Berkshire County Community-based Transitions Program

Berkshire Health Systems (Berkshire Medical Center; Berkshire Visiting Nurse Association)

Elder Services of Berkshire County, Inc.

OUR COLLABORATION

Elder Services of Berkshire County, Inc. (ESBC), the county's aging service access point and Area Agency on Aging, partnered with Berkshire Health Systems, Inc. (BHS), the major health care provider in rural Berkshire County, Massachusetts. These two partners bring together the majority of Berkshire County's healthcare and aging service providers and stakeholders - the hospital, visiting nurse associations, skilled nursing facilities, nursing homes, and affiliated physicians come together with the social, nutritional, transportation, educational, and caregiving services of the elder service sector.

OUR PREVIOUS EXPERIENCE

Berkshire Medical Center is a nationally distinguished leader in clinical quality, including cardiac care. BMC's Heart Failure Clinic has achieved remarkable clinical quality and readmission rate outcomes for its patients, averaging <3%.

In 2009, Berkshire Medical Center (BMC) joined the STAAR Initiative and formed a "cross-continuum team," to improve transitions across settings to reduce readmissions. The BMC cross-continuum team included the partners in this CCTP application. The cross-continuum team, conducting "readmission diagnostic interviews" of providers and patients/families, deepened all partners' insights about why patients in our community are readmitted.

ESBC is the longstanding elder services support agency for the county, offering in-home and community support services to help seniors remain living independently in their own homes for as long as possible. In 2010 and 2011, four ESBC staff were trained in the Coleman Care Transition model.

OUR COMMUNITY

Berkshire County consists of two cities and 30 towns distributed across 946 square miles of largely rural land in the western-most part of Massachusetts. Berkshire's CCTP partnership will serve Medicare fee-for-service beneficiaries living throughout the county.

Over 80% of Medicare FFS beneficiaries hospitalized in Berkshire County are hospitalized at BHS.

OUR TARGET POPULATION

Our root cause analysis revealed that our subpopulation with high 30-day readmission rates included our heart failure patients who were not connected to our outpatient Heart Failure Clinic, and those with a personal history of three or more hospitalizations in the past 12 months. This subgroup is 16% of our total Medicare FFS patients, who account for 34% of the total number of Medicare admissions annually. As a subgroup, their all-cause 30-day readmission rate is 36%.

OUR IMPLEMENTATION STRATEGY

1. ***Identify high risk patients on admission*** to arrange for transitional care services;
2. ***Create cross-continuum CCTP team led by a Transitions Advocate, to***
   - collaborate on comprehensive needs assessment,
   - facilitate timely referrals for services prior to discharge,
   - function as a "cross-continuum team" to improve "sending" and "receiving" processes, and
   - review readmission events from a multi-setting and patient perspective;
3. ***Provide the Care Transitions Intervention*** to eligible patients;
4. ***Provide a Transitional Care Nurse Practitioner to provide community-based clinical management*** in the post-discharge period (regardless of care setting) for complex high-needs patients;
5. ***Optimize and expedite referral for home and community-based services***;
6. ***Provide an urgent "support bundle"*** of services (Meals on Wheels, access to a case manager and transportation to medical appointments, if needed) for selected high risk patients starting on the day of discharge; and
7. ***Optimize referral to BMC's successful outpatient Heart Failure Clinic*** for patients who have been hospitalized with heart failure.