Obstructive Pulmonary Disease (COPD)
- Pneumonia
- Diabetes
- Sickle Cell Anemia
- Total Hip/Total Knee Replacement
- Persons who have had more than 2 unanticipated admissions in the past 12 months
- Persons with a length of stay greater than 4 days
- Persons who were screened as high risk

Program Details



Interventions

- Complete bio-psycho-social assessment
- Crisis management
- Linkage to various community based organizations
- Assessment of health literacy and health education reinforcement
- Advanced Care Planning discussions
- Medication assistance/education
- Communication with the physician regarding post hospitalization appointments
- Long term planning for needs

Paid services when needed

- Home delivered meals
- Transportation
- Medication co-pay
- Durable medical equipment
- Personal care
- Homemaking
- Medication set up and delivery
- Medication reconciliation with a RN
- Chore services

Goods Purchased

Scales	Talking Scales	Diabetic Supplies	Mattresses
Toilet Seat Risers	Medications	Phone Cards	Leaf/Snow Removal
Oximeters	Wedge Pillows	Sphygmomanometers	Walkers
Shower Benches	Canes	Medication Organizers	Pill Cutters

Transportation

- Spectran Passes
- Personal Transportation (Home Care Agency)
- Handicap Accessible Transportation (Home Care Agency)
- CATA/Eatran Bus Passes
- Blue Bus (Clinton County)

What Care Transitions is…

What Care Transitions Is…

- An evidenced-based program.
- A program with a proven success rate through the Bridge Care program.
- A program to help decrease unnecessary 30 day readmissions.
- An extension of the services provided by the hospital.
- A supplement to the clients existing support system.
- A program that helps assist the client in implementing the discharge plan that was put in place by the Discharge Planner.

What Care Transitions Is Not…

- Discharge Planning.
- A program which is in place of discharge planning.
- A program which will create a discharge plan.
- A long term program.
- A program that provides direct care/skilled care.

Referrals

- Contact the Case Manager
- Direct Referral
- Contact the Supervisor or Program Manager
- Any person can make a referral (self-referral, nurse referral, OT/PT referral)

Barriers

Internal Barriers

- Learning curve- new program, dealing with 'business' vs. non-profit
- Database- few to choose from, expensive
- Staffing- keeping appropriate staffing levels with unfunded program
- Logistics- offices space

External Barriers

- Getting in front of the right people- making the right contacts
- Communication with the hospitals- both what and how
- Sharing hospital data- very proprietary with data, hard to market to others without ability to share our success
- CBO- putting our community-based values in a very structured organization