THE FIRST THIRTY

30-Day Heart Strengthening Program

Using a Care Transitions Model to Improve Outcomes in Hospitalized Underserved Elderly Populations

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Introduction

- Transformation of the health care system has led to an increased focus on providing high quality, cost effective care.
- Hospitals are developing transitions of care programs targeted to high risk patients in order to reduce readmissions and other negative outcomes, avoid unnecessary expenditures, facilitate self-care skills, and improve quality.
- Hackensack University Medical Center established an effective transitions of care program designed to improve health outcomes in underserved elderly populations.
- Our program demonstrates the importance of addressing access to care, quality of care, socioeconomic and clinical barriers that affect this vulnerable patient population.

What is *The First Thirty*?

- It is a Transitions of Care (TOC) program designed to reduce 30-day hospital readmissions and improve quality of care.
- The initial project was designed to improve care provided to low-income, high-risk patients with congestive heart failure (CHF) and acute myocardial infarction (AMI).
- Patients/caregivers are involved with their needs addressed.
- A multidisciplinary approach is used to determine the patient's plan of care.
- Our goal is to expand *The First Thirty* Care Transitions model hospital-wide to other diagnoses, designing and implementing an evidence-based strategy to standardize transitions within acuity levels, at and after discharge.

Goals of Program for Underserved Elderly

- Design a quality transitions of care program addressing socioeconomic and clinical determinants of health in the underserved, underinsured elderly population.
- Use our evidence-based care transitions model to reduce 30-day hospital readmissions for CHF/AMI patients 65 years and older.
- Improve patient/caregiver satisfaction.
- Decrease spending by improving quality and access to primary health care.
- Counsel patients/caregivers regarding diagnosis, plan of care, self care, medications, community resources and emergency instructions.
- Perform accurate medication reconciliation on admission and discharge.

Methods

Inclusion Criteria

- Patients 65 years and older who are admitted to the hospital with a principal diagnosis of CHF or AMI
- Patients 65 years and older who develop CHF or have an AMI during the course of their hospitalization
- Patients 65 years and older who are enrolled in, or qualify for Charity Care, Medicaid, Medicaid Managed Care, and Dual Eligible patients

Exclusion Criteria

- Patients who are younger than 65 years of age
- Patients enrolled in a Hospice program
- Patients with a terminal diagnosis
- Patients with an oncology diagnosis, who are actively receiving treatment for a malignant condition
- Patients in Observation status (not yet admitted)
- Patients who decline enrollment into the program
- Patients enrolled in programs with a similar goal

The First Thirty Program's Five Key Interventions

- Upon admission, potentially eligible patients are captured by an auto-generated report that targets payers and diagnoses and are enrolled if appropriate.
- Pharmacist led admission medication reconciliation.
- Patients are given a Wellness Package, consisting of weight scale, blood pressure machine, pill box, and monitoring tools, free of cost.
- Patients are offered *Meds to Beds,* a program designed to fill and deliver discharge prescriptions to the bedside.
- All necessary follow up appointments, including physician, and financial aid are scheduled prior to discharge with transportation provided if needed.

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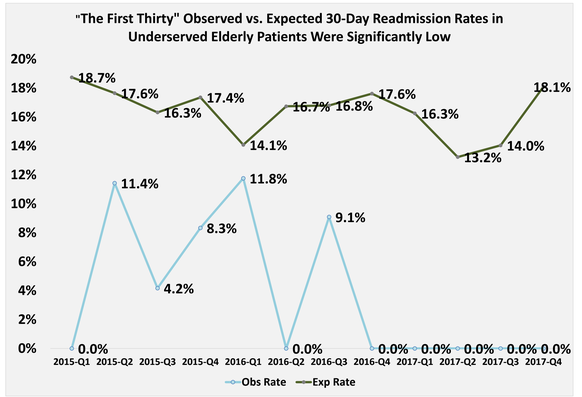
Results



- Previously there was no formal transitions of care program for the uninsured elderly population.
- Our model was designed to address current gaps in care and will continue to identify gaps in care, improvement opportunities and address any new problems.
- In the period from Mar 2015 to Dec 2017, there were only 10 readmissions in the 171 elderly patients in this cohort.
- The 30-day readmission rate was significantly low at an average of 5.8% versus an expected rate of 16.4% (O/E index of 0.36).
- Achieved patient satisfaction rate of 98%.

Sustaining Improvement

- Engaging leadership and including key stakeholders is key.
- Continue to identify and address gaps in care.
- Ensure coordination and communication between all care providers, patients & caregivers.
- Develop and strengthen community partnerships.
- Collect and share metrics/data with stakeholders and at internal and external meetings.
- Regularly monitor patient's self-care skills for 30 days and beyond.
- Use this model to expand transitions of care to other diagnoses and populations.

Conclusions

- The elderly underserved, underinsured patient is at high risk for readmission. They are more likely to live alone, have three or more chronic conditions, have limitations in activities of daily living and take a large number of medications (O'Connor et al., 2016). We have demonstrated that a well-designed, evidence-based, high quality transitions of care program which addresses socioeconomic and clinical determinants of health can improve outcomes in the underserved, underinsured elderly population with AMI and CHF.
- The significantly low readmission rates achieved in this group demonstrate the importance of recognizing the challenges for this population.
- Our TOC Program provides a framework for development of similar programs by other healthcare institutions.

RESOURCES

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