Project 2.b.iv: Care Transitions Intervention Model to Reduce 30 day Readmissions for Chronic Health Conditions

Domain 2: System Transformation Projects

Problem Statement:
The rates for potentially preventable hospital readmission in the FLPPS geography are higher for Medicaid patients than for the general population. In addition, rates for many chronic diseases are higher in the FLPPS region than the NYS average.

Summary Statement:
Hospital readmission rates are often related to non-adherence to post discharge care instructions, which can be the result of lack of health literacy, barrier to basic needs (i.e., transportation), non-compliance with medications and follow up appointments, and poor engagement with community based services.

Objective:
Provide a transition care manager to patients for a period of 30 days after hospitalizations for chronic ambulatory care sensitive conditions. The care manager can assist the patient in better understanding discharge plans and increase likelihood of adherence to that plan, thereby reducing preventable readmissions.

Core Components and Deliverables:
Development of protocols that follow the Care Transitions Intervention Model to include:

- Early notification of planned discharges
- Pre-discharge meeting between patient and care manager
- Transition of care records to patient’s providers
- 30 day transition of care period
- Engagement of key partners in protocol development and service delivery, including:
  - Medicaid Managed Care
  - Health Homes
  - Primary care/high risk primary care
  - Required network social and home based services

Target Populations:
- Primary: Adult Medicaid patients being discharged to home care or self-care following admission for chronic conditions including diabetes, respiratory diseases, cardiac and circulatory conditions.
- Secondary: Adult Medicaid patients with medical comorbidities, limited social supports, secondary behavioral health conditions, and more than one recent admission.
Assets:
- Existing collaborations between hospitals and various community based providers
- Existing standards and protocols for identification and referral to care transitions and health homes
- Strength of the workforce – care transitions trained professionals
- Existing practices for sustainability – to leverage for widespread MMC coverage
- IT infrastructure

Challenges:
- Information Technology variations
- Workforce expansion and training needed
- Regional variations in population density impact potential caseload sizes
- Transportation
- Need for cultural competency

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