



2.b.iv. CARE TRANSITIONS INTERVENTION MODEL TO REDUCE 30-DAY READMISSIONS FOR PATIENTS WITH CHRONIC HEALTH CONDITIONS

OBJECTIVE

Provide a 30-day supported transition period after a hospitalization to ensure discharge instructions are understood and implemented by patients at high risk of readmission, particularly those with cardiac, renal, diabetic, respiratory, and/or behavioral health disorders.

BACKGROUND

A significant cause of avoidable readmissions is non-adherence to discharge plans. Contributing factors include poor health literacy, miscommunication, and misunderstandings due to language issues, and preventable hospital use related to social determinants of health, such as housing, nutritional, and financial insecurity. In addition, a lack of engagement with needed community resources results in risk for readmissions. Ideally, these can be addressed by a transition care manager or home visiting clinicians working with the patient to identify and mitigate relevant risk factors.

The 30-day Medicaid readmission rates for 19 participating states in a large study averaged 9.4 percent and represented 12.5 percent of all Medicaid payments. Readmissions were driven by five diagnostic groups that accounted for 57 percent of readmissions. The most frequent diagnostic groups were mental and behavioral disorders; pregnancy, childbirth, and their complications; and diseases of the respiratory, digestive, and circulatory systems.¹

ACP has an affiliated transitional care team called Rapid Care Solutions (RCS) that provides services, consistent with the Coleman Model,² to ensure that patients are stable upon discharge and at home. Communication with and hand-off back to the patient's primary physician within the month will help mitigate the likelihood of a preventable readmission.

MAIN COMPONENTS

Once notification about a hospital admission or pending discharge is received by ACP or by ACP's affiliated transitional care team at RCS, the team will implement the transitional care program consistent with the Coleman Model:

- ▶ Encounter with the patient prior to discharge to address questions, concerns, and needs for successfully transitioning to home, reviewing and addressing concern about the patient's understanding of next steps and risks;
- ▶ Establish a 30-day care transition period to begin on day of discharge;
- ▶ Perform medication reconciliation, implement a self-care plan, and continue follow up via telephone or in-home contact to take place within 2-3 days after discharge to assess clinical stability. Follow-up calls or visits are arranged periodically as needed to ensure that patient returns to his or her PCP;
- ▶ Provide an updated patient medical summary to the PCP, including a problems list with physical as well as mental health conditions, medications, and allergies;
- ▶ Medication Reconciliation, to include all of the patient's medications, comparing those prescribed before the initial transfer to hospital with the current regimen as well as any over-the-counter medications and supplements the patient may be taking;
- ▶ Development of a follow-up plan denoting how outstanding tests and follow-up appointments will be completed;
- ▶ Provide Patient/Caregiver education: An explicit discussion with the patient and caregiver regarding warning symptoms or signs to monitor that may indicate the condition has worsened, along with the name and phone number of whom to contact if this occurs;

- ▶ Communicate the hospital summary and transitional care findings to the PCP;
- ▶ Refer the patient for community-based support when social determinants of health are identified as contributing to the admission or risk for readmission;
- ▶ Follow-up by Rapid Care Solutions during the 30-day transition period to ensure patient obtains all needed follow-up care.

INPATIENT PHASE

- ▶ ACP's affiliate, Rapid Care Solutions, receives alerts from participating hospitals and/or MCOs daily when its attributed patients are admitted. Patient's risk is stratified through RCS's Risk Stratification tools and Prediction Algorithms.
- ▶ A Transitional Care (TC) coach is assigned to each high-risk patient during the hospital stay.

OUTPATIENT PHASE

- ▶ Within 48-72 hours post discharge, the TC team will contact the patient to perform medication reconciliation and ascertain patient status and potential urgent needs. In addition, the TC coach assesses and reinforces discharge instructions, warning signs of worsening condition, and when to contact the PCP about a possible complication.
- ▶ Within 7-15 days post discharge, a transitional care visit is scheduled with the PCP office or with a TC provider in-home.
- ▶ The TC coach provides follow-up, education, and care coordination with multidisciplinary providers as necessary during the 30-day care transitions period.
- ▶ RCS TC coaches and Care Coordinators connect the patients with necessary services as needs are identified, such as home delivery meal providers, assistance in obtaining transportation, and myriad other services that can be leveraged to support better care outcomes.

For high-risk patients, i.e., those with a history of preventable readmissions, ACP may work with its affiliated health home and other CBO partners to ensure that required social services will be provided to address the social determinants of health, including housing, financial, and food insecurity as well as transportation, home health, and behavioral health care coordination. Transportation and durable medical equipment and home health service needs will also be identified and addressed.

ACP's transition of care protocol includes assuring that care transitions records with timely updates are provided to the patients' primary care and other providers essential for clinical stabilization.

ACP will demonstrate cultural competence in its approach to patients and in its development of educational materials. This project and others are designed to implement system transformation and address health disparities.

The ACP transitional care plan involves documenting a patient's needs, preferences (including advance directives), goals of care, and clinical status. These will be transmitted to the PCP of record and may be shared with other members of the team involved in the care of those with complex acute and chronic illnesses.

ENGAGEMENT AND OUTCOME METRICS

- ▶ The number of participating patients with a care transition plan developed prior to discharge.
- ▶ A count of patients who meet the criteria over a one-year measurement period. Duplicate counts of patients are allowed, provided they meet the criteria more than once.
- ▶ The percent of preventable readmissions.

/REFERENCES

¹<http://www.healthcarefinancenews.com/news/latest-medicare-readmission-rates>

²http://www.artowradvisory.com/uploads/2/8/5/8/28583365/falling_through_the_cracks_-_jags.pdf