Grant Outcomes Report

Assisting Elderly Patients in the Transition from Hospital to Home

KEY INFORMATION:

GRANTEE
Hudson Headwaters Health Network

GRANT TITLE
Transitioning Elderly Patients from Hospital to Home

DATES
February 1, 2008 – January 12, 2011

GRANT AMOUNT
$44,835 for planning (grant #1911942) and $484,375 for program implementation (grant #2584737)

FUNDING
2007 Cost RFP

The Problem:

In 2007, 18.5% of Glens Falls Hospital's Medicare patients were readmitted to the hospital within 30 days of a hospital admission, compared to the national average of 15%–21% and the statewide average of 12.5%–15%. These acute care readmissions are costly, often indicate a lack of care coordination, and threaten the financial viability of acute care institutions, especially under the provisions of Federal health reform. Hudson Headwaters Health Network (HHHN) and the Glens Falls Hospital proposed a collaborative approach to reduce hospital readmission rates among the Medicare population. The two organizations were convinced of—and the literature suggested—the need for collaborative care programs that address the fragmented care process. Under a New York State Health Foundation-funded planning grant (grant #1911942; $44,835), the two organizations identified a target population and program strategy. Under the grant, HHHN and Glens Falls Hospital analyzed Medicare admissions from 2006 and discovered that 1,353 patients were readmitted within 30 days of a prior admission that same year representing 2,429 admissions. The resulting analysis indicated that 40% of the patients (542) with specific medical conditions accounted for 80% of the admissions. After reviewing a more detailed account of the data with the project physicians, the HHHN and Glens Falls Hospital focused on developing a program that targeted this population and more directly addressed patients' needs. The second NYSHealth grant (grant #2584737; $484,375) supported implementation and evaluation of this program.

Grant Activities & Outcomes:

The resulting Transition Care Program was designed to address patient-centered care across multiple settings, practitioners, and organizations. The program focused on Medicare patients with primarily medical care conditions including congestive heart failure, chronic obstructive pulmonary disease, respiratory disease, diabetes, gastrointestinal disorders, and mental health disorders. The major goals of the program were to ensure patients would be seen by a physician/provider within 10 days of discharge and optimal coordination of their care, and that the program ultimately would reduce readmission rates by up to 20%. The program sought to develop and disseminate tools beneficial to staff, providers, patients, and caregivers. Lastly, the project sought to develop a plan to sustain the program.

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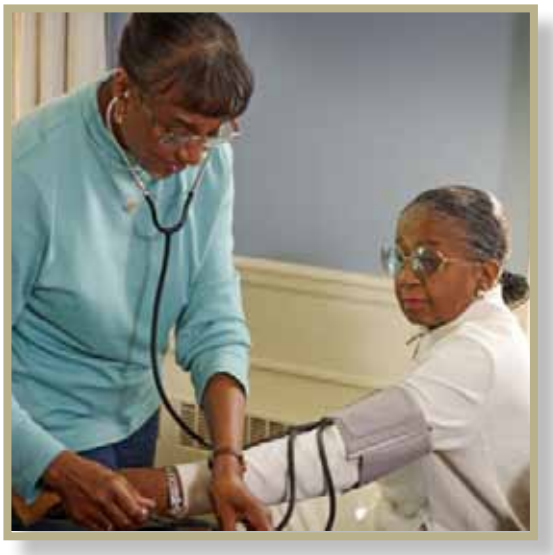
Project funds supported start-up activities including recruitment and orientation of project staff, development of written tools and materials for the program, and an orientation program for other staff affected by the program. Project funds also supported the program's implementation activities:

- Initiation of a hospital-based screening tool for high-risk patients, which allowed patient assignment to an intervention or control group and execution of patient consent.
- Coordination of care for the intervention group, including patient education, medication management and reconciliation, personal health records, patient and caregiver expectations, understanding of social and support needs, and ambulatory follow-up.
- Introduction of patient to an ambulatory transition coach who reiterates prior education, finalizes the discharge plan, coordinates the transition to home, and provides follow-up services by phone and visits including repeat assessment.
- Coordination of data flow, including availability of data for patient engagement, and financial analysis and potential engagement with managed Medicare firms.

The project initially targeted 542 patients to assign to intervention and control groups. A large number of patients rejected the opportunity to participate in the intervention group during the patient consent process. Thus, the targeted sample size was revised with a goal of 350 patients; the final sample size was 333 patients, with 173 patients assigned to the control group and 160 patients assigned to the intervention group.

As originally proposed, medication reconciliation was to be integrated into the structured discharge preparation checklist for the patient and family. The program had anticipated a fairly high rate of medication reconciliation errors—more than 80%—but did not anticipate the difficulty with the overall medication reconciliation process. Midway through the project, strict interpretation of the medication reconciliation produced an error rate of 81%. The rate continued to fluctuate between 80% and 90% with the program having more and more difficulty in reconciling medications at admission with changes during the stay at discharge. The challenges were so great in processing reconciliation that the hospital initiated a hospital-wide review of medication reconciliation. Because of this review, the program opted to concentrate on a solution rather than continue tracking the error rate.



The hospital's review of medication reconciliations included members from all areas of the organization including physicians, and information systems, nursing, and pharmacy staff. The hospital has designed a system that will create a medication list for patients so that they know what medications were changed (discontinued or

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new) during their stay. Previously, patients just received a list of medications. Hospital staff members are also contacting pharmacies and physician offices to get updated medication lists at admission. Public health liaisons (home health) are also updating home medication lists of the patients as they make their rounds at the hospital. The revised system was up and running in fall 2010 when the hospital implemented a major upgrade to its clinical information system.

By the end of the project, 71% of the intervention patients had seen a provider within 10 days of discharge. The program projected a reduction in readmission rates of up to 20% for the targeted population. These projections were based on data maintained by the hospital on its multi-year tracking of the hospital-wide Medicare readmission rate. Though data limitations made apples-to-apples comparisons somewhat difficult, the program found that more than 58% of the control group had been readmitted compared to 48.2% of the intervention group. Clearly, the program made a difference in terms of patients' understanding of their health, and an overall reduction in readmissions compared to the control group.

The program's evaluation included a cost-benefit analysis, which suggested a cost savings of $946 per patient (including the cost of services for the intervention) with a total difference of charges of $1,034. For every dollar spent on the program, a savings of $1.09 was realized. These cost savings are based on an intervention group of 160 patients. Program staff members strongly believe, however, that an experienced transition care program integrated into a medical home model of care could manage twice the number of patients utilizing the same resources.

The Future:

Locally, with implementation of the Adirondack Medical Home Pilot, HHHN began planning to implement and integrate a transition care program into its Medical Home operations. The Network is working with a number of commercial payers, most notably CDPHP, in designing effective benchmarking and incentive programs that will reward medical home models that improve outcomes and reduce costs. All the payers in the Medical Home Pilot have identified hospital admissions/readmissions as a potential for improving care and reducing costs.

Lastly, the New York State Department of Health, the facilitator and participant in the Adirondack Medical Home Pilot, applied for the Centers for Medicare and Medicaid Services' (CMS) Advanced Primary Care Program for Medicare participation in the Adirondack Medical Home Pilot. As a component of the application, the State had to identify ways to ensure budget neutrality for Medicare as a payer. The New York State Department of Health pointed to the work of the transition care program as the projected opportunity to ensure budget neutrality and, in fact, provide savings along with improved outcomes. "One-hundred percent of the cost savings argument in the State's proposal to CMS was based on the transitions care project funded by NYSHealth," according to Trip Shannon, Chief Development Officer at HHHN. CMS chose New York's Adirondack Medical Home Pilot project for participation in the Medical Home Pilot Demonstrations. By January 2011, CMS was in negotiations with the eight states chosen, and projects expected payments to begin in fall 2011.

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BACKGROUND INFORMATION:

ABOUT THE GRANTEE

Hudson Headwaters Health Network is a 501(c)(3) corporation licensed as a comprehensive diagnostic and treatment center by the State of New York and designated as a Federally Qualified Health Center with Section 330 funding since 1980. Originally organized to provide primary care to a large Medically Underserved Area in the Adirondack Mountains, the Network has grown to also become the largest medical practice and only primary care safety-net provider in the Glens Falls metropolitan area. In 2007, Hudson Headwaters logged 250,000 encounters by 60,000 individual patients within a service area approximately twice the size of the state of Rhode Island. With 12 widely dispersed full-service primary care sites, the Network has over the years added dedicated urgent care centers, behavioral health services, a dental center, expanded imaging services, a full-service clinical laboratory, and a women's health program. To complement and strengthen these programs, Hudson Headwaters provides enabling services, including patient transportation, social work, nutrition, and health education. In addition to its health center sites, the Network provides medical care at two hospitals, six nursing homes, 12 schools, two county jails and, most recently, house calls to the elderly homebound through support of a local foundation. Well established as an incubator of pilot programs for the State, Hudson Headwaters served as the organizer of both the Adirondack Rural Health Network and the Hudson-Mohawk Area Health Education Center, and is a charter participant of the Capital Adirondack Practice-Based Research Network (PBRN).

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GRANT IDs

1911942 and 2584737

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