Transitional care bridges treatment gaps, cuts hospital re-admissions

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With no one available to transport him to his appointments to follow up with his doctors, a legally blind man finds himself readmitted to Robert Wood Johnson University Hospital for heart failure. Thanks to the hospital's Transitional Care Program, the patient is diligently monitored by hospital staff and RWJ visiting nurses so that he can get the care he needs.

Now, his doctors visit him at home and his prescriptions are also delivered to him. His path to better health now has been paved.

RWJ is one of five area hospitals to team up with health-care entities to formulate programs that would not only decrease re-admission rates but improve patients' overall health-care management.

In January, RWJ teamed up with its partner, Robert Wood Johnson Visiting Nurses to establish its Transitional Care Program, which aids patients such as Irving Rosenthal of Monroe, who admits that he should eat healthier and exercise more.

After Rosenthal was discharged from the hospital and rehabilitation facility, and he returned home after treatment for congestive heart failure in April, he learned how the program would benefit him.

"The nurses review my medications, and they make recommendations about exercise and my diet. Being 92, it's not easy for me to change my habits; that's why it's important to have the support these nurses provide," he explained.

Teresa De Peralta, the hospital's transitional care coordinator, noted that Rosenthal's age and chronic heart condition placed him at risk for re-admission. However, the Transitional Care Program, funded by a $4 million grant from the RWJ Foundation, would give him the tools to improve his health.

As a result of provisions in the Affordable Care Act, beginning in October, many state hospitals will lose a portion of their regular Medicare reimbursements because of high re-admission rates for certain conditions, such as congestive heart failure, within a month of discharge. Efforts like the Transitional Care Program at RWJ are responses to this change and are part of an overall effort to improve the quality of care provided and keep patients healthy at home.

The program includes the development of an electronic interface among home-care providers and hospital faculty, community physicians, social workers and discharge planners. Patients also have access to a health-care advocate during their transition between the hospital or rehabilitation facility and their homes.

At RWJ, the advocate follows a patient during his or her hospital stay, becomes educated about his or her needs, and identifies possible risk factors that may lead to re-admission. The program also works to enhance palliative care programs for patients and improve medication management by using automated drug protocols which electronically "flag" patients who may need a medication review by a home care nurse or medication counseling provided by a pharmacist.

De Peralta explained that often patients become puzzled by the types of medicines they are prescribed or have no way of obtaining them. They also may not follow up with their physicians after being discharged, cannot find a way to get to their appointments or are unable to schedule them. All of these factors make them vulnerable, she said, because patients end up "giving up" and become re-admitted.

De Peralta believes that the Transitional Care model at RWJ works so closely in concert with each at-risk patient, with every case examined carefully every two weeks, that patients are able to take control of their lives in an empowering way.

Somerset Medical Center

At Somerset Medical Center, the hospital partners with the Community Visiting Nurse Association in Somerville, along with a range of other health-care providers, on an initiative similar to the Transitional Care Program at RWJ.

Last year, the visiting nurse association was awarded a $300,000 grant from the Robert Wood Johnson Foundation to aid patients suffering from chronic conditions, such as congestive heart failure and diabetes, by helping them manage their illness and improve their quality of life.

Through the grant, Somerset Medical Center established the CARE (Collaborative Approach to Reach patient Empowerment) Program, which seeks to reduce chronic disease complications, improve health outcomes and prevent unnecessary hospital re-admissions.

CARE is a joint effort by eight Somerset County health care providers, including Somerset Medical Center in Somerville, Arbor Glen Continuing Care in Bridgewater, Bridgeway Care Center in Bridgewater, Somerset Valley Rehabilitation & Nursing Center in Bound Brook, Green Knoll Care and Rehabilitation Center in Bridgewater, Greenbrook Manor Nursing and Rehabilitation Center and Raritan Health and Extended Care.

Through this initiative, an advanced practice nurse follows up with the patients from their stay at Somerset to acute care rehabilitation and home care, focusing on transfer communication between health-care providers, medication management and patient satisfaction.

To help patients learn to self-manage their disease, the CARE Program provides patients with customized disease management booklets, personal health diaries and scales to monitor their weight gain. Patients have access to support groups and educational programs.

Alyssa Kizun, director of care management at Somerset Medical Center, reported that, as of September 2011, CMS.gov (Centers for Medicare and Medicaid Services) reported Somerset Medical Center as having a 27.9 percent re-admission rate for congestive heart failure patients.

Kizun offered the example of a patient suffering from congestive heart failure who benefited tremendously from the CARE Program after he had been readmitted to the hospital three to four times since his initial visit. The patient had been using salt instead of following recommended restrictions, he could not afford his medication, and needed additional support. The CARE Program made all the difference.

“We are proud to partner with the Community Visiting Nurse Association and our other local health care providers to take a broad approach to addressing the systemic community issue of chronic disease,” said Kizun.

“By working together and consolidating our resources, we will make a difference in improving the health of our community,” she said.

Overlook Medical Center

The Safe Transition Program, which is offered at all of the hospitals in the Atlantic Health System, including Overlook Medical Center in Summit, is coordinated from an inpatient hospital stay throughout the transition back home.

Part of the hospital’s Accountable Care Organization, the focus of the program is care coordination, ensuring the patient’s comfort and helping them feel safe and capable after leaving the hospital.

According to Patricia Wallace, complex care coordinator of the Atlantic Accountable Care Organization, case managers screen patients while they are admitted to the hospital to see if they are considered “high risk.”

“About 24 to 48 hours after being discharged, patients receive a call to put their specific health-care plan into place,” she said. Depending upon that plan, which is coordinated through a high-touch telephone interactive program, some patients will be monitored every other day while some are evaluated every other week.

“We want to make sure that our patients are plugged into the right places to help them achieve the best outcome,” she said.

Technology is often a large obstacle for patients and their families, related Wallace, especially when they return home from the hospital with medical devices and machines. While they may exhibit an understanding of how to operate those devices following an in-hospital demonstration, when the patients and their relatives return home they may second-guess how to operate them.

“They may lose confidence in whether they can do it or wonder if they are doing it correctly,” said Wallace.

She recalled one patient was cared for at the emergency room after injuring their hand. Once the patient was discharged and an appointment for a wound check was made, the patient sounded out of breath over the phone when checked up on by the caregiver. Immediately, a plan was put into place to have a physician visit and the patient’s oxygen level was consistently monitored.

While Wallace indicated that the success stories associated with the Safe Transition Program are not quantitative, a survey distributed through Medicare will help the hospital evaluate its benefits.

The Atlantic ACO includes a partnership with Valley Health System in Ridgewood, and participation from more than 1,300 physicians, including more than 200 primary-care physicians, 50 nurse practitioners and 10 ancillary care providers in Bergen, Morris, Sussex, Somerset, and Union counties. Through its participating physicians, hospitals and staff, Atlantic ACO strives to improve the quality of health care and reducing the individual and clinical health care costs for the Medicare population served in these regions.

Hunterdon Healthcare System

Nicole Camporeale, administer director of clinical and quality management at Hunterdon Medical Center in Raritan Township, reported that there are three key programs in place at the hospital that “focus on promoting health, improving care and reducing overall cost.”

The Aetna Commercial Accountable Care Organization covers Aetna’s insured lives and HMC employees, just under 9,000 people, she explained. Aetna provides integrated technologies and data capabilities to enhance the secure exchange of health information across the patients care team. A dedicated registered nurse care coordinator will work with the patients to improve the health care experience though greater care coordination and patient engagement, while lowering the cost of care.

HMC also maintains Horizon Healthcare Innovations Patient-Centered Medical Home program, which covers approximately 18,000 patients. This program model uses embedded RNs (called “Medical Home Care Coordinators”) in designated primary care practices.

Another program at HMC, the CMS Comprehensive Primary Care Initiative, is a multipayer initiative that provides payments to primary care practices that demonstrate enhanced care management and care delivery to Medicare patients.

“Only 75 practices in eight states were selected to participate in this ground-breaking program. We proudly boast that 11 of our Hunterdon HealthCare Partner sites were chosen,” said Camporeale.

Hunterdon HealthCare Partners (HHP) is the Integrated Delivery System for Hunterdon Healthcare and is a clinically integrated network of primary and specialty care providers with enhanced data sharing capabilities through the NextGen Electronic Medical Record (EMR) software platform.

According to Camporeale, 80 percent of the providers use this platform.

She added that HHP has 24 National Committee for Quality Assurance Level 3 Patient-Centered Medical Home sites.

“The Medical Home designation represents a rigorous recognition process that ultimately designates a primary care practices with achieving the highest level of care delivery. It is a new way of delivering health care that puts the focus on the patient,” she said.

“Currently, our embedded Medical Home Care Coordinators work one-on-one with high-risk Horizon patients to make sure they have the resources they need to get healthy and stay healthy,” she said.

“They look at the whole person and work with patients to develop a care plan tailored to their individual needs. They contact patients while they are in the hospital and/or shortly after discharge to discuss their medications (including affordability and compliance), schedule a follow-up appointment with their primary-care provider, address any outstanding home-care needs, educate them about self-management techniques related to their specific condition(s) and discuss preventative care items such as colonoscopy and mammograms. We have received very positive feedback from patients who express their appreciation for the level of care and attention they receive from their MHCC and their medical home,” she said.

Saint Peter's University Hospital

Ann Scotti, care coordinator at Saint Peter’s University Hospital in New Brunswick, noted that, in its efforts to improve transitional care initiatives, the hospital has received recognition from the American Heart Association’s “Get With The Guidelines Heart Failure Program.”

The program provides hospital staff with tools that follow proven evidence-based guidelines and procedures in caring for heart failure patients to prevent future hospitalizations.

“This is viewed as a critical step in prolonging the lives of heart failure patients and in decreasing re-admission rates,” said Scotti, adding that patients are provided with the “right care at the right place at the right time.”

At-risk patients swiftly are identified for possible re-admission while they are admitted at Saint Peter’s. Follow-up appointments with doctors are made on the spot, as many patients must visit with their doctors within seven days. Patients are also coached on how to properly take their medications and fill their prescriptions.

Part of the transitional-care program at Saint Peter’s, which Scotti leads, oversees six sub-acute systems and three visiting nurse agencies. This “Transitions in Care Collaborative” meets approximately every six weeks to streamline and review their procedures and formulate better protocols.

The hospital will also be able to track patients and their needs through a special software solution, she indicated.

Karen Simone, senior care coordination nurse at Saint Peter’s, pointed to a specific story that proves the success of the hospital’s program.

“There was a male patient from out of state, staying with his daughter, with known heart failure, diabetes, hypertension and other medical problems who, over a three-week period, was hospitalized three times with one visit to the emergency room,” she said.

The Saint Peter’s team linked the patient and his family with the vital resources to have prescriptions filled and future medical care ensured during his stay in New Jersey.

“It is indeed the follow-up with patients that make all of the difference,” said Scotti, “and reaching beyond any barriers to make it happen.”