Transition Care: A Coordinated Approach To Discharge Planning

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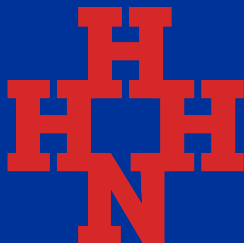
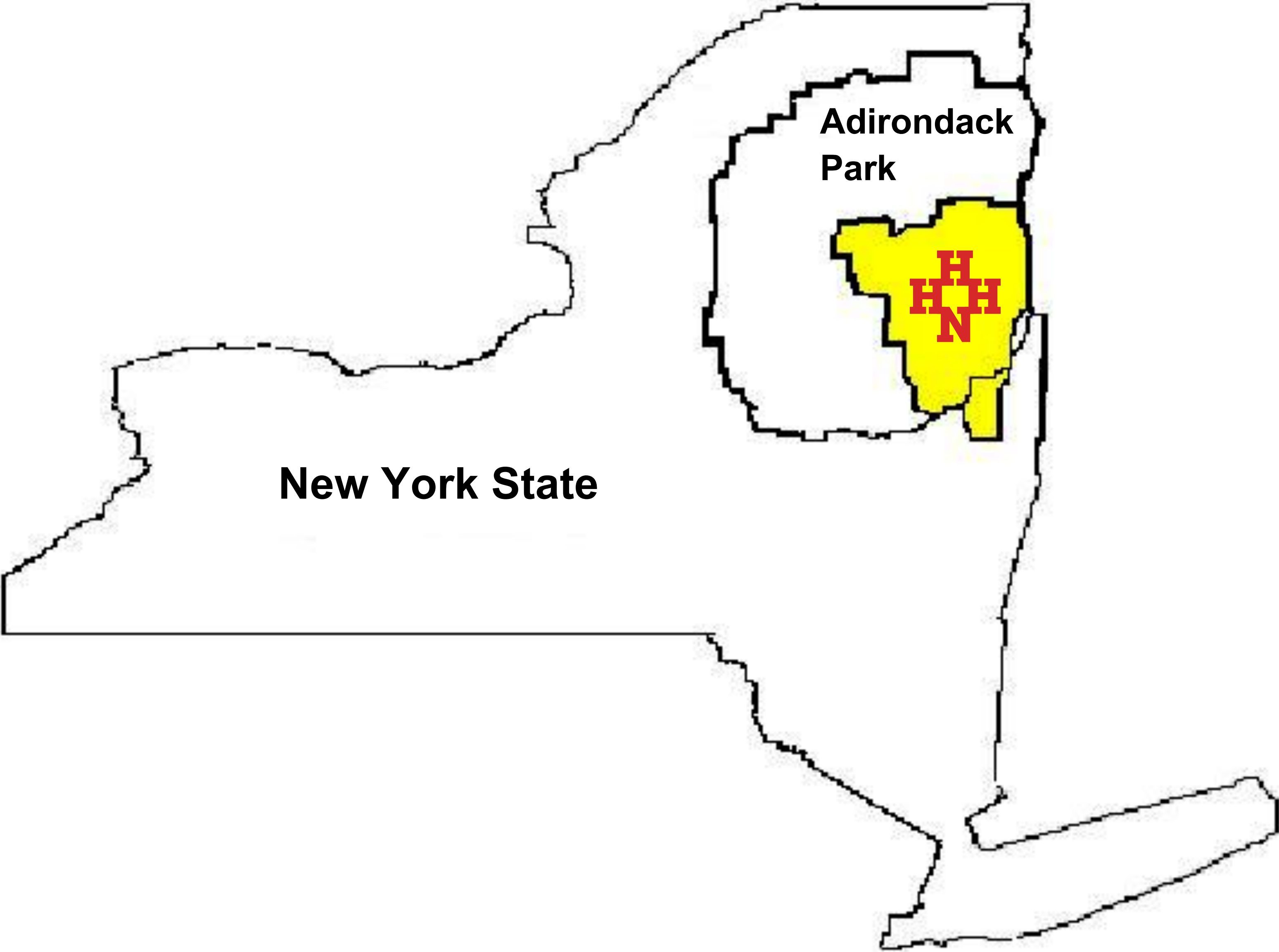
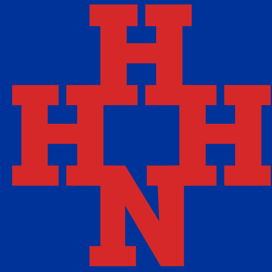



Adirondack
Park
HHHN
New York State



Vital Statistics

- 250,000 Patient Visits
- 60,000 Patients Annually
- Comprehensive Primary Care
- Federally Qualified Health Center
- High Percentage Medicare Patients

Vital Statistics

- **367 Affiliated Physicians**
- **25+ Specialties**
- **24 Regional Facilities**
- **276 Beds**

The Problem

- High Medicare Readmission Rate – 18.95%
- NYS & National Rate – 18.7% & 17.6%
- Average Medicare Cost Per Discharge - $7,300
- National Cost of $15 Billion
- CMS Considering Reimbursement Changes

Planning the Program

- Two Year Data Analysis
  - Diagnostic categories
  - Demographics including age and residency
  - Financial consideration including cost per admission
- Care Model Considerations
  - Looked at two care models; Coleman and Project Red
  - Chose Coleman model emphasizing patient engagement using RN's as more appropriate for rural area.

The Program

- Size
  - 350 patients
  - Intervention and control groups
  - 16 months

The Program

- **Eligibility**
  - **Medicare patients, traditional and Advantage**
  - **Medical conditions including diabetes, CHF, COPD and depression**
  - **Prior admissions, history of repeat admissions**
  - **Geographic location of home residence**

The Program

- **Transition Care Staff**
  - **One hospital based physician assistant**
  - **Two ambulatory based RNs**
- **Key Components**
  - **Patient engagement/education including home visits**
  - **Personal health record**
  - **Medication reconciliation**
  - **Follow-up physician appointments**

The Program

- Goals
  - Higher level patient engagement & understanding
  - Higher rate of medication reconciliation
  - Follow-up physician appointments within 7 days
  - Reduction in readmissions by 20%

Early Results

- Demographic/Clinical Characteristics
  - 301 patients over 9 months
  - 96% discharged to home
  - 43% can walk unassisted
  - 52% on home oxygen
  - 17% hearing impaired
  - 70% Medicare, 30% Medicare Advantage

Early Results

- **Patient Engagement**
  - **Clear, achievable health goals: 51% pre-intervention compared to 88% post intervention**
  - **Understood warning signs & symptoms: 73% pre-intervention compared to 92% post intervention**
  - **Clearly understood purpose for taking each of the medications: 69% pre-intervention compared to 91% post intervention.**

Early Results

- Medication Reconciliation
  - 82% have at least one discrepancy between discharge medication list and home (pre-admission list)
  - Program has resulted in hospital wide review of medication reconciliation
- Physician follow-up Appointments
  - 70% had seen a physician within 7 days of discharge
  - Difficult getting appointments with primary care physicians

Early Results

- Readmission Rate
  - 17.1% for intervention group
  - 17.8% for control group
- Cost Savings
  - To be determined
  - Hospital fixed costs
  - Need to engage the payers

Lessons Learned

- Communicate patiently with patients
- Engage the caregiver
- Initiate a conversation about Advanced Directives
- The primary care shortage is real
- Financial incentives are backwards
- Engage the payers

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