

## South Central PA

CLOSING THE LOOP ON CARE TRANSITIONS

he Aligning Forces for Quality (AF4Q) initiative in South Central Pennsylvania is led by The Healthy York County Coalition (HYCC). Its mission is to engage consumers in order to improve the quality of health care for all who live, work, and play in this community. Goals are accomplished by sharing resources and information, implementing proven practices on the ground, and measuring outcomes. The Leadership Team includes people and organizations from five main community stakeholder groups: providers, employers, consumers, community leaders, and health plans. AF4Q-South Central PA's health care partner providers (Family First Health, Hanover Hospital, Memorial Hospital, and WellSpan Health) have committed to championing the incorporation of more efficient strategies to manage care within their health systems.







## Closing the Loop on Care Transitions

Aligning Forces for Quality of South Central Pennsylvania, in partnership with the York County Area Agency on Aging, the Adams County Office for Aging, and other regional organizations, is leading targeted efforts to provide care transitions services to Medicare beneficiaries discharged from York, Hanover, and Gettysburg Acute Care Hospitals. Together, AF4Q and the York-Adams Care Transitions Coalition have formed a strong collaborative body and are creating a community-wide infrastructure for effective care transitions for seniors.

In March 2013, the Centers for Medicare and Medicaid Services announced that the York-Adams Care Transitions Coalition was part of the fifth round of awardees to be offered an agreement to participate in the Community-based Care Transitions Program (CCTP). The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, improve quality of care, reduce readmissions for high-risk beneficiaries, and document measurable savings to the Medicare program.

Seniors are readmitted to the hospital for three primary reasons: confusion over medication use, unclear discharge instructions, a lack of follow-up from a primary care practice, or some combination of all three. The goal is to realize a 20 percent reduction in hospital readmissions for Medicare patients. The coalition is addressing these issues head-on with coaches dedicated to working to help recently discharged patients and their families take charge of their medical conditions, keep track of prescriptions, and identify any problems.

The process begins with an assessment by a lead care transition coach, who monitors admitted patients and flags higher-risk patients based on a history of hospitalizations, types of conditions, and quantity and type of medications prescribed.

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Primary care practices are now receiving emails from York and Gettysburg hospitals, which make up 70 percent of the area's inpatient market, informing them that their patients were admitted and discharged from the hospital to facilitate their patients making follow-up appointments. "One of the lynchpins of improving care transitions is getting discharged patients to their primary care doctor within seven days after a hospital stay," said Christine Amy, Aligning Forces for Quality South Central Pennsylvania's project director. "Coupled with better patient education within the hospitals, this work downstream with providers will reduce readmissions."

Rather than being passive, primary care practices are encouraged to reach out to recently discharged patients to schedule appointments. With full information from discharge summaries, practices have more information at their fingertips to clarify discharge instructions and reconcile medications. "The services provided through

the CCTP are not clinical. They're more about teaching patients how to manage themselves to avoid readmission," explained Deanna Ruff with the York County Area Agency on Aging.

Health Coach Julia Assi with Gettysburg Adult Medicine huddles with her case manager and social worker at Wellspan Gettysburg Hospital every day to review patients in transition. She is the first point of contact for patients in between the hospital and their primary care physician, reaching out within 48 hours after patient discharge to review medication lists, make referrals to specialists, and schedule a follow-up appointment. Assi said, "I'm the sidelines coach—I encourage patients in the right direction. A lot of patients are surprised to hear from me, even though they were told I'd be calling."

Health coaches help nudge patients toward a preventive approach, which Assi says can be difficult, especially for older patients. "We're not sending you home and forgetting about you. Far from it!" she said. She uses a variety of methods to help patients avoid a re-hospitalization, like setting exercise and nutrition goals for managing diabetes or reminding patients about discharge

instructions that start to slide once at home. She even moves appointments up if patients' health begins to decline before seven days have passed.

"It's easy to keep bad habits, and hard to change," Assi added.

The coalition aims to provide care transitions services to about 2,000 of the estimated 13,400 Medicare fee-for-service beneficiaries admitted to participating hospitals annually. The local agencies on aging estimate the program could save Medicare nearly \$2.7 million annually. "It's one a day. If we keep one person out of the hospital per day, we will reduce readmissions by 22 percent," noted Ruff.

Even before the award from the Centers for Medicare and Medicaid Services, Aligning Forces for Quality-SCPA was building its capacity with its coalition partners. Thirty-day hospital readmissions were reduced for York and Gettysburg Hospital from April 2011 to March 2012 by 73 readmissions. Said Amy, "We had a good foundation. With the infrastructure in place, we are now seeing better communication between hospitals and primary care physicians."

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