An Innovative Adaptation of the Transitional Care Model in a Rural Setting

Final Report of the Vermont Health Care Innovation Project Provider Sub-grant Program

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Southwestern Vermont Health Care

Bennington, Vermont

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Vermont Health Care Innovation Project

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Acknowledgments

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Executive Summary

In 2013, Southwestern Vermont Health Care embarked on a journey to prepare for healthcare reform in anticipation of value based payment in the future. Eighty percent of healthcare delivered in our service area occurs in outpatient settings versus twenty percent delivered in the hospital. In spite of that, most of the clinical expertise remains in the acute care setting. Three inpatient clinical nurse specialists with an interest in changing our model of care, were identified to move our focus of care from an inpatient model, to a Transitional Care model. These nurses attended training through the University of Pennsylvania's Transitions of Care program based on successful work by Mary Naylor PhD, RN, and implemented this model based out of Southwestern Vermont Medical Center. Partnering with primary care providers, the nurses navigate with patients from one setting to another, providing education on chronic disease, medication management, symptom identification and actions to be taken. Crucial information is shared from one provider to the next and gaps in care are identified and remedied whenever possible. This pilot project demonstrated success in decreasing hospitalizations and Emergency Department visits for their patient population and helped support primary care providers struggling to meet the needs of large patient panels. Expert clinical nurses traveling from the hospital, to skilled nursing facilities, to physician office practices and to homes clearly identified where there were gaps in available resources, communication, education, support services. The Vermont Health Care Innovation Project was available at an ideal time to help us bridge some of the important gaps in our community.

Three Transitional Care Nurses (TCN) traveling across our service area were unable to partner with all primary care providers wanting services. The grant allowed us to hire and train our 4th TCN who travels east to Deerfield Valley and south to Massachusetts to allow patients who could benefit from transitional care services to be served. With this nurse on board, we have successfully partnered with all primary care provider offices in our community and continued to expand the number of patients with decreased hospitalizations and ED visits as a result. Recent data shows a 63.6% decrease in hospital admissions observation status and 25.3% decrease in ED visits measured 180 days before and after the transitional care intervention. Providers appreciate access to this valuable resource being their "eyes and ears" in the hospital, skilled nursing facility and home, often providing a clearer picture of what the patient may need to improve their health and quality of life. Some providers are asking TCNs to visit patients following an office visit that demonstrated deterioration in health (elevated blood pressure, blood sugar readings, increased shortness of breath, edema) hoping to avoid hospitalizations. Many times, the TCN may find the root of the problem such as not taking medications correctly, or lack of understanding of how to manage symptoms, management of nebulizers and oxygen therapy, and can provide or identify and coordinate resources for these issues.

One gap identified early in the pilot program, was the number of patients with addiction and behavioral health issues frequenting the Emergency Department and not getting their needs met in that setting. Primary care providers requested assistance with this population so the TCNs attempted to partner with them to see if we could make a difference. Most of the patients did not require education or symptom management of chronic disease but needed multiple resources that were not available to them. Coming to the ED with complaints of chest pain allowed them to receive a few hours of attention and care, imaging studies, blood work and social contact, sometimes a meal, always a warm blanket and caring staff. Unfortunately, when they were discharged, the issues that brought them to the ED, were still present, which caused many of them to cycle back within hours, days or weeks. Fortunately, SVMC had attended a presentation by Middlesex Hospital in Connecticut during a Magnet conference (MAGNET) where they demonstrated success with the creation of a Community Care Team to assist with this population in their Emergency Department.

With support from the VHCIP grant, SVMC was able to replicate this successful program, by hiring a Health Promotion Advocate (HPA) stationed in the emergency department 40 hours per week. The Health Promotion Advocate connects with patients, builds a trusting relationship and identifies out how best to meet their needs. The HPA carried a cell phone when on duty and patients could call her for support, to set up meetings with her and get advice on how to connect with other resources to assist them. Working closely with our compliance officer and hospital attorney, we created a consent form for patients interested in the help of the Community Care Team. This team consisted of representatives from the emergency department, counseling services, Medicaid case managers, workforce development, soup kitchen, addiction services, social workers and housing service agencies and created an integrated "wrap-around care plan." The Community Care Team meets monthly and has confidential conversations about patients who have consented to the program. Often, multiple agencies at the table know pieces of information about this individual, but together can get a clearer picture and combine resources to develop a coordinated approach to providing needed services. Over the past year, we have made significant strides with 40% of the individuals in the program, some kicking their addictions, getting a job and safe place to live and no longer needing to spend time in the Emergency Department. Equally as important, relationships have developed with Community Care Team members who now know and respect the need for each other to be more successful in meeting the needs of even more members of our community.

The third gap we identified through our Transitional Care Model, was the large number of patients readmitted to the hospital from skilled nursing facilities in our community. The Centers for Living and Rehabilitation (CLR) is a 130-bed skilled nursing facility affiliated with our healthcare system that had the highest rate of readmissions, above benchmarks across the state. Eighteen months previously, we had hosted a day long program at a local restaurant and invited all of the area nursing homes to hear about the INTERACT program (Interventions to Reduce Acute Care Transfers) from skilled nursing facilities. This evidence based program demonstrated success by training staff to speak up when they noticed changes in patient conditions using the Stop & Watch Early Warning Tool, nursing staff had access to standardized communication and assessment tools for clinician notification. The goal of the program is to identify changes condition promptly, monitor identified patients closely, diagnose the problem, and if appropriate provide early treatment within the facility to avoid the need for hospitalization. Our hope was that these nursing homes would implement the program on their own, which did not happen. This was due to lack of resources and funds to support the program. The VHCIP funding allowed us to hire an INTERACT Education Coordinator, who was stationed at CLR, where she implemented INTERACT as a pilot project. Immediately, it made a difference as we were able to decrease the number of readmissions from CLR as well as improve communication, documentation, quality of care and teamwork. In the past 6 months, our INTERACT education coordinator has assisted with program implementation at other skilled nursing facilities in our community, demonstrating success in three out of four facilities. Super users have been identified and trained in each setting and we will continue to monitor progress moving forward.

These three successful projects have demonstrated positive change for the people who live in our community. Each project meets the tenets of the triple aim. Patients are delighted with the transitional care nurses helping them, appreciate the work of the community care team and are relieved and happy not to keep being transferred to the hospital multiple times. Each program is meeting the needs of patient populations and improving quality outcomes through education, prompt and appropriate care, improved teamwork and access to appropriate resources. In each program, we have decreased the cost of care by eliminating waste, duplication, non-value-added tests and treatment, hospitalizations and ED visits. Because of the results we were able to demonstrate, support of these programs will continue at Southwestern Vermont Health Care, as resources have been allocated in the 2017 budget.

We greatly appreciate the support of the Vermont Health Care Innovation Project for providing this opportunity by providing financial resources for us to implement programs that are laying the foundation for value based care and healthcare reform.

DISCUSSION

Project Description and Goals

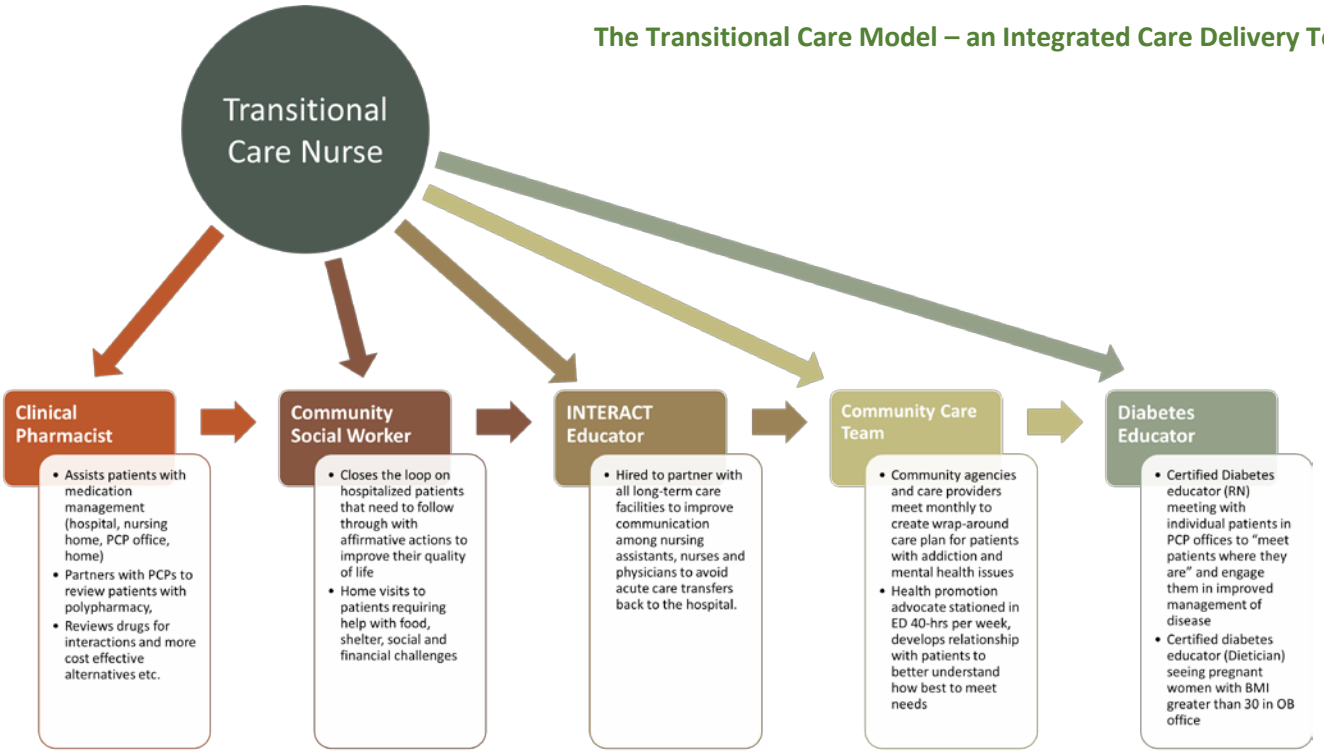
SVMC's Transitional Care model is based on the work of Mary Naylor, PhD, FAAN, RN of the University of Pennsylvania's Medical School. Dr. Naylor's model is a research project of advanced practice nurses navigating complex chronically ill patients through a complex healthcare system teaching them how to self-manage their disease. Transitional Care Nurses (TCN's) meet their patients wherever they are; in the hospital, accompanying them to their Primary Care Physician appointment, or seeing them at home. These TCNs are the only clinician who is seeing the patient wherever they are, which provides a broader picture of their needs and barriers and allows for communication of critical information across settings.

The SVMC Transitions in Care Program, supported though the Vermont Health Care Innovation Project proved to be very successful, and exceeded our expectations of performance for each of our identified goals:

1. *Design and share plans of care and identify gaps as we deliver integrated healthcare in the Bennington Service Area.*

   The SVMC Transitional Care Model builds an integrated care delivery system that empowers patients to actively manage their care, to set individualized goals, and to make informed decisions while improving the patient experience, improving the health of the population and decreasing cost. The program builds on a new way of delivering care that would meet the triple aim to reduce costs, while improving quality and enhancing the patient experience. The program was initiated in 2013 as TCN focused program, but as we identified gaps, we knew that we needed to make additional services available to our patients to provide integrated care to our patients. The Vermont Health Care Innovation Project helped us to do this successfully by funding an additional Transitional Care Nurse position. This allowed us to cover all of the primary care practices in our service area. We now have expanded further to include clinical pharmacists, a social worker, diabetes education and respiratory therapist as part of our team.

The Transitional Care Model – an Integrated Care Delivery Team



2. *Create an interdisciplinary team to better meet the needs of behavioral health/drug and alcohol addicted patients that frequent the Emergency Department at SVMC.*

The Bennington County Community Care Team (CCT) is comprised of a number of community agencies that specialize in the care of patients struggling with substance abuse and/or mental health disorders. The goal of the team is provide patient centered care and improve health outcomes by developing and implementing a safety-net of alternative services through multi-agency intervention and care planning. Currently over 20 community agencies participate in monthly meetings held at Southwestern Vermont Medical Center. The target population are high risk individuals who are experiencing acute and chronic mental health issues and or substance abuse with high emergency department utilization.

Patients with mental health and addiction diagnoses who seek care in the emergency department often do not get their needs met. Instead, they are exposed to unnecessary radiation, costly work ups and at times invasive procedures that do not have a positive impact on their health. This is a source of concern and frustration for providers who feel unsuccessful when caring for this population, leading to increased provider burnout and job dissatisfaction.

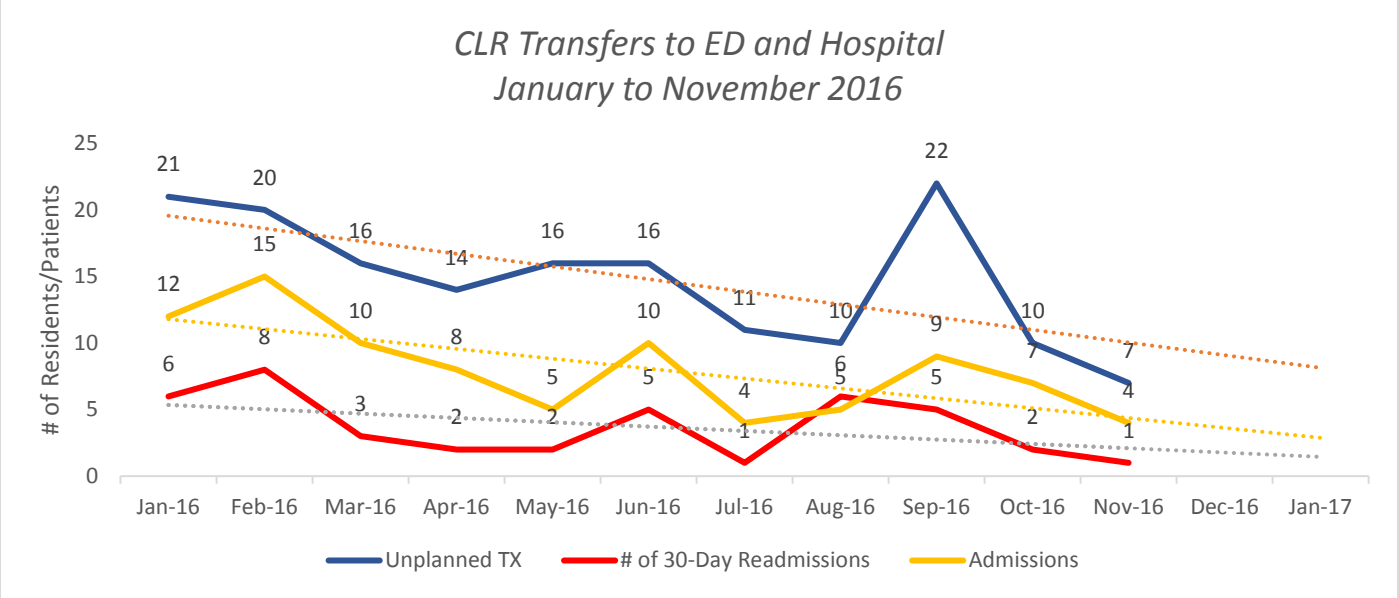
The Community Care Team was designed as a multi-agency, multi-disciplinary team aimed to provide compassionate supportive care to patients and their families while facilitating access to services. This is accomplished by bringing together representatives from mental health, addiction, workforce development, Medicaid, Economic Services, social work, case management and primary care providers. The Health Promotion Advocate, supported through this VHCIP grant, is stationed full time in the ED, providing telephone support, care planning and referral services to participating clients.

While the number of patients with mental health and addictive diagnoses continue to grow, the number of patients who have been helped by this program is encouraging. To date the team has discussed over 65 individual cases. According to our preliminary data, which looked at a cohort of 23 patients there was a 41% decrease in emergency department visits 6 months post community care team intervention, and a 47% reduction in total healthcare cost. Through this integrative approach, the Community Care Team is meeting the triple aim; improving the patient experience of care, improving the health of populations; and reducing the per capita cost of health care.

3. *Decrease the number of hospital admissions and ED visits of high risk chronic care patients in our Bennington Service Area.*

Transitional Care Nursing Program - The Transitional Care Program has demonstrated a decrease in hospital admissions and ED visits of high risk chronic care patients through its innovative wrap-around program of care. Through the first 120 days pre and post intervention by the Transitional Care Nurses, a decrease in Emergency Department, Inpatient and Observation encounters was demonstrated. The analysis captured 436 patients and demonstrated a 25.8% decrease in ED encounters and a 68.0% decrease in Inpatient and Observation encounters. As the program continued, the data was replicated 180 days pre and post intervention with a total of 394 patients. This data confirmed the positive impact of this program with a decrease of 25.2% ED encounters and a decrease of 65.9% in Inpatient and Observation encounters.

INTERACT Program - SVMC had identified that we had an increased number of patients being readmitted from SVHC's own skilled nursing and rehabilitation facility, the Centers for Living and Rehabilitation, as well as from other skilled care facilities in our community. Through the support of the VHCIP Grant, we were able to hire a INTERACT nurse to facilitate the implementation of this evidence-based program in all skilled care facilities. INTERACT is a quality improvement program designed to improve the early identification, assessment, documentation and communication about changes in a resident's status or condition. The program demonstrated both a decrease in ED visits and decrease in hospital readmissions.



4. *Create required reports and disseminate information on project progress and lessons learned through toolkit and regional conference.*

SVMC, with the support of the Vermont Health Care Innovation Project held the "Leading Health Care Reform by Building Accountable Communities" Regional Conference on September 20, 2016. Additional sponsorships included Dartmouth-Hitchcock Medical Center, Organization of Nurse Leaders, Rutland Regional Medical Center, Southern Vermont College and Vermont Technical College. Close to 150 attendees heard keynote speaker Mary Naylor PhD, FAAN, RN, of the Univ. of Penn School of Nursing, Kevin Stone, BA, MBA and Heidi Klein MSPH present on relevant topics such as "The Relationship of Transitional Care to Population Health & System Redesign," "Financial Implications of Accountable Care Organizations," and "Integrating Population Health and Prevention in Health Care Reform: Vermont's Exploration of Accountable Communities."

Posters were accepted and displayed at the Leading Healthcare Reform Conference on topics such as Nine Elements of an Accountable Community from Northeastern Vermont Regional Hospital, Caring for Opioid Dependent Mothers and Families, Home Health Care, as well as SVMC's Transitional Care Program, INTERACT and the Community Care Team.

Twenty table discussions were part of the Conference. Participants were able to attend two table discussions on topics such as SASH (a community service agency), Substance Abuse Programs, Food Sustainability, a Falls Community Program, VT Blueprint, Housing Programs and financial models as well as the TCN Nursing and Pharmacy programs, INTERACT and the Community Care Team. We received very positive feedback on this opportunity for attendees to sit and discuss these topics in more depth.

At the Regional Conference, the Transitions in Care Toolkit was distributed to all attendees. This toolkit included information from all poster presentations, table discussions, Mary Naylar PhD, FAAN, RN's presentation, and a white paper on the Bennington Blueprint.

Project Activities

Beneficiaries Impacted

Transitional Care Program – Three Transitional Care Nurses were in place prior to the start of the VHCIP. With the support of this grant, a fourth TCN was hired which allowed the program expand to support patients from all the medical practices in our community. The program included a total of 4 Transitional Care Nurses, and expanded to cover all physician practices in the service area which included 18 Physicians, 4 Physicians Assistants, and 7 Nurse Practitioners. Interactions involved Home visits, Inpatient hospital visits, phone calls to patients, visits with patients to their PCP offices, visit with in the Nursing Home or Emergency Department.

TCN	2013	2014	2015	2016	Program Totals August 2013- November 2016
# of admission assessments by TCN's	24	366	413	367	1170
# of TCN visits in the community	238	1282	1790	1285	4595
% of patients that met criteria for TCN services	83.3%	83.3%	82.6%	88%	84.3%
% of eligible patients who accepted TCN services	90%	73.1%	73.9%	79.3%	79.1%
Average Duration of TCN Services (Days)	135.4	2.92	46.6	22.7	64.1

Health Promotion Advocate / Community Care Team - The Health Promotion Advocate identified patients who were challenged with addiction and behavioral health problems, with frequent visits to the Emergency Department. Sixty-six patients were identified and signed releases to participate in the program. These patients were presented to the Community Care Team to develop a wrap-around plan for services. Meetings were held monthly and participants from community agencies, state programs and SVMC practitioners participated. Referrals were made for these patients, coming out of the monthly meetings or during visits to the Emergency Department or following additional interventions, such as support phone calls, or meetings in the community with the patients, to support the development of a successful plan for each of these patients. During the time of this grant, the Health Promotion Advocate made 569 referrals to a total of 60 community agencies, providers, support programs and other services. This comprehensive program of support services resulted in a decrease in visits to the Emergency Department, a decrease in overall health care costs, and an improvement in quality of life for many of these individuals.

INTERACT Program – The INTERACT Nurse was involved in the implementation of the INTERACT program at SVHC's Centers for Living and Rehabilitation, the Center for Nursing and Rehabilitation, Vermont Veteran's Home, Bennington Health and Rehabilitation, and Crescent Manor Rehabilitation. This program demonstrated that with both sub-acute care residents and long term care residents, the implementation of the IMPACT program was effective in decreasing readmission rates. (Refer to data in Appendix 1). In addition, Staff evaluated the program to be effective in the following areas; 91% of staff report that INTERACT tools are useful in daily

care, 94% of staff report improved communication about changes of condition at CLR, and 97% of staff report feeling listened to & respected when communicating changes of condition.

Transitions in Care Curriculum - As part of our SVMC's commitment to the Transitions in Care model, we have partnered with two nursing schools in the Bennington area to develop the curriculum for a "Transitions in Care" course being taught at Southern Vermont College and Vermont Technical College's BSN Nursing Programs.

Magnet Recognition Program of the ANCC (American Nurses Credentialing Center) – SVMC received its 4th Magnet Designation in 2016. During the Magnet Visit the Transitional Care Nursing Program was identified as an exemplary program. The Transitional Care Nurses were invited to present at the National Magnet Conference, and Barbara Richardson MSN RN-BS CCRN was awarded the National Nurses Award for Structural Empowerment.

Sharing Outcomes - The Transitional Care Nurses and INTERACT Nurse have shared the successes of the Transitions in Care Program in a number of ways and at a number of additional conferences. In conjunction with Jennifer Fels, they published an article in the Home Health Care Journal. They have presented at OANE the Organization of Nurse Executives, ONL the Organization of Nurse Leaders, NICHE Nurses Improving Care for Healthsystem Elders, the Leading Healthcare Reform Conference, the Annual Nursing Research & Evidenced Based Practice Symposium and the World Health Congress. The INTERACT Program is scheduled to present at Pathway to Excellence Conference in the spring.

Project Challenges

Administrative Oversight – Due to lack of an available resource, administrative management of the grant was absorbed by Billie Allard MS, RN, assisted by Kathy Arabia. This proved to be challenging to juggle with other work responsibilities and required many additional hours weekly to be successful and meet deadlines. At the time, it seemed like the best solution to minimize time wasted on handover but was overwhelming especially during the conference planning and execution.

Documentation for transitional care program -It was important for care providers from multiple settings to view TCN documentation on patients to deliver integrated care. The IT Department worked tirelessly with us to find the best option which required multiple trials, edits and standardized formats to achieve a system to meet our needs. Our goal continues to be a system that will allow us to mine data from the documentation seamlessly, a work in progress at this time.

Data Collection – With multiple projects requiring various data sets, we underestimated the time, resources and expertise necessary to provide timely data reporting and analysis. Part way though the project, work responsibilities shifted for a key player that represented delays in maintaining our data management. We have requested dedicated resources to assist us as we move forward with population health project management. Presently we are working with Polaris to do a financial analysis as well.

Marketing the program to be used by clinicians – Despite communicating by multiple modalities (meetings, emails, brochures, presentations) busy providers did not always use the available resources offered by the transitional care program and community care team. We learned quickly that it did not represent a lack of support or appreciation but rather lack of available time to make referrals. Marketing to others in the office settings was helpful and sharing data related to patient referred has improved the situation.

Fee for service vs Value-based payment model –Much of the cutting edge work we are doing is preparing for a different payment model. The uncertainty of the timing for this has been a challenge as the work we do negatively impacts the revenue of the hospital, despite the fact that it is often services that should not be provided as they are not solving the root cause of the problem.

Lessons Learned

Building relationships is the foundation – Since the beginning of a transitional care journey, it has been apparent that success could not be achieved without building relationships, demonstrating patience and increasing our understanding of the lived experience of our partners across all settings. From the medical home case managers to the primary care providers to the united counseling case workers, each one plays a vital role and it often takes a village including so many to be successful. Our Interact educator needed to embed herself in the skilled nursing facility to really experience their reality and seek feedback on how this program could benefit the care providers as well as patients. The Health Promotion Advocate in the ED had a lived experience of working as a technician in the ED but needed to better understand the reality for other colleagues in addiction support, housing, food services and work force development. She also needed to meet patients outside of the hospital to see their world more clearly. Transitional care nurses needed to get outside of the hospital representing the medical model of care delivery and recognize patients make choices and decisions to impact their health, not doctors or nurses.

Start with a pilot, collect base line data and then demonstrate success – With each of our projects involved in the grant, this is what we did. It was ideal to have grant funding to cover the FTE necessary for implementation and then focus on successful implementation of evidence based practice.

Involve stakeholders as you develop the ideas/concepts – As we began to design the role of the transitional care nurse, we met with our skilled nursing facility, home care partners as well as medical home and community agencies and physicians. This impacted our plan and helped others feel like they had a voice in the eventual plan. Their input set us up to be successful in many keys areas.

Keep abreast of early adopters across the country – Continuously, we surfed for articles, attended online presentations, looking for best practices that were working in other locations. It was also essential to stay involved at the OneCare Vermont RCPC (Regional Clinical Performance Committee) and stay current with potential changes in payment and reimbursement as healthcare reform evolved

Involve the CFO and other stakeholders early and often – It was imperative to partner with the CFO and Executive Management Team as we moved forward with this work. We knew that our success would most certainly have a negative impact on the hospital bottom line, despite being the right thing to do for the patient. It has been like walking a tight rope every step along the road.

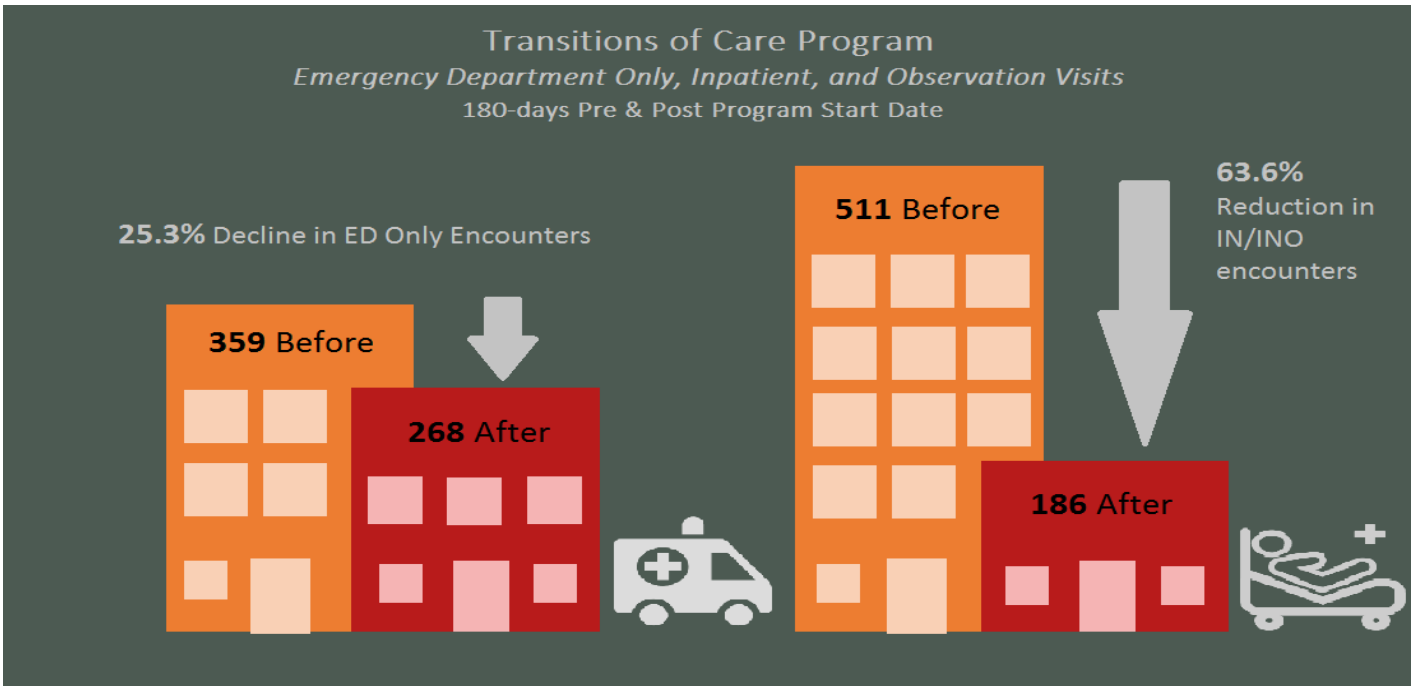
Collaboration not competition is a challenge – We have been excited to share our story across the state of Vermont and beyond as we believed that it could be beneficial in other communities as well. At first, we were disappointed with the reception we received, and sometimes still are. We really want to share and collaborate and help others in any way we can. We are not telling our story to brag and be congratulated but to help better serve the people that live in our community that are struggling with the complexities and barriers to healthcare. Much of our work is based on those who came before us and others have just as much to offer us as we have for them.

Having well-respected clinicians as transitional care nurses jump-started our program's success – Picture taking three clinically expert nurses, known and respected by the medical staff and giving access to them to primary care providers struggling to meet the needs of chronic care patients. That is what we did and it worked. Providers listened to the nurse's input and suggestions, trusted their judgment and appreciated their help. They communicated directly with them and facilitated patient care which resulted in decreased need for hospitalizations.

Meeting regularly with team, mining for identification of gaps – initially, we had weekly huddles checking in to see how things were going, any needs identified, barriers encountered. Quickly we determined it was a time to identify gaps that potentially needed to be filled. Those meetings have created a blueprint for creating integrated care delivery in our community. Quarterly combined meetings with all partners fill in more blanks and help us set priorities jointly for the future.

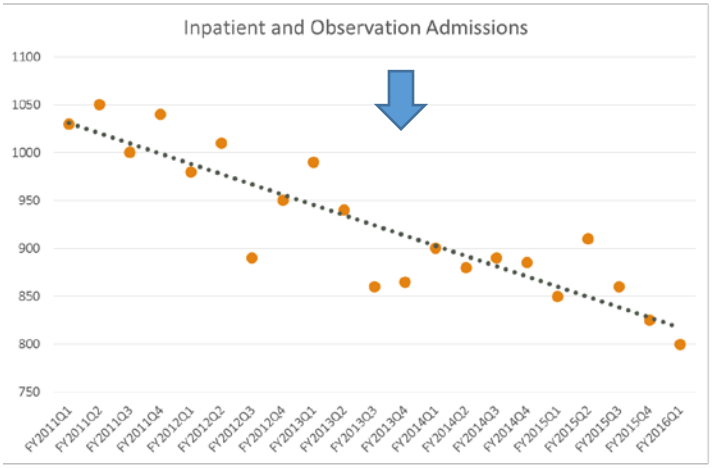
PROJECT EVALUATION

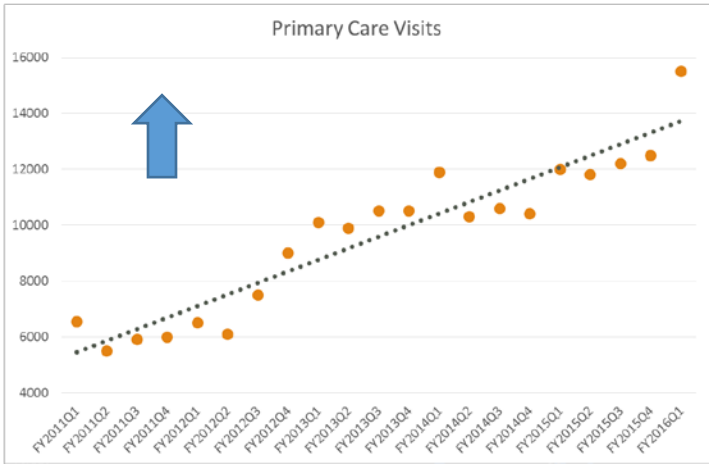
Transitional Care Nursing Program Improves Population Health



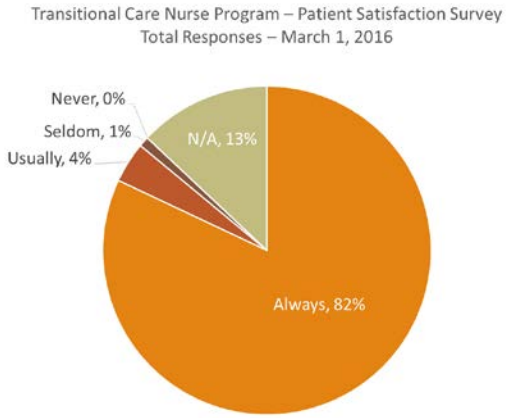
Transitional Care Nursing Program

Decreases Healthcare Costs through Decreased Utilization of High Cost Care





Transitional Care Nursing Program Improves the Patient Experience

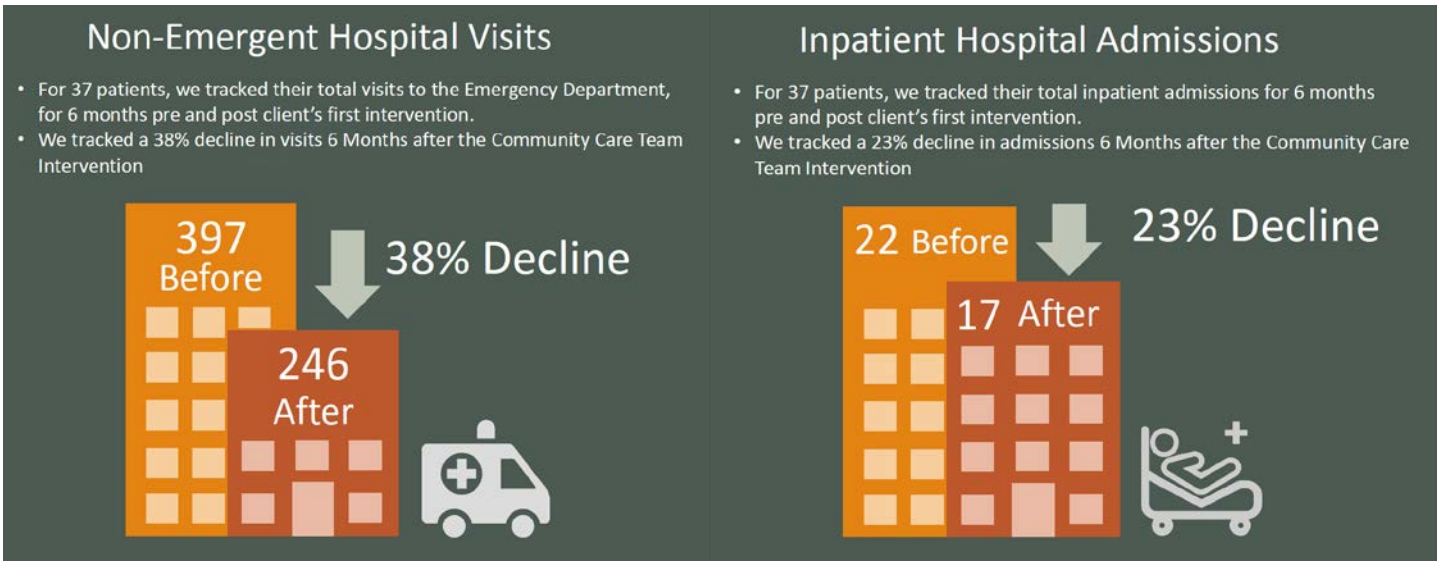


This graph illustrates the total Likert scale responses to the following questions.

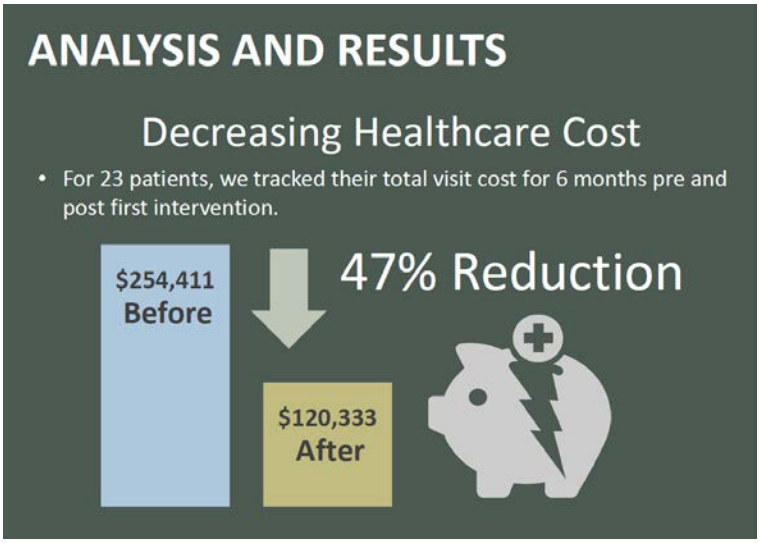
My Transitional Care Nurse helped me:

- feel more confident that I can manage my medications
- feel more confident that I can follow my discharge plan
- learn when to call the doctor, go to the emergency room or call 911
- learn about my illness and how to manage it better
- develop goals that matter to me
- connect with services that I needed
- connect with a hospital pharmacist who explained things so that I could understand

Community Care Team demonstrates decreased ED and Inpatient admissions over 6 months.

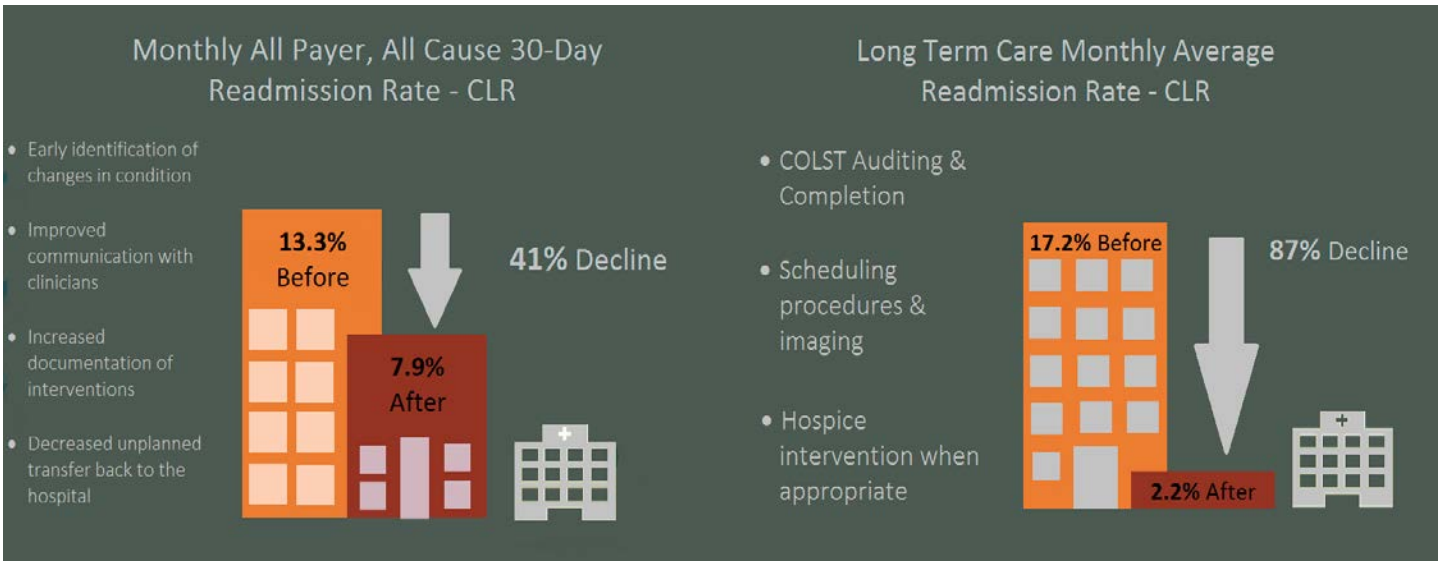


Community Care Team demonstrates decreased health care costs over 6 months.



INTERACT PROGRAM

INTERACT Program demonstrates decreased rate of readmissions from SNF setting



PROJECT SUSTAINABILITY

Financial Analysis - SVMC conducted a financial analysis of the Transitional Care Nursing Program. This demonstrated a decrease in overall health care costs due to a decrease in utilization of high cost services such as Emergency Department visits and Inpatient hospital admissions and observation encounters. Although this does not result in a positive bottom line for SVMC due to a resulting decrease in volume, it is recognized by SVMC Administration that this is the right thing to do for these patients in our community, and as we move towards a new system of health care reform, we will be poised to manage costs more effectively. SVMC has committed to support the continuation of the Transitions in Care program within the SVMC operational budget.

Transitional Care Nursing - The Transitional Care Nursing Program will continue in the SVMC Operational Budget. One TCN Nurse has retired, and due to less time required for startup of the program, and improved efficiencies, the program will continue to cover all primary care practices in our community with three Transitional Care Nurses. The Pharmacist, Respiratory Therapist and Social Work components of the Transitional Care Program are already funded through the SVMC operational budget.

INTERACT - The INTERACT Program was funded for one year for the implementation into area nursing homes. Education was provided this quarter to train super users for each nursing home to sustain this program moving forward. Four Director of Nursing / Nurse Managers completed Certified INTERACT Champion Training. The INTERACT Nurse position will not continue, but through the effective implementation of this program, the work will continue and positive impact should continue.

Community Care Team / Health Promotion Advocate - The Health Promotion Advocate positon has been incorporated into the SVMC operational budget. The positive impact of this position on these high risk patients and decreased utilization of high cost care has justified this position. SVMC has recently received a SBIRT (Screening, Brief Intervention and Referral and Treatment) grant which will also work to support our substance abuse patients and those at risk for substance abuse. A Social Worker position is funded in the ED to screen for risk and implement immediate intervention including referrals to many of the community agencies included in our Community Care Team.

CONCLUSION

A multidisciplinary collaborative approach is needed to support the patients in our community. The groundwork laid down by each of these innovative programs has continued to cultivate the transformation of care delivery at SVHC.

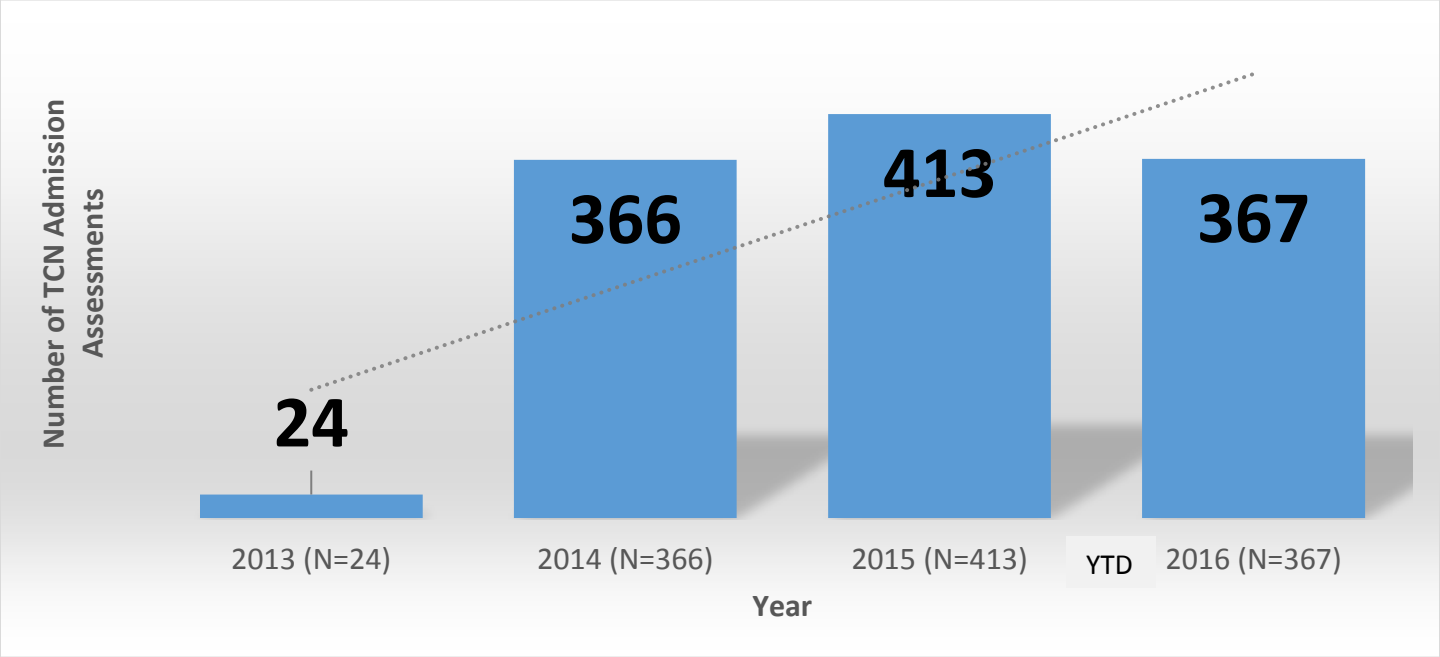
The Transitional Care Nurses have a unique opportunity to transcend care across all services lines just as the patient does. They are able to meet patients where they are, have the most accurate picture of the patients current circumstances, and a realistic sense of their goals and priorities. This invaluable experience and knowledge base allows them to tailor the TCN services to their patients.

Each one of the projects had a common goal – to improve patient outcomes by meeting the triple aim. As a result all three programs took similar approaches, understanding that the patient must be the center of their care plan or it will not be successful. The TCN's, CCT, and the INTERACT education coordinator all sought feedback from their respective patient populations along the way, making real time change to the program implementation and care delivery for the best possible outcomes.

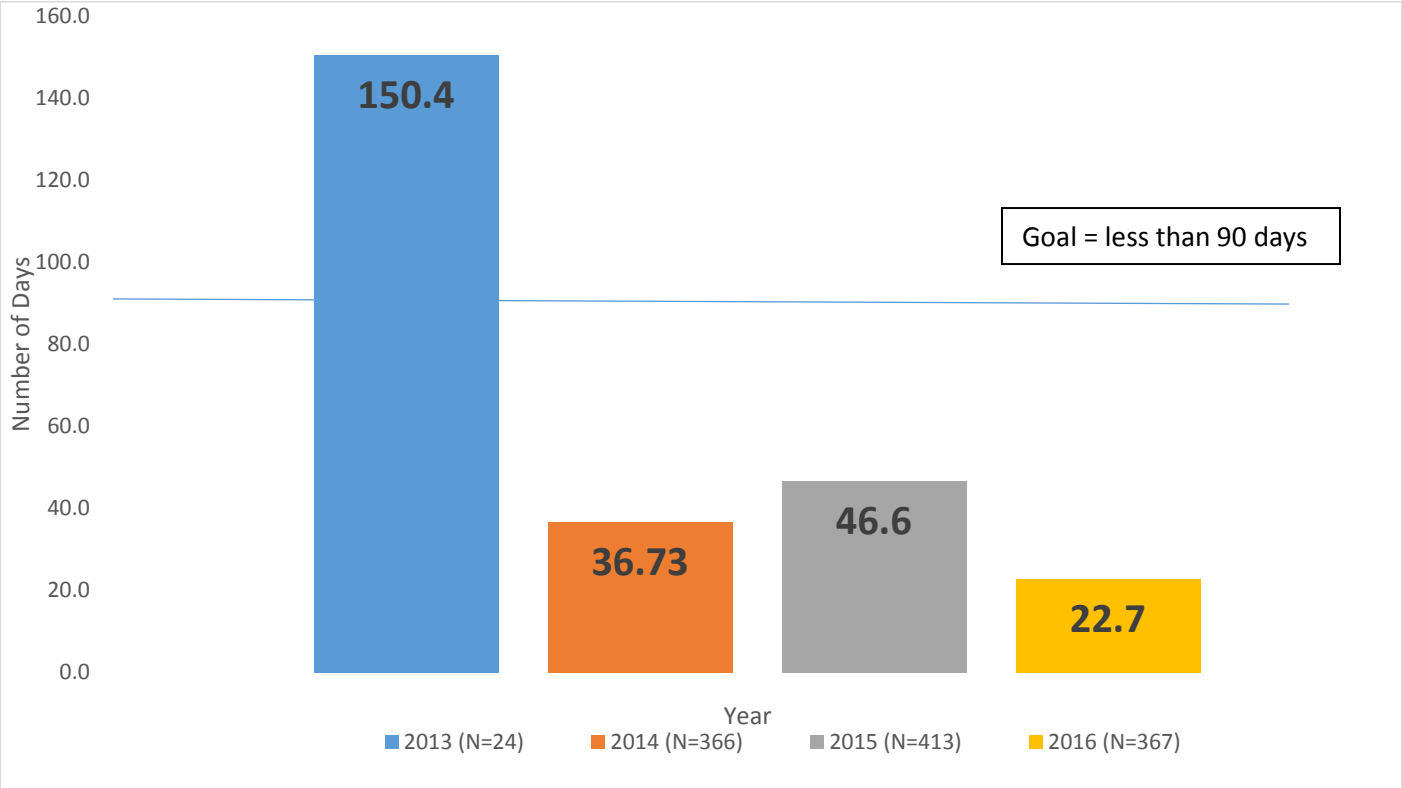
Appendix ADDITIONAL DATA

TRANSITIONAL CARE NURSING PROGRAM

Admission Assessments



Transitional Care Nursing Program – Average Duration of TCN Service Episodes

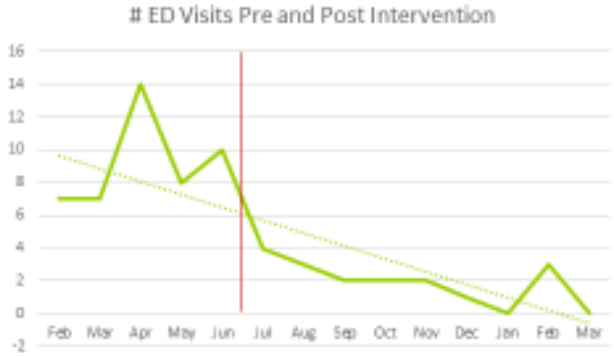


Community Care Team
Demonstrates decreased ED Visits & Admissions

CCT Case Study # 1

Hx 51 ED Visits Jan-Jun 2015
Intervention July 2015:
8 ED visits last 6 months

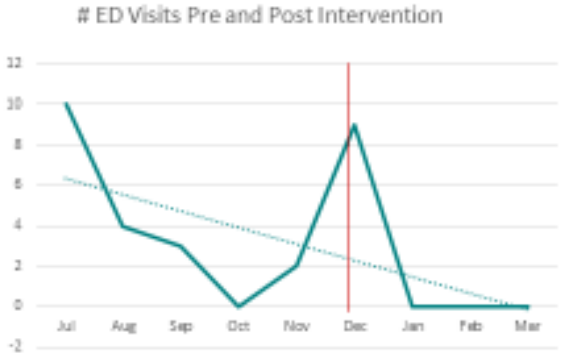
CCT Interventions:
Community Based referral, Shared living provider, Health Promotion Advocate visits and phone support



CCT Case Study # 2

Hx 28 ED Visits July-Dec 2015
Intervention Dec 2015
0 Visits last 3 months

CCT Interventions:
Facilitated move from homelessness to appropriate State Hospital for treatment.



CCT Case Study #3: Alcohol Abuse:
Hx ED visits since 2010
2013 15 ED visits / 7 inpatient admits
2014 40 ED visits / 8 inpatient admits
2015 Jan-June 10 ED visits

CCT Case Study #4: Developmental Disability: Hx ED visits since 1995
2014 68 ED visits
2015 Jan-June 59 ED visits

INTERACT Program

INTERACT	Q1: November 2015 – January 2016	Q2: February 2016 – April 2016	Q3: May 2016 – July 2016	Q4: August 2016 – October 2016	Program Totals
# of Stop & Watches Initiated	64	87	128	100	379
# of Progress Notes Written	453	569	1019	727	2768
#f Sets of Vitals Obtained	458	594	950	670	2672
Average % of Compliance with Vitals	92%	92%	92%	91%	92%
Average % of Compliance with Notes	86%	81%	93%	92%	88%
Average % of Compliance with ECS documentation	71%	87%	97%	96%	88%
Average % of Compliance with Checklist	78%	100%	100%	97%	94%
# of Transfers to the ED from CLR	46	50	43	41	180
# of Hospital Admissions from CLR (INPT & OBS)	28	33	19	19	99
# of 30-Day Readmissions	17	13	8	13	51

INTERACT Program Case Study

Long Term Care Case Study

Intervention

Long Term Care Resident, medically complex, Full Code.

- *2015*: 3 ED visits & 2 Inpatient Admissions
- *2016*: No ED visits or Inpatient Admissions

Interventions:

- Stop & Watch Early Warning Tool
- COLST discussion at quarterly care plan meets
- SBAR communication tool

Outcome