Arkansas Care Transitions Program

Central Arkansas Area Agency on Aging, d.b.a. CareLink
University of Arkansas for Medical Sciences, St. Vincent Infirmary
ARcare, Jefferson Comprehensive Care Systems, Inc.

OUR COLLABORATION

ACT is a partnership made up of the following: The Central Arkansas Area Agency on Aging d.b.a. CareLink; the University of Arkansas for Medical Sciences (UAMS), the state's only academic medical center and a high readmissions hospital; St. Vincent Infirmary (SVI) in Little Rock; Arkansas Foundation for Medical Care (AFMC), the QIO for Arkansas; and two community health centers -- Jefferson Comprehensive Care Systems, Inc. (JCCS) and ARcare.

OUR PREVIOUS EXPERIENCE

Both hospitals have experience with care transitions programs. UAMS piloted Project RED in their 30-bed Cardiac Unit. Also, the UAMS Department of Geriatrics partnered with the Arkansas Department of Human Services on a two-year care transitions program based on the Coleman's Care Transitions Intervention (CTI). SVI operates an internal transitions program for discharges that is based on the Coleman CTI model.

The three community based agencies have extensive experience providing care coordination and other services to help patients as they discharge from the hospital. As an Area Agency on Aging, CareLink specializes in serving people 60 and older and dual eligibles.

OUR COMMUNITY

ACT will serve targeted Medicare beneficiaries in five central Arkansas counties which blend urban and rural areas: Pulaski, Saline, Faulkner, Lonoke, and Jefferson. CareLink will provide care transition services in Pulaski and Saline (gold), ARcare will serve Faulkner and Lonoke (yellow), and JCCS will serve Jefferson (beige). Both hospitals are in Little Rock (*), and serve the entire region.

OUR TARGET POPULATION

St. Vincent Infirmary will target AMI, CHF, and PNEU. SVI expects to discharge 492 patients a year who fall within these 3 DRGs.

UAMS identified a set of 20 DRGs that hospital discharge data identified as the MS-DRGs for which Medicare patients have a high risk for re-hospitalization within 30 days. The DRGs identified by UAMS include AMI, CHF, and PNEU as well as 17 additional DRGs identified in the Root Cause Analysis. UAMS projects that 435 patients per year will be eligible for ACT.

OUR IMPLEMENTATION STRATEGY

The Root Cause Analysis (RCA) was made up of three parts: 1) analysis of hospital discharge data, 2) analysis of interviews with discharged patients, and 3) input from hospital staff. In addition to identifying target DRGs, the RCA also indicated the need for simplified and expanded patient and caregiver information. Information should be simplified so it is more understandable and expanded so patients and caregivers have a full understanding of the discharging patient's condition and post-hospital care.

Patient and staff interviews indicated that about half of Medicare patients who readmitted within 30 days had not seen a physician in the community. Further, many patients lacked resources that would enable them to access care and potentially minimize readmission.

The results led to the selection of the Care Transitions Intervention (CTI) as the foundation to reduce 30–day admissions. CTI includes a transitions coach to deliver a 4 week bundle of services that address 1) medication reconciliation/self-management, 2) patient understanding of condition and recommendations (patient-centered record), 3) follow-up with community physician, and 4) patient understanding of "red flags" of condition deterioration.

In addition to the services provided as part of the Coleman CTI model, ACT will also provide transportation as needed to facilitate follow-up care, which will include up to four one-way, non-emergency transportation units per patient. The ACT staff will also conduct a falls prevention assessment that may reduce environmental risks for re-hospitalization.