Eastern Virginia Care Transitions Partnership:

A formal community partnership of health systems, area agencies on aging, independent physicians' groups, 69 skilled nursing facilities and other public and private health and human service providers.

HEALTH SYSTEMS

Sentara Healthcare

Bon Secours Health System, Inc.

Mary Washington Healthcare

Riverside Health System

MANAGED CARE ORGANIZATIONS

Anthem, Humana, Virginia Premier

AREA AGENCIES ON AGING

Bay Aging – Lead Community Based Organization

Eastern Shore Area Agency on Aging and Community Action Agency, Inc.

Peninsula Agency on Aging, Inc.

Rappahannock Area Agency on Aging, Inc.

Senior Services of Southeastern Virginia

EVCTP Readmission Trends
February 2013 - April 2015

Eastern Virginia Care Transitions Partnership

Readmission Comparison

Riverside Health System

February 2016 - November 2016

		Discharges	30 Day Readmissions	Readmission Rates
AMI	*Hospital Reported*	168	27	16.1%
	EVCTP Enrolled	87	8	9.2%
COPD	***Hospital Reported***	**208**	**31**	**14.9%**
	EVCTP Enrolled	**368**	**29**	**7.9%**
HF	*Hospital Reported*	521	88	16.9%
	EVCTP Enrolled	414	26	6.3%
PNEU	***Hospital Reported***	**205**	**26**	**12.7%**
	EVCTP Enrolled	**231**	**11**	**4.8%**
Contract Target Group Total*	*Hospital Reported*	1102	172	15.6%
	EVCTP Enrolled	1100	74	6.7%
DM	***Hospital Reported***	**134**	**13**	**9.7%**
	EVCTP Enrolled	**18**	**2**	**11.1%**
SEPSIS	*Hospital Reported*	602	82	13.6%
	EVCTP Enrolled	7	0	0.0%
AFIB	***Hospital Reported***	**230**	**38**	**16.5%**
	EVCTP Enrolled	**18**	**0**	**0.0%**
Target Group Total	*Hospital Reported*	2068	305	14.7%
	EVCTP Enrolled	1143	76	6.6%
All-Cause Total	***Hospital Reported***	**7819**	**1088**	**13.9%**

A significant 30 D readmit reduction

*Target Group data reported by hospitals includes only those diagnoses that are considered primary to the admission, while EVCTP includes target diagnoses that may be primary or secondary to the admission.

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Improving Patient Health and Safety in Virginia

Area Agencies on Aging Coalition
Caring for the Commonwealth
Coordinated and Transitional Care for Virginia

INTRODUCTION

VAAACares is the statewide expansion of the Eastern Virginia Care Transitions Partnership. Endorsed by the Virginia Center for Health Innovation, VAAACares is an Area Agency on Aging collaboration to deliver services for insurers, health systems and other providers.

The VAAACares program serves as a one-stop shop for comprehensive care coordination, care transitions, and a host of other home and community based services that support the health and safety outcomes for Virginians with chronic health conditions and disabilities.

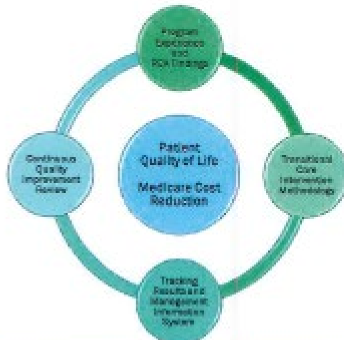
VAAACares services provide techniques that promote patient and caregiver engagement to take an active role in their health care. VAAACares facilitate new behaviors and self-management strategies that result in successful responses to common health problems that occur after transitions between health care settings. One major key to success is getting into the home! The places where people live, learn, work, and play, the choices made, and the opportunities they have all play a role in their physical, mental and social well-being. Only by going into the homes and learning more about the patients can we begin to execute meaningful plans of care that lead to successful recovery, reduced readmissions, lower healthcare costs, and improved communication between patients and their PCP's.

IMPLEMENTATION STRATEGY

Three Root Cause Analysis (RCA) tools were utilized – Hospital Readmissions Review, Physician and Staff Expert Panel Review, and Consumer Focus Group Surveys.

The key findings of what contributed to readmissions included end stage disease/co-morbidity, lack of patient compliance with discharge plans, medication mismanagement, lack of follow-up with the patient's primary care provider, and acuity of the patient. These findings dovetailed with the Four Pillars of the Coleman Care Transitions Intervention® model leading EVCTP to select this as the preferred model – supplemented with enhanced services.

Partner hospitals submit daily census to EVCTP for screening. Eligible participants are referred to Area Agencies on Aging for coaching – including a hospital visit, home visit, follow-up phone calls, and coordination of any enhanced services that improve the after hospital care of the patient.



IMPACT

EVCTP Care Transitions Intervention Performance for Chronically Ill Target Group

High-Risk Chronic Illnesses:

AMI, CHF, COPD, PNEU, Septicemia, Stroke, AFIB, Diabetes, Renal Failure

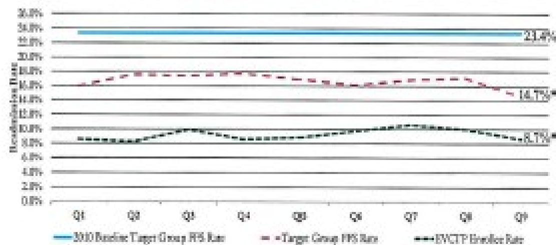
Demonstration Period: September 2013 – December 2015

High Risk Target Group
22,397 Patients
23.4% Baseline Readmission Rate
Before Care Transitions Intervention

Care Transitions Intervention Reduced Overall Target Group to a 14.7% Readmission Rate in the final quarter

Care Transitions Intervention Enrollees with a Home Visit
21,857 Enrollees
8.7% Readmission Rate of Enrollees in the final quarter

EVCTP Quarterly 30-Day Readmission Trends
September 2013 - December 2015



*Readmission rate refers to Q9 only.

PATIENT EMPOWERMENT

When given the opportunity to gain insight and skills, engaged patients are better equipped to manage their conditions, remain at home longer, and more likely to use fewer healthcare services, thereby reducing healthcare costs.

Confidence Question: *On a scale of 1 to 10, with 1 being not at all confident and 10 being completely confident, consider the following:*

I am confident that I can manage and control most of my health problems.

CONCLUSIONS

Since 2013 EVCTP successfully collaborated with acute care medical facilities and insurers to improve patient post discharge outcomes. Success led to the development of VAAACares, a statewide expansion to improve patient care and decrease acute care hospitalizations.

Data results illustrate the blend of Care Transitions, Care Coordination and Evidence-Based Prevention Education and Patient Empowerment is very effective for patients at-risk for re-hospitalization by improving health and safety outcomes for Virginians with chronic health conditions and disabilities.

VAAACares utilizes the "blend of services" coupled with the expertise of Area Agencies on Aging. VAAACares has proven to be a highly successful model of patient-centered care.

Similar results experienced with Medicaid population.