Quality Improvement through Community Based Transitional Care

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Sessions Objectives

- How implementation of a Community Based Transitional Care Program can:
  - Reduce Cost
  - Improve Quality of Care
  - Reduce hospital readmission rates
  - Improve patient self-care

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Catalyst for Change

- Centers for Medicare and Medicaid Services demonstration projects
- Readmission penalties for hospitals
- Improve communications
- Patient Protection and Affordable Care Act
  - Reduce cost

The Shifts

- From fee for service to bundled payments
- From inpatient care to outpatient services
- From episodic care to care across the continuum
- From siloes of providers to collaborative health care delivery programs.

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Pilot Criteria

- 2 units 4 North and 4 South
- Lace Score > 7
- Discharge to home
  - Works with Home Health Agencies
  - Referrals to Home Health Agencies
- Accepts the program

Implementation

- Coaches vetted through Human Resource Dept.
- Visit the hospital and enroll patients
- Receive reports (LACE Score, Discharge)
- Weekly meetings with Quality/Case Management
- Sharing of information

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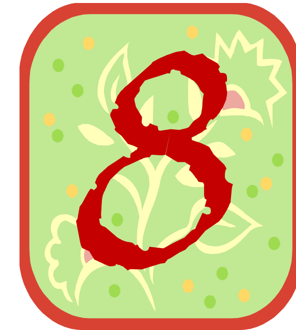
Social Issues



1. Follow up with primary care physician
2. Able and willing caregiver
3. Home environment
4. Discharge instructions

Social Issues (continued)

5. Diet
6. Medications
7. Transportation
8. Health literacy

Bluegrass “TLC” Transitional Care Program

Bluegrass Area Agency on Aging and Independent Living

Hospital to Home

BLUEGRASS "TLC" TRANSITIONAL CARE PROGRAM

Bluegrass Area Agency on Aging and Independent Living

The **Bluegrass Area Agency on Aging and Independent Living (AAAIL)** has provided an array of in-home and community based services and supports to seniors, persons with disabilities, their caregivers and family members for the past 40 years. While the AAAIL is best known for its elder services, the agency has expanded, in recent years, to offer programs for individuals of all ages, targeting assistance with community long- term services and supports. This includes the establishment of the **Aging and Disability Resource Center (ADRC)**, which provides a single point of contact for all individuals in the Bluegrass Region needing information, assistance, and access to public and private services and supports, the **Medicaid Consumer Directed Options Programs,** and the **TLC Program,** providing transition services to patients transitioning from hospital to home.

Bluegrass Area Agency on Aging and Independent Living

Safe, effective, and efficient care transitions require thoughtful collaboration among health care providers, hospitals, social service providers, patient caregivers, and patients themselves.

Bluegrass Area Agency on Aging and Independent Living

The Facts

•1 out of 5 discharged from a hospital return within 30 days.

•One in three are readmitted within 90 days

• 76% of these readmissions could be avoidable.

•$26 billion is spent on avoidable readmissions annually.

•40% to 50% of readmissions are linked to lack of community resources and social issues

•50% of those discharged do not attend their required follow-up visits with their physicians

"MedPAC 2007"

Bluegrass Area Agency on Aging and Independent Living

Poor transitions of care can compromise patient safety and quality of care.

Fragmented care and inefficiencies, increases cost to patients, providers, payers, and employers.

(The Institute of Medicine)

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The Problem

Patient medication errors including members not having their prescriptions filled
Poor communications and coordination between providers from inpatient to out patient
Post discharge follow-up including making physician appointments. (Even though some are scheduled, they are often not attended)
Lack of understanding of hospital/doctor's orders upon discharge
Lack of involvement of the caregiver during discharge
Lack of caregiver understanding regarding patient care needed or proper training to provide care
Ignoring warning signs or symptoms of changing health conditions that result in readmissions
Lack of knowledge of community resources or access issues with needed services

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Top Conditions for Admission & Readmission

- Diabetes
- Pneumonia
- Heart Failure
- COPD
- Falls
- Medication Mismanagement

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Addressing the Need

Program Development

Guidance from CMS and Administration for Community Living

- **Aging and Disability Resource Center (information and referrals)**
- **Care Management Services**
- **Family Caregiver Support Services**
- **Grandparent Support Services**
- **Chronic Disease Self Management Services**
- **Medication Management**
- **Transportation**
- **Meals**
- **Contracted In-Home Services**

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Addressing the Need

Bluegrass Transitional Care, “TLC”, Partnership

The “TLC” partnership targets services to address specific needs. The Partnership will improve patient care, patient health, bridge the gaps between the medical and community services, reduce or prevent unnecessary admissions, readmissions, ER use, and reduce overall health care cost.

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Addressing the Need

Services include two groups;

•Transitional Care “TLC” , services for those moving from Hospital to home

•Community Choice, services to address individual needs and assist the patient in attaining their maximum functional potential

Bluegrass Area Agency on Aging and Independent Living

Transitional Care "TLC" Services

"Transitional Care (TLC)" services, provides an **evidence-based model of care** to assist the patient with post hospital discharge and their transition back home. **"TLC" staff is there at a time when the patient is most in need of assistance, when transitioning from hospital to home, and to assist the patient with their healing process.** These services can either be implemented for the short-term (30 days), or extended-term (up to 90 days). These models, in coordination with the care management models, have been proven to reduce or prevent hospital admissions, readmissions and emergency department use.

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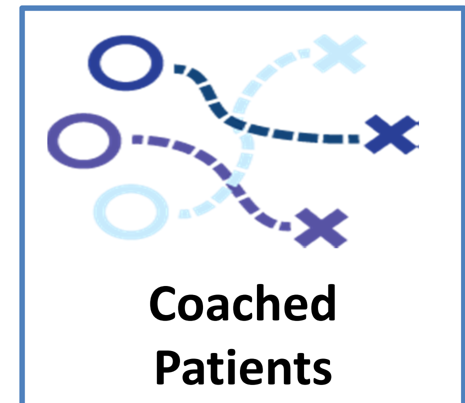
Transitional Care "TLC" Services

Services are **"Person-Centered"**, and **"Individually Planned"**, to address each patients' specific needs. "TLC" services will standardize the transition process, efficiently transfer clinical information and actively engage patients. Services may include;

•In-hospital visit with patient and discharge staff to **introduce the Transition Navigator/Coach, Evidence Model, and Personal Health Record.**
•Timely and culturally competent **post-discharge education including patient-centered self-management support** and information specific to the patient's condition
•Timely **interaction between patients and post-acute and outpatient providers** including reminders to insure patients' schedule and attend all appointments
•**Medication review**, including counseling and self-management support
•**Assessing the home environment**
•Creating an **individualized care plan**
•**Monitoring** the patients condition
•**Assisting** with patient's transitions between sites and providers
•**Educating and supporting the patients caregivers**
•**Facilitating access** to other community resources



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Transitional Care "TLC" Services

TLC – Tier1- (30 Day Transition Model)

Covers seven key areas of focus for the patient;

1. **Medication management**
2. **Personal Health Record**
3. **Medical care follow-up**
4. **Educating the patient about red flags**
5. **Transitions Planning**
6. **LTSS Assistance**
7. **Caregiver Assistance**

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Transitional Care “TLC” Services

TLC – Tier 2- (90 Day Transition Services)

TLC-Tier2 services is a short term transitional service available to all discharge patients but **targets those who are medium to high risk**. TLC services are tailored to meet the individual needs of the patient and **provide a more intensive follow-up**.

Options Counseling will be available to assist the patient, or their caregiver, to make informed choices about care options and link them with community services if needed.

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Transitional Care "TLC" Services

"Community Choice" Services

Community Choice, services may be provided under a cost per service unit as determined by the beneficiaries care plan. These services may also be purchased separately by other funding sources or by the beneficiary. Services will not replace or duplicate services already being provided to the patient by other sources. Service units are based on current services being provided by the AAAIL. Some services are subject to change based on procured pricing.

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Transitional Care "TLC" Services

"Community Choice" Services

Personal Care
Homemaker
Caregiver Respite
Home Delivered Meals
Options Counseling
Care Management
Benefits Counseling -
Caregiver Counseling/Education
Chronic Disease Management
Escort/Transportation
Medication Management

Supplemental Services including Home Adaptations -(Supplemental services can include, but are not limited to, specialized equipment, supplies and home modifications)

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Transitional Care "TLC" Services

CLIENT CENTERED BENEFITS

Client Centered Benefits are made available to all patients of Transitional Care, "TLC" at no additional cost. These services will target the patients' specific needs, assist them to become more comfortable in making decisions toward their personal health care and provide a reliable and trusted source of support when needed. These services include;

Community Resource Packet - Each resource packet contains contact information and phone numbers of community services available in the county of the patients' residence. These include: Adult Day Care Services, food and clothing assistance, assisted living facilities, legal assistance, senior center information, etc.

Information and Assistance – by phone and web site

Community Link - Referrals to other community services

Beneficiary and Caregiver Education Programs

Caregiver Support Groups (based on availability)

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Key Takeaways

- Improvement of social assessment
- Better Treatment of many chronic diseases – Chronic Disease Self Management
- Program and community services are necessary for patient/caregiver support
- Communication is paramount
- Education (Patient and Caregiver)
- Creative follow up "must think out of the box"
- On July 9th, TLC program was notified of receiving the "Innovations" award from the National Association of Development Organizations

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Bluegrass “TLC” Transitional Care Program

Bluegrass Area Agency on Aging and Independent Living

BG TLC (Transitional Care) PROGRAM

May 1, 2014 thru April 30, 2015

731 Referrals

384 In Study Group (No Services)

46 Readmissions for Study Group(12%)

347 In program

23 Program Readmissions (6.6%)

Bluegrass Region Overall (from Home)Readmissions = 16.43%

Kentucky Overall (from home)Readmissions = 17.54%

Program Cost

- 23 x 11,200 (all cause readmission) =$ 257,600
- Cost of the program = $ 138,800
- Savings to Medicare = $ 118,800

Benefits to the Hospital

- Improved Medicare Spend per Beneficiary
- Improved Patient Experience (satisfaction)
- Population Health
- Care Transitions with evidenced – based model
- Meets Joint Commission standards
- 2014 quality award

Key Takeaways

- Transitions of Care – Community Based Model Terry Altpeter, Baptist Health Lexington.
  - Addresses social issues
  - Provides comprehensive program to meet the patient needs
  - Importance of collaboration and communication – all providers