Project 2.b.iv

Using Care Transition Protocols to Reduce Hospital Readmissions

DISCOVERING WHAT WORKS, ONE PATIENT AT A TIME

After recognizing a patient needing extra assistance, the case management team at Claxton-Hepburn Medical Center sat down with her and worked one-on-one to determine what kinds of help would best fit her needs and levels of engagement.

This patient was a frequent utilizer of the hospital and had not been receptive to various suggestions for help. However, with the help of Case Manager Amber LaShomb, the patient agreed to try services offered by Maximizing Independent Living Choices (MILC), a DSRIP CBO partner. Since then, she has been able to remain out of the hospital for more than 30 days and has become more engaged in her care.

NORTHCOUNTRY INITIATIVE

"...WE ARE ON THE RIGHT TRACK TO ENSURING OUR PATIENTS CAN SAFELY AND POSITIVELY BE NAVIGATED THROUGH THE CONTINUUM OF CARE."

Michael Beldock
Claxton-Hepburn Medical Center

Project Achievements

- **30-day Care Transition protocols** have been adopted by more than 100 partner sites, including primary care practices, hospitals, behavioral health providers and a variety of other community organizations.
- **Collaboration and communication** between medical and social service providers have improved.
- **Alerts for providers** have been implemented, allowing them to be notified when their patients are treated in an emergency department or are admitted to inpatient hospital care.
- PPS Care Transitions protocols have improved warm hand-off processes, so patients get continiuty of care.