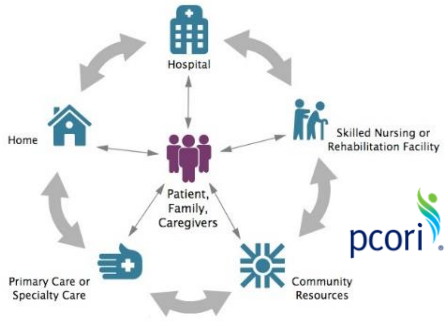
Southwestern Vermont MEDICAL CENTER

Transitional Care Nursing Program

Southwestern Vermont Health Care. Bennington, Vermont (SVHC) partners with Dartmouth-Hitchcock Health and is an integrated non-profit health system that includes a 99-bed hospital, 25 primary care and specialty care practices, and two nursing homes. SVHC serves more than 70,000 people in the towns and villages of Bennington County, western Windham County and southern Rutland County in Vermont; eastern Rensselaer County in New York; and northern Berkshire County in Massachusetts.

Transitional Care Program



1 https://www.pcori.org/topics/transitional-care/about-transitional-care

Patients often transition between clinicians or settings during the course of their illness. Hospital to home or hospital to nursing facility are just two examples and they can be a vulnerable time for patients. They are also a challenge to manage, especially when medically complex. Poorly executed care transitions can lead to bad outcomes like unnecessary readmissions and lower quality of life for patients. They also result in unnecessary costs.

A Transitional Care Program (TCP) builds upon an integrated care delivery system that empowers patients to actively manage their care, to set individualized goals, and to make informed decisions while improving the patient experience, improving the health of the population and decreasing cost. It systematically steers transitions of care from one setting to the next (graphic).

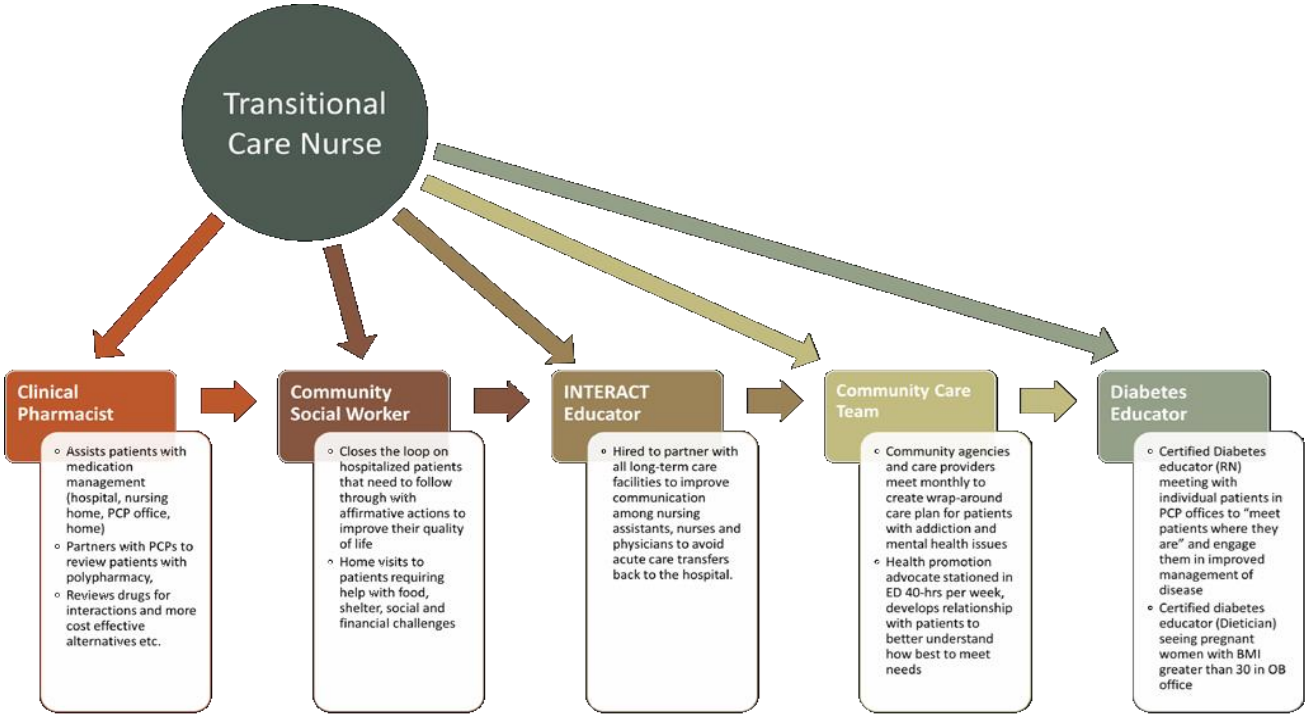
The vision for a TCP at SVMC arose from several factors. Practice patterns had flipped from 80 percent inpatient to 80 percent outpatient. The hospital was losing revenue as a result of declining inpatient volume, but retained the expense of providing inpatient care. The community was aging in place and the patient population grew increasingly older and frailer. With shorter lengths of stay and more frequent outpatient and post-acute care being provided, transitions were becoming more complex and readmissions were becoming more frequent. In addition, the incidence of acute substance abuse and behavioral health events were increasing and patients were presenting in the emergency department more frequently due to a lack of community resources.

In 2013, under the leadership of its nursing director, three clinical nurse specialists were trained at University of Pennsylvania's Transitions of Care program as Transitional Care Nurses (TCNs). The goal was to introduce the TCP to SVMC as a new way of delivering care that would retain skilled clinical professionals and reduce costs, while improving quality and enhancing the patient experience.

At the time of hospitalization, the TCN (1) conducts a comprehensive assessment of the patient's health status, health behaviors, level of social support, and goals; (2) develops an individualized plan of care consistent with evidence-based guidelines, in collaboration with the patient and her doctors; and (3) conducts daily patient visits, focused on optimizing patient health at discharge. Upon discharge, the TCN conducts periodic home visits and/or scheduled phone contacts with the patient based on a standard protocol.

In 2014, the TCP earned a $400,000 grant from the Vermont Health Care Innovation Project (VHCIP) to expand. VHCIP is a state innovation model funded by the Centers for Medicare and Medicaid Innovation. Under the expanded program, TCNs worked with a clinical pharmacist and forged partnerships with each of the ten primary care offices in the area to improve communication. For example, in older, chronically ill patients the TCN may find the root of the problem may be as basic as not taking medications correctly, managing diabetes, or management of nebulizers and oxygen therapy. SVMC TCNs guide patients from one setting to another identifying any gaps in the coordination of care and coordinate resources to fill these gaps.

In its report[1] to the VHCIP[i], TCNs identified a significant gap with the number of patients with addiction and behavioral health issues frequenting the Emergency Department (ED). Patients would present in the ED with multiple symptoms. After diagnosis, treatment and observation they would be released. Unfortunately, when they were discharged, the issues that brought them to the ED, were still present, which caused many of them to cycle back within hours, days or weeks.



To assist this population, SVMC established a Community Care Team (CCT) in the ED. The CCT was designed as a multi-agency, multi-disciplinary team with representatives from across SVMC and the community, aimed to provide compassionate supportive care to patients and their families while facilitating access to services. A clinical social worker called a Health Promotion Advocate (HPA) stationed in the ED 40 hours per week would refer high frequency ED utilizers to a TCN who could then work with the CCT to address the clinical and social needs of a patient.

[1] An Innovative Adaptation of the Transitional Care Model in a Rural Setting, Final Report of the Vermont Health Care Innovation Project Provider Sub-grant Program, Billie Lynn Allard MS,RN, December 9, 2016

Yet, another gap identified by the TCNs was the large number of patients readmitted to the hospital from skilled nursing facilities in the community. SVMC hired an Interventions to Reduce Acute Care Transfers (INTERACT) Education Coordinator, who is stationed at an area skilled nursing facility (SNF). There she implemented INTERACT as a pilot project. It immediately made a difference by decreasing the number of readmissions from the SNF as well as improve communication, documentation, quality of care and teamwork.

Additional motivation for the SVMC TCP was creation of OneCare Vermont, a state-wide, all-payer accountable care organization aimed at lowering overall health care costs while aligning more effectively with high-quality outcomes. SVHC saw the launch of this ACO in line with the goals of their TCP.

Results

The TCP has demonstrated a decrease in hospital admissions and ED visits of high risk chronic care patients through care coordination across settings. Through the first 120 days pre and post intervention by the TCNs, a study of 436 patients demonstrated a 25.8% decrease in ED encounters and a 68.0% decrease in inpatient and observation encounters. As the program continued, the data was replicated 180 days pre and post intervention with a total of 394 patients. This data confirmed the positive impact of this program with a decrease of 25.2% ED encounters and a decrease of 65.9% in inpatient and observation encounters.

While the number of patients with mental health and addictive diagnoses continue to grow, the number of patients who have been helped by this program is encouraging. The team has discussed over 65 individual cases. According to early data, which looked at a cohort of 23 patients there was a 41% decrease in ED visits 6 months post CCT intervention, and a 47% reduction in total healthcare cost.

In addition, SVHC organized a network of community stakeholders to address patient social determinants of health and the results were almost immediate. Within 6 months ED visits dropped among this patient cohort and high-risk patients had access to tools and support they did not know existed.

The TCP also established SVMC as a lower cost provider of OneCare Vermont. It was instrumental in generating savings while maintaining or improving patients' experience of care.

Conclusion

Under the expanded model, TCNs partner with pharmacists and primary care providers, social workers and others to help patients navigate the system, identifying and closing gaps in care. Particular focus is given to linking with local home care agencies, skilled nursing facilities and other community care partners. Nurses spend time in multiple care settings, including medical practices and in patient homes, and communicate through a variety of approaches to help make this commitment to continuity of care a reality, including through telemedicine. Establishing a CCT in the ED has furthered reduced visits while guiding those with substance use and behavioral health needs to the appropriate resources. The approach has helped to address many of the social determinants of health that contribute to chronic illness in rural Vermont. This includes mismanagement of medications, unsafe and unsanitary conditions at home and lack of financial resources.

[i] Funding for this report was provided by the State of Vermont, Vermont Health Care Innovation Project, under Vermont's State Innovation Model (SIM) grant, awarded by the Center for Medicare and Medicaid Services (CMS) Innovation Center (CFDA Number 93.624) Federal Grant #1G1CMS331181-03-01.