Community-wide Care Transitions Intervention

Lifespan of Greater Rochester, Rochester General Hospital, Strong Hospital, Highland Hospital, Unity Hospital, Visiting Nurse Service, Lifetime Care & Finger Lakes Health Systems Agency

OUR COLLABORATION

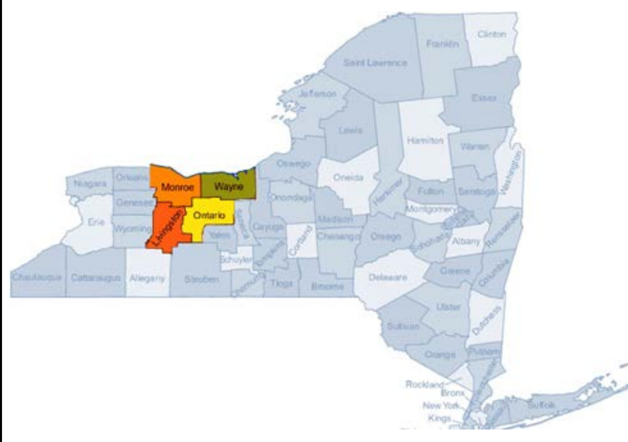
Lifespan, an AOA-funded non-profit in Rochester, NY, is collaborating on the Community-wide Care Transitions Intervention with four acute care hospitals (Rochester General, Unity, Strong Memorial, and Highland), two home health care agencies (Visiting Nurse Service of Rochester (VNS) and Lifetime Care) and the Finger Lakes Health Systems Agency (FLHSA), the regional independent health planning organization.

OUR PREVIOUS EXPERIENCE

Our community enacted a multi-payer pilot of the Coleman Care Transitions Intervention™ (CTI) in 2010. Home health care agencies and community-based organizations provide coaching services for PPO, HMO or Medicare Advantage patients insured by two commercial plans and by the local Medicaid HMO. Coaching is currently implemented at four hospitals – two with high preventable readmission rates as reported by CMS. A recent award of a New York state HEAL19 grant is implementing coaching for uninsured and Medicaid fee-for-service (FFS) patients.

OUR COMMUNITY

Monroe, Wayne, Livingston & Ontario counties NYS



OUR TARGET POPULATION

Our target population is Medicare FFS beneficiaries flagged with an active Preventable Quality Indicators (PQI) dx or having 2 or more characteristics putting them at-risk of re-hospitalization:

- > 3 co-morbid chronic illnesses;
- > 5 prescription medications;
- > 2 hospital admissions in the past 12 mos;
- Failure of "teach back" in the hospital;
- Special circumstances subject to interdisciplinary judgment including such risk factors as living alone, absent social supports, or no transportation.

OUR IMPLEMENTATION STRATEGY

Our collaborative designed a two-pronged intervention – the Coleman model CTI and enhanced hospital-based interventions for an estimated 5500 patients. Approximately 70% of the 5500 patients will be offered coaching and the enhanced hospital interventions.

Approximately 30% of the 5500 patients discharged to skilled nursing facilities will receive just the enhanced hospital interventions. Transition Coaches™ will complete one hospital visit, one home visit, and three follow-up phone calls within a 30-day period after discharge.

Based on our local experience providing CTI to date, we expect a coaching acceptance rate among qualified patients of 60-70%.

Enhanced hospital-based services include:

- Pharmacist assistance upon admission to obtain an accurate medication history;
- Pharmacist to attend daily patient huddles;
- Comprehensive medication discharge reconciliation completed by pharmacist to identify potential drug-related problems;
- Use of hospital-based call centers to improve the transfer of information from the hospitalist to PCP and nursing homes.