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CENTERS OF CARE
Nassau University Medical Center
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Family Health Centers
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Transitions of Care Progress Report

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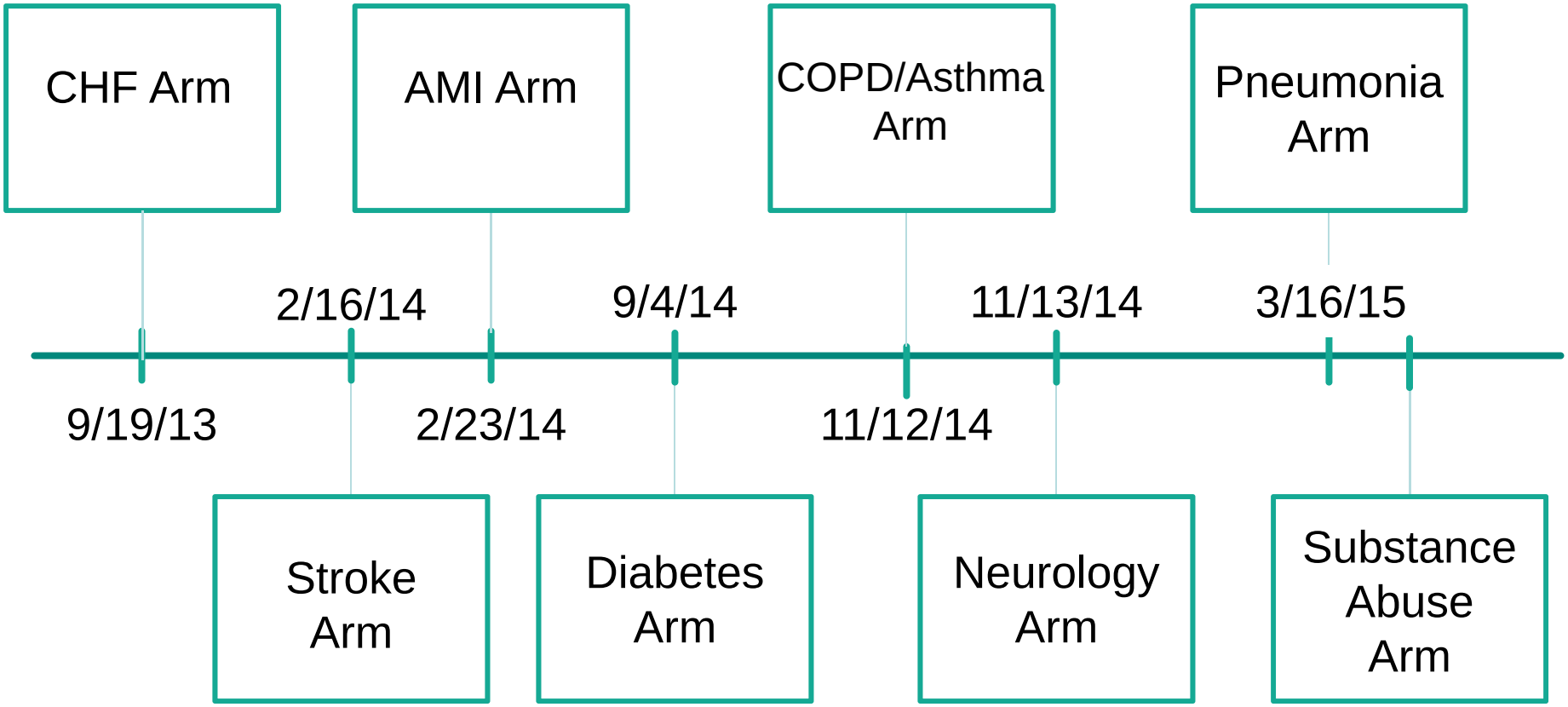
TOC Enrollment History



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Key TOC Considerations

- Four tier program supported by Transitional Coaches designed by Eric Coleman, MD, MPH
- Self management skills
- Meets patient's needs during transitions of care
- Focuses on reconciling incongruent medication regimens
- Enhanced continuity across health care settings

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Post-Discharge Follow-Up Calls

Patient With CHF

Patient Enrolled

Day 2:

CHF Call 1

Patient Responses

- Not Following Low Salt Diet
- Not Weighing Self Daily
- Does Not Have Scale

Triggers Alert

"Spoke to pt's daughter… Will get the scale… Cardio appointment went well. She has labs in two weeks. She has a vomiting x1 episode last night… she didn't eat before her meds… I reinforced the importance of her diet."

CHF- Congestive Heart Failure

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Care Transition Intervention Model

- ***Structure discharge lists – The Goal:* *Patient Care Plan***
  - ***Empowers patient before discharge***
- **Sessions with transitions coach – before discharge, home visits, and follow-up phone calls → ensures continuity**
- Medication self-management – educate patients regarding medications
- **Use of Personal Health Record – Patient understand and uses PCR for communication and continuity of care**
- PCP and Specialist follow up – Patient schedules and completes follow up visits, empowers to be an active participant
- **Knowledge of Red Flag – Educate patients about indications and signs of worsening conditions; how patients should respond and where to seek help**

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TOC Quarterly Readmission Report

Program Population	Q3 - 2014			Q4 - 2014			Q1 - 2015			Q2 - 2015		
	Total 30-day Readmits	Total Patients Enrolled	Readmission Rate	Total 30-day Readmits	Total Patients Enrolled	Readmission Rate	Total 30-day Readmits	Total Patients Enrolled	Readmission Rate	Total 30-day Readmits	Total Patients Enrolled	Readmission Rate
AMI	0	6	0%	0	3	0%	0	9	0%	0	11	0%
CHF	4	41	10%	2	32	6%	1	71	1%	1	43	2%
Stroke	6	60	10%	5	56	9%	3	83	4%	3	93	3%
Diabetes	1	19	5%	13	77	17%	6	110	5%	4	100	4%
COPD	-	-	-	6	27	22%	7	115	6%	5	117	4%
ALL	11	126	9%	26	195	13%	17	388	4%	13	364	4%
Cum	11	126	9%	37	321	12%	54	709	8%	67	1073	6%

July 2014 – June 2015; n = 1,073 patients enrolled

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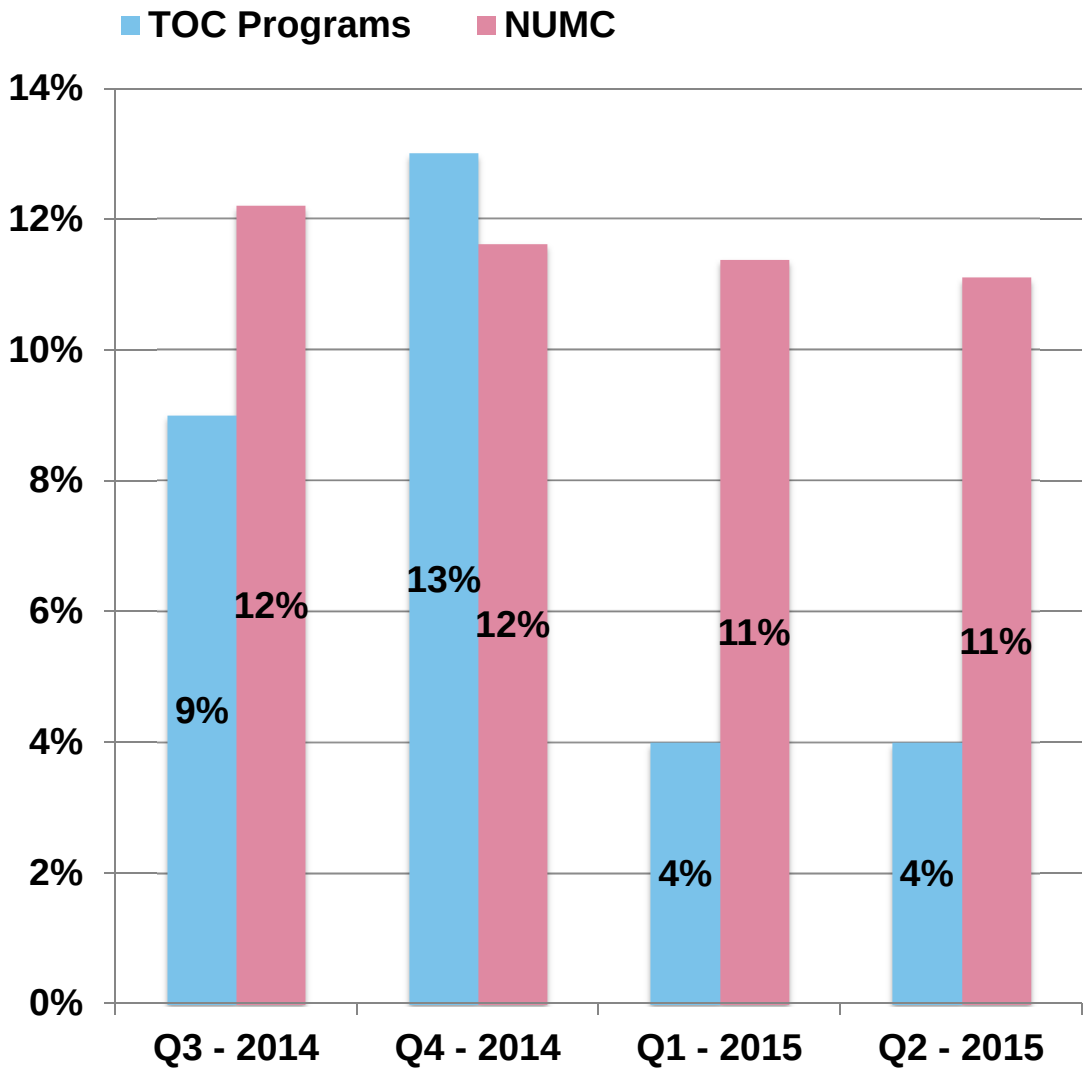
Impact of TOC Program



Source: Olawale Akande & CipherHealth

In 2015, the readmission rate has been **63% lower** for TOC patients than patients not enrolled

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Impact of Follow-Up Calls on Readmission Rate

One Successful Call ➡ 50% Readmission Reduction

Four Successful Calls ➡ 80% Readmission Reduction

Program	Unreached			At Least One Follow-Up Call			All Follow-Up Calls		
	Total 30-day Readmits	Total Patients Enrolled	Readmission Rate	Total 30-day Readmits	Total Patients Enrolled	Readmission Rate	Total 30-day Readmits	Total Patients Enrolled	Readmission Rate
AMI	0	8	0%	0	21	0%	0	6	0%
CHF	4	29	14%	3	140	2%	0	41	0%
Stroke	6	96	6%	11	179	6%	2	31	6%
Diabetes	5	55	9%	19	233	8%	1	29	3%
COPD	13	86	15%	5	156	3%	0	20	0%
Total	**28**	**274**	**10%**	**38**	**729**	**5%**	**3**	**127**	**2%**

Source: Olawale Akande & CipherHealth

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Summary

- Early identification of eligible candidates for TOC intervention
- Planning for discharge period begins soon after admission
- Potential impact upon outcomes may occur via identification and involvement of support system and utilization of CBOs
- Early post-discharge contact with resolution of potential readmission factors
- Decreased failure to follow-up
- Progressive decline in readmission trending

CBO: Community Based Organizations

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TOC Future Projections

- Expand TOC patient population to include all disease processes and psychosocial issues

- Discharge survey including Patient Portal satisfaction scoring

- Readmission survey:
  - Identify reasons for readmission

- Vetting for solutions to iatrogenic readmissions

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TOC Future Projections

- Utilization of valid risk assessment tool

- Increased community presence and outreach; increase collaboration with CBO*s

- Early post-discharge contact:
  - oReinstitute home- and SNF^ visits with resolution of potential readmission factors

- Provision of devices to examine targeted clinical parameters:

Scales	Recording logs
Peak flow meters	Glucometers

*CBO: Community Based Organizations
^SNF: Skilled Nursing Facility

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Acknowledgments

NuHealth Administration and Clinical Staff Members

Transitions of Care
Social Work
Case Management
Quality Improvement

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