4) Reducing Hospital-Acquired Conditions and Readmissions

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PROJECT DESCRIPTION

Passage of the federal Affordable Care Act led to creation of the Center for Medicaid and Medicare Services (CMS) Innovation Forum, a fund designed to support multi-year transformation grants nationwide to develop and test innovative approaches to address the cost-containment and quality improvement goals for health care services, particularly in key populations at high risk for costly and preventable services, such as hospitalizations.

This organization has worked to address this challenge through the Community-based Care Transitions Program (CCTP), as part of one of the regional teams awarded CMS funding in the first round. CCTP defines a broad spectrum of interventions and services for elder patients at high risk of hospital re-admission, provided by a partnership between acute care hospitals and community based organizations.

The goal of this 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), tests models of care by targeting patients 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. This 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) often referred to as health coaches; work closely with hospital case managers and staff to identify patients as medically complex at discharge. Under the Coleman model, the TF sees the patient in the hospital, establishes rapport, and visits the patient in the 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.

OUTCOMES ACHIEVED

- The program has successfully provided services to more than 2,000 total individuals within the high-risk target group
- Measured progress has been made towards the program goal and the CMS prescribed goal of 20% reduction in hospital readmissions in high risk groups
- This organization 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
- Please refer to graphs in results section

LESSONS LEARNED

- The impact of the community based partners must not be underestimated, they work in the community and know what patients need, embrace the CBO staff in your hospital culture, make them part of the team
- Patients need consistency in an ever changing healthcare environment to connect with healthcare providers to become engaged and motivated
- Some of the smallest interventions make all the difference for our patients such as transportation or obtaining prescriptions