

COPE Health Solutions' Care Transitions & CoordinationSM Program

<p>Problem to Be Resolved:</p> <ul style="list-style-type: none">From June 2006 to June 2009, Hollywood Presbyterian Medical Center (HPMC) was experiencing a readmissions rate for patients with congestive heart failure (CHF) that was higher than the national average. This indicates that patients were not receiving appropriate care and resources once discharged from the hospital and put HPMC at risk for a Medicare penalty beginning in 2013.	<p>Hospital: Hollywood Presbyterian Medical Center</p> <p>Location: 1300 North Vermont Avenue Los Angeles, CA 90027</p> <p>Contact: Chinyere Nwodim Senior Project Manager Care Transitions & Coordination, COPE Health Solutions chinyere@copehealthsolutions.org</p>
<p>Category:</p> <ul style="list-style-type: none">E: Exit <p>Key Words:</p> <ul style="list-style-type: none">Medical HomeCare TransitionsCare CoordinationMedicare ReadmissionsFrequent ED VisitsCare Manager	<p>Hospital Metrics: <i>(Taken from the American Hospital Directory)</i></p> <ul style="list-style-type: none">Annual ED Volume: Approximately 25674Hospital Beds: 443Ownership: PrivateTrauma Level: NATeaching Status: Yes
<p>Tools Provided:</p> <ul style="list-style-type: none">Medical Home Flyer: This is an outreach tool to solicit participation from frequent ED users for the Care Transitions & CoordinationSM Program. The form explains the benefits of a Medical Home and is completed by ED staff with the patient's appointment date and questions to ask their doctor.Patient Encounter Sheet: This tool works as a referral for the Care Transitions & CoordinationSM Program and is to be completed by ED Care Coordinator.Patient Enrollment Agreement: This form describes the Care Transitions & CoordinationSM Program, including the services the patient can expect to receive from the program and is signed by participants who agree to enroll in the program.Patient Satisfaction Survey: This survey is administered after the patient has been connected with a Medical Home to assess their compliance with the appointment and their satisfaction with the Medical Home location and services.	

Innovation

The Care Transitions & CoordinationSM (CT&C) Program is a turn-key strategy that can be implemented through partnerships between hospitals, private physicians, community health centers, independent physicians and/or medical groups in order to build capacity for population health management and success under new financial incentives for patient care.

The CT&C program:

1. Empowers patients to be more engaged in managing their own care by connecting them with appropriate information, tools and resources to access care in the appropriate settings.
2. Develops a coordinated network of care involving the hospital and surrounding ambulatory care providers to provide seamless transitions between care settings and ensure that patients are connected with a primary care home after a hospital visit.
3. Improves access to the right care at the right place at the right time and enhances the bond between patients and the health care network.

CT&C comprises three primary components:

- Care Management for the most at-risk, chronically ill patients
- Emergency Department Care Coordination for patients needing help with connection to a medical home
- Medical Home Network Development

As part of the Patient Protection and Affordable Care Act (federal health reform), the Centers for Medicare and Medicaid Services (CMS) will seek to improve quality of care by connecting reimbursements with hospital performance. Hospitals will be penalized for 30-day readmissions rates that are higher than the national average for three specific conditions: heart attack, congestive heart failure (CHF), and pneumonia.¹ Hospitals that are found to have higher readmissions rates will be penalized with a 1% reduction in total Medicare payments, beginning in 2013. This penalty may increase to 3% over time.

As a part of an effort to reduce this risk and improve their ability to better manage the health of their patient population, HPMC partnered with COPE Health Solutions to implement to Care Transitions & CoordinationSM program to manage its most complex and challenging patients, with a special emphasis on patients with CHF.

Results

Preliminary readmissions data were analyzed for the period of July 15, 2010 through January 31, 2011 for patients enrolled in the CT&C program. The 30-day readmissions rate for CHF patients enrolled in the CT&C program at the end of the initial six-month period was 24.5%² representing a **15% reduction** in the readmissions rate from HPMC's baseline³ for the previous period.

While this preliminary data represents a small number of patients over six months, it reveals a potentially significant impact on the readmissions rate for CHF patients. As the program continues to manage a larger

¹ These penalties will apply initially to only Medicare Fee For Service patients.

² This 30-day readmissions rate represents 55 patients admitted with congestive heart failure from July 15, 2010 through January 31, 2011.

³ HPMC baseline readmissions data (for June 2006 through June 2009) for CHF patients is **28.7%**, compared to a national average (over the same period) of **24.7%**. Data obtained from www.hospitalcompare.hhs.gov.

number of patients, its true impact will be through the reduced financial impact and risk for the hospital, and, more importantly, improved health for the patient as indicated by reduced ED visits and hospital readmissions.

This program may also be expanded to impact additional Medicare patients diagnosed with pneumonia and heart attack to ensure patients are actively engaged and educated about their conditions, and receive the appropriate resources to manage their care outside of the hospital setting. The key will be in identifying the primary drivers of readmissions for these patients and bridging the gap between hospital admission and primary care.

Timeline

It took 3-4 months to fully implement the CT&C program. This period includes evaluations to review current discharge processes, information sharing mechanisms between the hospital and clinics, and challenges unique to the hospital and specific patient population. Care managers can also use this period to build relationships with the community health centers surrounding the hospital, bridging the gap between inpatient care and the primary care setting where the patient will be cared for long term.

Innovation Implementation

Patients selected for participation in the CT&C program were complex, chronically ill patients identified by the hospital staff as having a high risk for readmission or inappropriate utilization of hospital based services. These patients were managed over a 1-3 month period, depending on patient complexity and needs, during which time a dedicated care manager helped to establish the patient in a medical home, worked to gain specialty care access for the patient, connected the patient with support groups, and assisted the patient with self management and goal setting. Each of these patients was visited by a care manager during their inpatient stay, assessed for their needs outside the hospital, included a home visit, and coached on how to better manage their health and navigate the health care system. The care manager also assisted the patient with:

- Education on appointment and medication adherence;
- Connection with specialty care services;
- Assistance applying for additional social services and coverage (In Home Support Services, Medi-Cal/Medicare coverage, Supplement Security Income(SSI)/Disability, In-home food delivery, Access Paratransit, Emergency housing placements, Rehabilitation, etc.); and,
- Additional services as needed by the patient.

Implementation of the CT&C requires close coordination with both hospital and clinic based staff. In the hospital, it is critical to involve ED intake staff, nurses and physicians to identify frequent ED users. Case management and social work departments also provide a vital mechanism for admitted patients to be connected with CT&C.

As of June 30, 2011, 312 patients received intensive care management intervention through the Care Transitions & CoordinationSM program. An additional 2271 ED patients were educated on the importance and appropriate use of a primary care medical home. These patients are expected to have better coordination of care and improved health as evidenced by a reduced rate of readmission to HPMC following a hospitalization and a lower number of visits to the Emergency Department.

Cost/Benefit Analysis

The most significant expense in this program was having a dedicated care manager to work with the patient during their transition from the hospital to a primary care setting. Hospitals, however, can work with

community health centers and private physicians in their area to ensure that patients receive a warm handoff along the continuum of care by creating mechanisms to notify clinics and physicians when their patients have been seen at the hospital and share clinical information. While this will bridge some of the gaps, programs like Care Transitions & CoordinationSM will remain important in addressing the patient needs that cannot be assessed by the hospital or clinic.

Advice and Lessons Learned

1. The key issues that impact the patients' ability to effectively manage their care outside the hospital include:
 - a. Obtaining prescription medication
 - b. Attending a primary care appointment within 7 days of discharge
 - c. Obtaining transportation to the primary care appointment
2. Many patients with CHF are often readmitted for non-cardiac issues, such as falls in their homes.
3. The difficulty for most hospitals is ensuring that challenging, medically complex patients receive the appropriate care once they have been discharged from the hospital. The CT&C program focuses on proactively engaging patients before their discharge.
4. Often patients do not have significant family support and are unable to arrange for certain services such in home support services, transportation, etc. By visiting the patient's home, the care manager is able to fully assess their needs, noting if the patient's home presents any hazards, such as hoarding, that may increase the patient's risk for additional injury. This key component is often missing from hospital or clinic based case management.

Tools to Download

- [Medical Home Flyer](#)
- [Patient Encounter Sheet](#)
- [Patient Enrollment Agreement](#)
- [Patient Satisfaction Survey](#)

Related Resources

- [Urgent Matters E-Newsletter Volume 7, Issue 5: Best Practices, Improving Care Transitions and Coordination for Frequent ED Users \(Kern Medical Center\)](#)