Domain 2: *System Transformation Projects*

Project ID*: 2.b.iv*

Project Title*: Care transitions intervention model to reduce 30 day readmissions for chronic health conditions*

Objective:

Provide a 30-day supported transition period after a hospitalization to ensure discharge directions are understood and implemented by the patients at high risk of readmission, particularly patients with cardiac, renal, diabetes, respiratory and/or behavioral health disorders.

Description:

A significant cause of avoidable readmissions is non-compliance with discharge regiments. Non-compliance is a result of many factors including health literacy, language issues, and lack of engagement with the community health care system. Many of these can be addressed by a transition case manager or other qualified team member working one-on-one with the patient to identify the relevant factors and find solutions. The following components to meet the three main objectives of this project, 1) pre-discharge patient education, 2) care record transition to receiving practitioner, and 3) community-based support for the patient for a 30-day transition period post-hospitalization.

Target Patient Population:

Patients discharged from in-patient hospitalization who are considered to be at high risk of readmission, particularly those with cardiac, renal, diabetes, respiratory and/or behavioral health disorders, in addition to individuals who are Health Home eligible or dual eligible, as these populations experience high social needs and co-morbidities that present additional readmission risk factors.

Actively Engaged Patients for DSRIP Reporting Purposes:

The number of participating patients with a care transition plan developed prior to discharge.

Providers Expected to Participate:

Primary care physicians, non-PCP practitioners, clinics, health homes / care management organizations, behavioral health providers, substance abuse treatment providers, skilled nursing facilities / nursing homes, community based organizations, and others.

Project Milestones
Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.
Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.
Ensure required social services participate in the project.
Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.
Ensure that a 30-day transition of care period is established.
Use EHRs and other technical platforms to track all patients engaged in the project.