BACKGROUND

In November 2014, as part of early pilots, the Maimonides Medical Center (MMC) Department of Population Health convened a 30-Day Care Transitions Workgroup comprised of operational leaders from hospitals, health plans, community-based organizations, post-acute providers, and other local stakeholders to develop the 30-day care transitions intervention. The group defined the target patient population and workforce, developed operational workflows, and prepared for implementation.

In October 2015, Community Care Bridges (CCB) implemented a care transitions model at its network hospitals, which aims to reduce preventable hospital utilization among a high-risk, safety-net patient population by improving care coordination and addressing social determinants of health.

TRANSITIONAL CARE TEAMS

- CCB's care transitions model required five hospitals to assemble high-functioning transitional care teams (TCTs), comprised of Transitional Care Nurses (TCNs) and Transitional Care Managers (TCMs) to work together to support patients deemed at risk for readmission and to ensure effective transitions of care.

- TCNs screen patients for risk of readmission using a modified IADG Length of stay (LOS) tool, or consultants, NAACOG, Yorkton tool and a social determinants of health screening tool. TCNs use the screening tools to assess patients and prioritize patients in place to address any needs.

- TCNs work with TCTs to address the following needs:
  - Activities of daily living
  - Medication adherence
  - Education/Health Literacy
  - Financial support/security
  - Risk/security
  - Housing stability
  - Substance use
  - Supportive services

- If goals are supported, TCNs order patients to the following community resources for support post discharge:
  - Agency: Home-based services, agencies that connect patients with home care or community-based programs to develop home-based self-management programs for atrisk patients.
  - CCB-NYLAG Legal Health Clinic: Medical legal partnership that provides free legal assistance to patients struggling with health-related legal issues.
  - Maimonides Medical Center Department of Population Health: Work with patients in primary care and medical clinic patients who have been trained and certified to engage patients in creating self-management goals and supporting patients’ care coordination and engagement.
  - Mental Health Providers: Licensed provider advocates that support patients with behavioral health conditions in hospital settings and community settings.
  - Nonclinical Workgroup: Remote-based platform that connects patients and clients to community resources based on identified need.
  - Recovery Peer: Licensed peer advocates that support patients in need of substance use treatment and assist patients in developing and maintaining safe, healthy, and stable in community lives.

- TCNs create an individualized, patient-centered 30-day care plan comprised of the following elements:
  - WAMFT: Specific, Measurable, Achievable, Relevant, and Time-bound patient-directed goals
  - Development of patient’s strengths and needs
  - Patient education, taught using the teach-back method and motivational interviewing
  - Effective linkages to follow-up care, including primary care, specialists, homes, homes, home care, agents, employers, neighbors, friends, and other providers
  - Medication reconciliation and management throughout the care plan period
  - TCTs work with all patients to ensure post discharge, making follow-up within 30 days and 90 days for patients within 1, 30-day day after discharge and 90 days thereafter. TCNs schedule and remind patients of follow-up appointments and address any barriers to patients attending.
  - TCNs conduct wound of clinical and non-clinical providers to ensure continuity of care.

INTEGRATING THE MAX METHODOLOGY

- CCB engaged each of its six network hospitals in developing Medical Hospitalized Exchange (MHEX) Action Teams and helped the hospitals developing ongoing improvement strategies, such as an action plan at the Fm. Fm, Cm. Mtc, Lc. Mtc, Mtr. Mtc, and Td. Mtc coordinators with MHEX requirements.

- Each MHEX Action Team identified facility-specific priority populations and each population’s unique driven of utilization. They developed action plans to address the drivers at the system level and continue to convene interdisciplinary care conferences to discuss individual cases and make treatment recommendations.

- Consistently, with this goal, each hospital’s perspective for value-based contracting and overall OSBP efforts, CCB’s agreements with participating hospitals include pay-for-performance and quality improvement measures.

INPATIENT UTILIZATION

- There were reductions in percentage of patients with readmission between the 90-day pre- intervention period and the 90-day post-intervention period for each quarter of program implementation across all five hospitals ranging from 14.0% to 18.7%.

- There were reductions in the number of inpatient admissions for each quarter of program implementation, ranging from 14.4% to 22.0%.

- There were reductions in inpatient discharges between the 90-day pre-intervention period and the 90-day post-intervention period for each quarter of program implementation across all five hospitals ranging from 13.1% to 14.4%.

- There were reductions in the number of all-day visits for each quarter of program implementation, ranging from 5.6% to 10.7%.

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- There were reductions in percentage of patients with ER utilization between the 90-day pre- intervention period and the 90-day post-intervention period for each quarter of program implementation across all five hospitals ranging from 14.0% to 18.7%.

- There were reductions in the number of ER visits for each quarter of program implementation, ranging from 8.0% to 13.6%.

- There were reductions in ER readmissions for each quarter of program implementation, ranging from 11.5% to 15.0%.

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