

AN EVIDENCE-BASED CARE TRANSITIONS APPROACH

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Community-based Care Transition Program (CCTP)

- Sect. 3026 of the Affordable Care Act
- A pilot managed by Centers for Medicare & Medicaid Innovation
- CCTP is a Partnership for Patients initiative – aim to reduce hospital readmissions by 20%
- Targets Medicare Fee For Service beneficiaries discharging from hospital
- Currently 72 participating sites

CCTP – Project Requirements

- Community-based Organizations (CBOs) partner with hospitals
- Document need and priority populations through a Root Cause Analysis
- Use evidence-based care transitions model
- CBOs paid an all-inclusive rate per eligible discharge, limited to once per 180-day period

CCTP – Project Requirements

- Project goals that include: number served, all-cause readmission rates, and readmission rates for individuals served
- Participate in quarterly virtual and on-site Learning Collaboratives
- Expected to conduct rapid process improvement cycles addressing key performance areas
- Quarterly monitoring reports track process and outcome goals

CCTP – Metro Care Transition Collaborative

- CBO Partners –
 - ▣ Multnomah County Aging, Disability & Veterans Services – lead
 - ▣ Clackamas County Social Services
 - ▣ Community Action Team of Columbia County
 - ▣ Washington County Disability, Aging & Veterans Services

- Hospital Partners –
 - ▣ Adventist Medical Center
 - ▣ Legacy Health Systems (4 hospitals)
 - ▣ Oregon Health Sciences University

Metro Collaborative

- Risk Targeting – clients must have an eligible diagnoses or have 2 hospital admissions (no dx limit)

COPD	Orthopedic Surgery
Diabetes	Renal Failure
Pneumonia	Deep Vein Thrombosis
Cerebral Vascular Accid.	Coronary Artery Dx
Coronary Atherosclerosis	Ischemic Heart Dx
Aortic Valve Dx	Atrial Fibrillation
Cardio Myopathy	Unstable Angina
Congestive Heart Failure	Acute Myocardial Infarct

Metro Collaborative

- Intervention – Coleman Care Transitions Intervention (CTI)
 - ▣ Focus on patient activation & “teach back”
 - ▣ Identify and meet patient in the hospital
 - ▣ Home visit within 72 hours of discharge
 - Medication self-management
 - Dx red flags
 - PCP follow up visit & communication
 - Patient-centered health record
 - ▣ Up to 3 phone calls within the following 3 weeks
 - ▣ Wrap-around community services – in-home care, home delivered meals, transportation, etc.

Metro Collaborative – key features of partnership

- ❑ Coordination of transitions initiatives
- ❑ Hospital champions
- ❑ CBOs conduct case finding in hospitals
- ❑ Use of electronic medical record for case finding
- ❑ Rapid process improvement cycles
- ❑ Evolution of coach staffing model to Hospital/Field coaches
- ❑ Addition of wrap-around services
- ❑ Tracking SNF discharges
- ❑ Database to track patients & services

Metro Collaborative - Outcomes

- Participant 30 day readmission rate – 11.3%
 - ▣ Significantly lower than project total of 15.7%
- 30 day all-cause readmission rates for all Medicare FFS – reduced from 18.4% to 17.4%
 - ▣ Project total – reduced from 20.2% to 19.5%
- Visited a physician w/in 7 days of discharge – 36.3%
 - ▣ Slightly lower than project total of 38%
- Served 14.4% of Medicare FFS patients in partner hospitals (173 individuals in January)

Metro Collaborative – Future Goals

- Reduce 30 day all-cause readmission rates for all Medicare FFS beneficiaries to 14.7% (20% reduction goal)
- Increase rate of participants visiting physician w/in 7 days to 40%
- Serve 30% of Medicare FFS patients in partner hospitals – 360/month
- Expand program to new hospitals
- Expand program to new payors



□ Questions?

□ Metro Care Transitions Collaborative Contacts

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