Care Transitions

Getting well at home

The Problem:

Hospital Readmissions are Costly and Many Can be Avoided

Medicare beneficiaries who are discharged from hospitals are often readmitted within 30 to 90 days. Many of these readmissions can be avoided. Often, they are due to a fragmented health care system that does not adequately support patients when they are transitioning from the hospital to other settings, such as nursing facilities, rehabilitation facilities and their own homes.

In fact, 90 percent of patients nationally who are readmitted to a hospital have experienced a breakdown in post-discharge care. Readmissions cost Medicare an estimated $15 billion a year, $12 billion of which is for cases considered preventable.

- Beginning in October 2012, Medicare can withhold a portion of payments to hospitals that have higher than expected readmission rates for patients with certain conditions such as heart failure and pneumonia.
- The 30-day hospital readmission rate in southwestern Ohio ranges up to 29 percent for these conditions in some hospitals.

OVERVIEW

Care Transitions is a health coaching and intervention program in Greater Cincinnati for older adults who have been hospitalized for serious and usually chronic conditions, such as heart failure. It is designed to:

- Help frail seniors who have been discharged from the hospital avoid future preventable hospital admissions
- Help patients access the most appropriate post-acute medical care and home and community-based services (and avoid the more costly nursing facility placements when not necessary)

Care Transitions improves quality of life by empowering seniors to manage their chronic health conditions. It also saves Medicare dollars. The program will serve an estimated 5,400 seniors per year and will bring an annual net savings to Medicare of more than $1 million, achieved through reductions in hospital readmissions.

The program is operated by the Southwest Ohio Care Transitions Collaborative at five regional hospitals. Partners include Council on Aging of Southwestern Ohio; the Greater Cincinnati Health Council; Hamilton County Mental Health and Recovery Services Board; HealthBridge; Health Care Access Now; the Health Collaborative; and the following hospitals: The Christ Hospital; Clinton Memorial Hospital; The Jewish Hospital - Mercy Health; Mercy Health - Fairfield Hospital; and UC Health - University Hospital.

HOW IT WORKS

Patients eligible for *Care Transitions* are Medicare beneficiaries hospitalized at participating hospitals and diagnosed with heart failure, heart attack, pneumonia or multiple chronic conditions.

Electronic health information and exchange: During patients' hospitalization, hospital staff conduct a risk assessment for readmission and if criteria are met, staff notify a Council on Aging (COA) Care Transitions Coach® who works at the hospital.

Health coaching: Eligible patients receive a visit from a COA Care Transitions Coach® before leaving the hospital. The coach explains the program, encourages participation, and walks the patient through a discharge checklist. The checklist helps ensure that patients understand their medical instructions and what they should do as they transition home or to another care setting.

Over the next four weeks, the coach also:

- Visits the patient at home or in a nursing facility within three days post-discharge for clinical coordination and referrals for social services. The patient also receives a Personal Health Record, which includes space to write down goals, questions for doctors, medical information and instructions.
- Completes three patient phone calls at regular intervals to ensure follow-up with personal physicians and specialists (who often aren't aware their patients were in the hospital) and to work with patients to reconcile new and existing medications. (Medication mix-ups are a major reason for avoidable readmissions.)

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HOW IT WORKS (cont.)

Avoidance of unnecessary institutionalization: *Care Transitions* program partners connect patients to the most appropriate community resources. These include:

- Council on Aging's programs for in-home and community-based care. Services include home-delivered meals, home-making, personal care and transportation
- Connection to Health Care Access Now for patients who do not have consistent access to primary care and specialty services
- Referral to Hamilton County Mental Health and Recovery Services for assessments of patients with behavioral health concerns

THE CARE TRANSITIONS MODEL

Patient Coaching, Information Technology and Coordination Across Care Settings

Two years ago, Council on Aging and UC Health - University Hospital launched a pilot program using the proven Care Transitions Intervention® model developed by Eric Coleman, MD, MPH, of the University of Colorado. According to a report of the intervention, anticipated cost savings over 12 months is $295,594 for a typical Transitions Coach® panel of 350 chronically ill adults with an initial hospitalization.

In six months, the COA/University Hospital pilot reduced 30-day hospital readmissions among participants to 7.5 percent – or about one-third the national average for patients with the same conditions.

FUNDING

In November 2011, following a competitive application process, the Southwest Ohio Care Transitions Collaborative became one of the nation's first recipients of a multi-million dollar contract from the U.S. Centers for Medicare and Medicaid Services (CMS). CMS is awarding funding to programs and partnerships around the country that have demonstrated effectiveness at reducing harm to older hospital patients, returning them home as quickly as possible, and preventing avoidable and costly readmissions to the hospital.

This funding is allowing the Care Transitions Collaborative to expand *Care Transitions* to the five participating hospitals. CMS will make payments to the Care Transitions Collaborative based upon a per-patient rate. The agreement with CMS is for two years and may be extended on an annual basis for an additional three years.

In addition to designing, implementing and evaluating the program, the Southwest Ohio Care Transitions Collaborative is participating in CMS' national effort to share experiences and findings from this initiative.

TO LEARN MORE

Visit Council on Aging's Web site:
www.help4seniors.org

Contact Kim Clark at Council on Aging:
(513) 345-8651.

Southwest Ohio Care Transitions Collaborative:
Roles of Member Organizations

- *Participating hospitals:* facilitation of discharge planning to transition coaches and physician offices
- *Council on Aging*: project management, data collection and analysis; provides health coaches for the care transitions services
- *Greater Cincinnati Health Council:* program coordination with COA, coordination of quality management processes, program evaluation
- *Hamilton County Mental Health and Recovery Services Board:* mental/behavioral health assessment of identified patients
- *HealthBridge:* health information technology and exchange
- *Health Care Access Now:* coordination of patient access to primary care and specialty services
- *Health Collaborative:* facilitation of physician participation and physician education