UniNet Discharge Transitions Program

UniNet, Eastern Nebraska Office on Aging, Alegent Health

Bergan Mercy Medical Center, Immanuel Medical Center, Lakeside Hospital, Mercy Hospital, and Midlands Hospital

OUR COLLABORATION

UniNet Healthcare Network is a clinically integrated PHO formed in 1998 and located in Omaha, NE. There are 13 member hospitals and affiliated ancillaries and over 1400 providers. Participating in the Discharge Transitions Program are the following Alegent Health hospitals: Bergan Mercy Medical Center, Immanuel Medical Center, Midlands Hospital, Lakeside Hospital, and Mercy Hospital. UniNet has also partnered with the Eastern Nebraska Office on Aging (ENOA) to support our Discharge Transition Program. ENOA provides services to older adults in a 5 county region in eastern Nebraska that includes the Omaha metropolitan area.

OUR PREVIOUS EXPERIENCE

In 2010, UniNet partnered with a local commercial payor on a shared savings project focused on potentially preventable readmissions (PPR). Using the Coleman model, two nurses met with patients in the Alegent Health and Creighton University Medical Center hospitals, and followed up with phone calls once they were dismissed. We managed 2500 patients through this program and reduced PPRs by 15%. This equated to a savings of $860,000 to the plan the first year. In 2011 we expanded this model to include additional Medicare Advantage payors and Alegent Health employees. In 2012 we are partnering with the Eastern Nebraska Office on Aging (ENOA) to provide home visits.

OUR COMMUNITY

OUR TARGET POPULATION

The target population includes 8,523 beneficiaries living in Douglas and Sarpy counties in Nebraska and Pottawattamie Counties in Iowa. The eligibility criteria include one or more of the following:

- Admission with one of thirteen MS-DRGs that were identified in our RCA as predictors of hospital readmission, and one additional co-morbid chronic disease
- Index admission through the Emergency Department (odds ratio 3.96)
- Discharged to a skilled nursing facility
- History of a previous readmission (odds ratio 5.87)

OUR IMPLEMENTATION STRATEGY

The UniNet Discharge Transitions Program (DTP) is based on the Coleman model for patients discharged to home over the 30-day transition period following discharge. The UniNet Discharge Transition Nurses ensure that all the necessary information from the hospitalization and the post-discharge period are available to the clinic physician at the follow-up visit so that all vital care issues are addressed. We have enhanced our current program with referrals to ENOA to provide home visits for patients who do not qualify for home health service but have one or more of the following risk factors for readmission:

- Have sensory impairments which create potential barriers in a successful discharge plan; or
- Lack reliable informal supports to ensure adequate resources are secured to successfully carrying out discharge plan; or
- Have a cognitive impairment; or
- Have demonstrated poor judgment regarding medication management and/or follow through on healthcare recommendations.

Nurse Practitioners affiliated with our Nursing Home Network will provide transition services using the Coleman model for beneficiaries in skilled nursing facilities and long term care. Ambulatory Care Coordinators in our Patient Centered Medical Homes will also provide discharge transition services to beneficiaries.