The purpose of the New York State Department of Health's Delivery System Reform Incentive Payment (DSRIP) Program is to restructure the healthcare delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years. In partnership with hospitals, public health agencies, physicians and community-based organizations, the North Country Initiative is advancing state-wide projects to transform the healthcare system, coordinate care, and improve the health and wellness for our population.

2.b.iv

Care Transition Intervention Model to Reduce 30-Day Readmissions for Chronic Health Conditions

Project Objective:

To 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.

Project 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.

Patient Population:

The target population are those at high risk of readmission, particularly patients with cardiac, renal, diabetes, respiratory and/or behavioral health disorders.

Identified Community Need:

According to our recent Community Needs Assessment, there is a substantial need to support smooth care transitions from inpatient to outpatient settings for at risk patients with chronic disease and mental health illness within the region. Due to rural demographics and transient military population, once they leave the "teaching/engaging" moment at the hospital, the Health Home Care Managers are unable to find them and engage them in outpatient service and active participation in their care plans that would prevent future hospitalizations and emergency department use.

2.b.iv

Care Transition Intervention Model to Reduce 30-Day Readmissions for Chronic Health Conditions

Project Milestones	
1	Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.
2	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.
3	Ensure required social services participate in the project.
4	Transition of care protocols will include early notification of planned discharges and the ability of the transition case manager to visit the patient while in the hospital to develop the transition of care services.
5	Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.
6	Ensure that a 30-day transition of care period is established.
7	Use EHRs and other technical platforms to track all patients engaged in the project.