Katy, Texas Care Transitions Program Coalition

Harris County Area Agency on Aging/Care Connection Aging and Disability Resource Center, Houston Department of Health and Human Services, CHRISTUS St. Catherine Hospital, Memorial Hermann Katy Hospital, Houston-Galveston Area Agency on Aging, Gateway to Care, Care for Elders, Heritage Park, Oakmont, The Concierge, Kissito Post Acute Care

OUR COLLABORATION

The Katy, Texas Care Transitions Program Coalition includes The Harris County Area Agency on Aging/Care Connection Aging and Disability Resource Center, a community based organization (CBO) and two hospital partners on CMS' high readmissions list, CHRISTUS St. Catherine Hospital (CSC) and Memorial Hermann Katy Hospital (MHK). The coalition also includes other organizations and skilled nursing facilities (SNFs). Our goal is to reduce recidivism and improve patient transitions.

OUR PREVIOUS EXPERIENCE

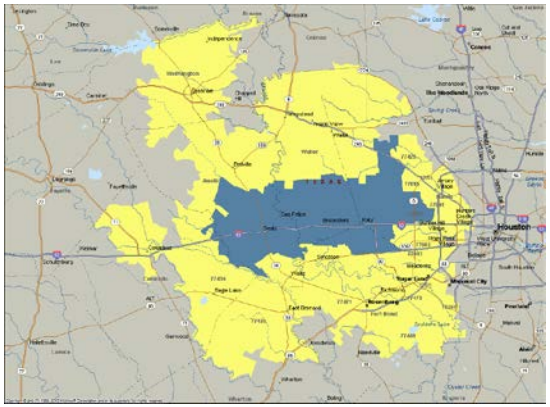
The CBO's experience in reducing readmissions has been on a patient level rather than an institutional level. When patients and caregivers received guidance from hospitals in the past, they were told to contact the CBO and CBO staff would identify resources available within and outside the CBO.

Thus far, CHRISTUS St. Catherine's strategies to reduce readmissions include: dietary consults for all heart failure patients; pharmacists conducting bedside education about medications and a modified Project Re-Engineered Discharge (RED) to improve discharge processes.

Based on MHK's Root Cause Analysis (RCA), physicians recommended re-education of hospital staff around various practices. Many MHK physicians, who are also medical directors at local SNFs, encouraged SNFs to collectively address recidivism. These steps led to hiring a Transition Nurse Navigator (TNN) in June, 2011.

OUR COMMUNITY

Katy, Texas is located just west of Houston, TX on Interstate Highway 10, at the intersection of Harris, Fort Bend and Waller Counties.



OUR TARGET POPULATION

Both hospitals will target Medicare fee-for-service beneficiaries with diagnoses of HF, PNEU and AMI. In addition, CSC will target other high risk patients who: a) have a history of readmissions; b) present with multiple co-morbid conditions or a high Charleston Comorbidity score; c) are frail; d) have limited support in the community/at home or who live alone; e) are taking six or more medications. Memorial Hermann Katy will target patients with the following high risk indicators: poly-pharmacy, problems managing medications, poor health literacy, limited social support systems, patients in need of palliative care, patients with psychological issues and patients with a history of readmissions.

OUR IMPLEMENTATION STRATEGY

Based on CHRISTUS St. Catherine's RCA, the most appropriate evidence-based interventions are Project BOOST and the Care Transitions Intervention (CTI). Additionally, patients will be eligible to receive enhanced medication reconciliation by a hospital pharmacist during their hospital stay.

Memorial Hermann Katy's RCA helped hospital personnel identify Project BOOST and Project RED for use pre-discharge and the CTI post-discharge as the most suitable interventions. A TNN will support patients who go into SNFs and an emergency room case manager will assist high risk patients who enter the hospital through the emergency room. Transitions coaches who have been trained to use the CTI will work closely with both hospital case management departments and patients post discharge.

Hospitals and the CBO will offer training and educational workshops to SNF staff to help reduce recidivism among patients who enter nursing facilities after discharge from either hospital. Skilled nursing facility staff from Heritage Park, Oakmont, The Concierge and Kissito Post Acute Care will play key roles in guiding recidivism efforts related to post acute care.

Other organizations, including Houston-Galveston Area Agency on Aging, Gateway to Care and Care for Elders will provide various forms of support as a part of the coalition to ensure smooth transitions are taking place in the community.

Goals of the collaborative include: reducing recidivism by at least 20% in both hospitals; ensuring that patients are seen by a primary care physician 30 days after discharge; connecting patients to community services and supports needed to assist patients during their recovery period and beyond; and enhancing efforts that are already in place throughout the Katy area that reduce recidivism.