The Greater New Haven Coalition for Safe Transitions and Readmission Reductions: GNH CoSTARR

[Agency on Aging of South Central Connecticut,
Hospital of Saint Raphael and Yale-New Haven Hospital]

OUR COLLABORATION

The Agency on Aging of South Central Connecticut (**AASCC**) is partnering with the Hospital of Saint Raphael (**HSR**) and Yale-New Haven Hospital (**YNHH**) in New Haven, CT, to reduce their Medicare readmissions. **HSR** and **YNHH**, the only acute care hospitals in New Haven, are high re-admission hospitals. The GNH CoSTARR partners have a long history of serving the area's vulnerable Medicare population and include many community-based groups on their advisory council: community health centers, skilled nursing facilities, adult day care centers, hospice care, senior housing.

OUR PREVIOUS EXPERIENCE

AASCC has served older adults since 1974 with programs and services that support independent living. **AASCC** has coordinated with **HSR** and **YNHH** on transition services through its Medicaid Waiver Program. **HSR** and **YNHH** also have geriatricians overseeing multidisciplinary inpatient geriatric programs to assess and support patients' ability to return home successfully. Both hospitals have had success in a state collaborative to reduce congestive heart failure (CHF) readmissions. **HSR** also uses integrated ElderClinics and mobile clinics to assist patients in remaining out of the hospital. **YNHH** has also utilized Project RED by assigning a dedicated care coordinator to follow all CHF patients, educate them about their condition and its management, provide medication reconciliation, ensure post-discharge follow up and make a post-discharge phone call. Readmission rates have dropped to less than 20% since December 2010.

OUR COMMUNITY

GNH CoSTARR serves towns and cities in lower New Haven County, CT with the lowest per capita income and highest imputed healthcare needs in the county. **HSR** and **YNHH** are the only acute care facilities for the general population in this area.

OUR TARGET POPULATION

Patients over the age of sixty-four who:

1. Have a previous 30-day readmission or non-elective hospitalization in the last six months ***or***
2. Come from the local community and receive their care at **HSR**'s Adult Primary Care Center or a Project ElderCare clinic; **YNHH**'s Primary Care Center; or one of the city's two federally qualified health centers; or who have no primary care physician (PCP) ***or***
3. Come from skilled nursing facilities (SNFs) or primary care practices with higher than average readmission rates

These are the economically disadvantaged and vulnerable older adults most in need of additional community resources and careful care transitions.

OUR IMPLEMENTATION STRATEGY

GNH CoSTARR will utilize special Care Transitions Teams (CTT), comprised of hospital-employed care coordinator (CC) RNs and **AASCC**-employed social workers (SW) based inside each participating hospital to develop holistic, patient-tailored discharge planning, educate patients about community resources and support them through post-hospital care transitions. Early involvement of **AASCC** personnel will enable us to continue the comprehensive intervention after the patient transitions home.

The CTT CC will conduct the Project BOOST assessment on all eligible elder patients. The CTT SW will conduct a comprehensive inpatient geriatric assessment of medical and psychosocial needs on those at highest risk of readmission. The CTT will initiate processes to ensure that enrolled patients have a smooth transition to home or SNF (making follow-up appointments and phone calls post-discharge, ensuring medication reconciliation, educating patients on their health status, etc.). The CTT will also involve community-based PCPs in the transition and provide them with clinical and contact information to seamlessly transition care. In addition, the CTT SW will ensure that eligible patients receive services such as Meals on Wheels, home health care and transportation to prevent unnecessary readmission. The CTT will consult with home health services and SNF staff to ensure the participant, family and providers have mutual goals for care. The CTT will also be available by phone or in person as a point of clinical and social services contact for participants and their families, PCPs and SNF staff until the participant is safely transitioned to community-based care.