COBBLE HILL
health center

WE KEEP BROOKLYN HEALTHY…HAPPY…HOME.

Brooklyn Care Transition Coalition

Cobble Hill Health Center
The Brooklyn Hospital Center
Interfaith Medical Center

OUR COLLABORATION

Cobble Hill Health Center (CBO) partnered with two neighboring high readmission hospitals, Interfaith Medical Center and The Brooklyn Hospital Center, to create the Brooklyn Care Transition Coalition. The Coalition is supported through many organizations - NYC Department for the Aging funded senior centers, Spanish Speaking Council for the Elderly, Puerto Rican Family Institute, all essential links in our integrated, patient-centered care transitions program.

OUR PREVIOUS EXPERIENCE

Cobble Hill Health Center collaborates closely with the participating hospitals. The Brooklyn Care Transition Coalition's comprehensive coordination framework is centered on patient advocacy, navigation and empowerment. Patients are assessed for issues of poly-pharmacy, duplication of services, and social service needs. The Care and Case Management components are unique features of Cobble Hill Health Center's current program. Care Management (direct care and coaching) includes counseling, teaching, and instructions addressing patient's needs. Case Management (overall coordination) assesses the patient's need for services; coordinates and monitors its delivery, assists the patient in gaining access to needed care, and ensures overall coordination and implementation of complex plans in an efficient way.

OUR COMMUNITY

The Brooklyn Care Transition Coalition is located in the heart of the Brooklyn (Kings County), New York. The targeted area includes many ZIP codes that the federal government designated as health professional shortage and medically underserved areas.

OUR TARGET POPULATION

The Coalition defined their target population after reviewing patient/physician interviews, community data, and the results from recent readmission improvement activities. The intervention targets patients with diagnoses of CHF, AMI, PNE and other high risk/high readmission conditions found in patients in this community. Eligible patients will meet the following criteria: Medicare FFS or dual-eligible beneficiary; discharged home (including ALF or home of family) with or without home health services; and resides in a targeted ZIP code; and has a working telephone in the home.

OUR IMPLEMENTATION STRATEGY

The BCTC's Coaching Intervention is a patient-centered intervention designed to improve quality and contain costs for patients at high risk of readmission. The coaching intervention incorporates many familiar components (pillars) adapted from the Eric Coleman, MD Care Transition Intervention®, including hospital visit(s), home visit, and post-discharge follow-up calls; all addressing some of the BCTC's key readmission drivers. To address the community's other readmission drivers, the intervention includes three additional components – complex medication therapy management, nutritional support (home delivered meals if needed), and coordination with community service organizations. All patient-specific coaching information is electronically captured in an internet-based software application that provides the capacity for monitoring patients through interactions, activation with each component, and activities required for reporting. Depending on their readmission risk score, patients will be provided a standard or modified coaching intervention. The standard coaching intervention (described above) is designed for at-risk patients with higher scores. In most cases, these patients have multiple chronic conditions, poly-pharmacy, takes at-risk medications, had a previous admission or ED visit within the last year. The modified coaching intervention is designed for at-risk patients with lower scores. It is appropriate for patients with less than two chronic conditions, has not had an admission within the past year, and has caregiver support. The intervention differs from the previous model; the in-person home visit is replaced with a "telephonic visit" and has also proven useful when patients do not desire visitors in the home.