Brewster Place Leads New CMS Demonstration Project

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A coalition of Topeka area health care providers lead by Brewster Place, a COLLAGE member, has been approved for a CMS Affordable Care Act demonstration project called the Community Based Care Transition Program Medicare Demonstration (CCTP). The demonstration is designed to identify strategies that improve care transitions and reduce hospital readmissions to Stormont-Vail and St. Francis and began August 12, 2013.

The Topeka project has been approved for a two year demonstration and is the only one of its kind in Kansas. More information about the strategy and implementation plan is available HERE.

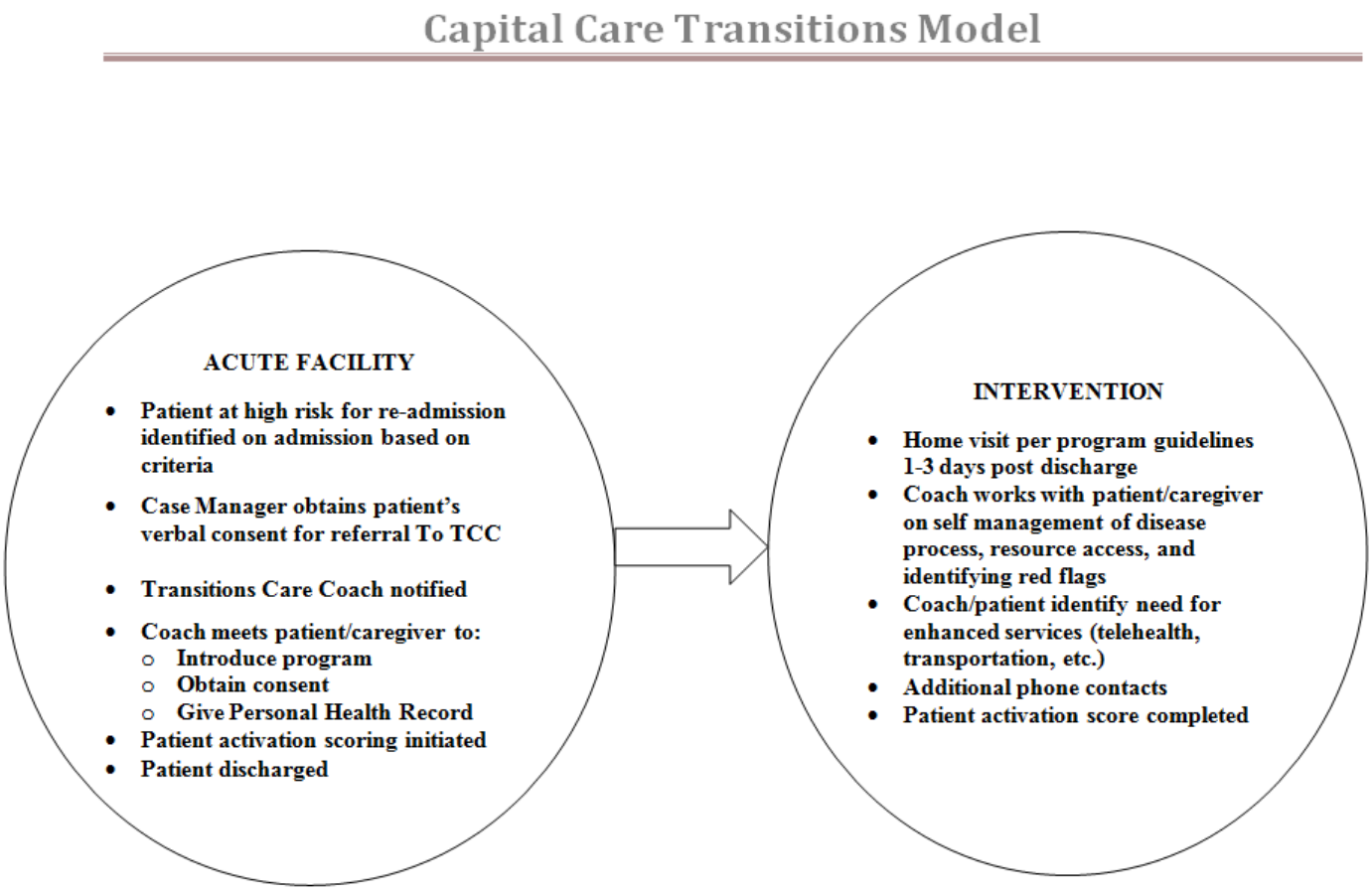
Strategy and Implementation Plan

The Capital Care Transitions Coalition will use the Coleman Care Transitions Intervention (CTI) as the framework for post-discharge care and services for patients discharged from the hospital directly to their homes. Stormont-Vail and St. Francis personnel will identify qualifying patients who are being discharged to home. Each Care Transitions Intervention will be overseen by a Transition Coach who will ensure the coordination and continuity of health care as patients transfer from the acute care hospital.

In contrast to traditional case management approaches, the Care Transitions Intervention model facilitates self-management and patient empowerment. The CTI model works with older adult patients to identify the key self-management skills needed to assert a more active role in their care. The intervention focuses on four conceptual domains:

1. Medication self-management
2. Use of a dynamic patient-centered record, the Personal Health Record
3. Timely primary care/specialty care follow up
4. Knowledge of red flags that indicate a worsening in their condition and how to respond

The following diagram shows how the process works and the interface with the hospital discharge planning process.



Target Population: The Topeka area health care coalition has identified the high risk population through a comprehensive root cause analysis (RCA) investigating individuals readmitted to the participating hospitals within thirty days. Specifically, patients who have one or more of the identified diagnoses and have had a change in medication or identified poly-pharmacy; 65 years of age or older; and receiving Medicare benefits. Based on the RCA, intervention efforts are focused on six discharge diagnoses associated with the high risk population:

- Congestive Heart Failure (CHF)
- Pneumonia (PNEU)
- Heart Attack (AMI)
- Diabetes Mellitus (DM)
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Bypass Graft Surgery (CABG)

Each inpatient admission from the partnering acute care hospitals meeting these screening criteria will be provided information about the care transitions program by the hospital case management staff, who will obtain verbal consent and make a referral to the Transition Coach for interview and

admittance to the program. While patients are encouraged to participate by the case management staff, they are informed this is a voluntary program and may opt out of it. We anticipate about 75% of the eligible population will choose to participate, 199 patients per month based on historical data.

The Model: The Coalition coaches will utilize the evidence-based CTI model and enhance the model with additional services. Additional resources will be employed based on the individual circumstance and need. The enhanced services include telehealth equipment and monitoring, home health services and case management, automatic personal emergency response (AutoPERS) safety net and alerts system, transportation to physician appointments, referrals to the Area Agency on Aging, Meals on Wheels and other community resources, comprehensive wellness assessments and development of a healthy aging plan, and daily automated telephone welfare checks.

Organizational Structure: As the Community Based Organization (CBO) for the CCTP project, Brewster Place leads the Capital Care Transitions Coalition (CCTC). The CCTC includes St. Francis, Stormont-Vail, Washburn University School of Nursing, Jayhawk Area Agency on Aging (JAAA), Northeast Kansas AAA, Shawnee County Health Department, Topeka Visiting Nurses Association, and Holton Community Hospital. The Kansas Foundation for Medical Care (KFMC) facilitated formation of the coalition and assisted with program development.

Eileen McGivern, RN BSN, is the Project Director and will provide overall program management and chair the CCTC advisory board, with representatives from all of the coalition members, to provide additional project monitoring and oversight and to facilitate shared learning. Transition Coaches were selected by the Coalition and will be Brewster employees but will be identified as working for the Capital Care Transitions Coalition. Eileen will oversee the Transitions Coaches with the assistance of Lead Coach Dee Moore. Eileen has twenty-five years of experience in acute care, rehabilitation services and hospice services, and currently serves as Wellness Director at Brewster Place and Director of Brewster at Home. She is a Certified Trainer for Care Transitions Coaches. Dee has a Doctor of Chiropractic Degree and is a Certified Care Transitions Coach.

As the CBO for the project, Brewster is responsible for recruiting, training and supervising all of the Coalition staff and providing care transition services to each patient for 30 days post discharge. Brewster will bill CMS for each transition and be reimbursed by CMS at a negotiated rate. Washburn University School of Nursing will conduct satisfaction surveys, measure readmission statistics and other relevant outcome measures for program management. Jayhawk Area Agency on Aging, Northeast Kansas AAA, Shawnee County Health Department, Topeka Visiting Nurses Association, and Holton Community Hospital, along with other community health and social services providers, will provide additional post-discharge supports and services.