1. **LCU Name and Project Title**

Northeast PHO  
Enhanced Care Transitions Program

2. **Project leader (name, phone # and e-mail address of the primary contact who can provide additional information on request)**

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3. **LCU overview (location, communities served, HPHC membership, total number and general specialty distribution of physicians and practices)**

Northeast PHO, located in Beverly, MA is comprised of 75 primary care physicians, 250 specialists and 50,000 managed care plan members of which 9,000 are HPHC members. Northeast PHO serves the surrounding North Shore communities including Beverly, Salem, Danvers, Peabody, Middleton, Ipswich, Topsfield, Essex, Manchester, Gloucester and Rockport.

4. **Brief Project Description**

The Enhanced Care Transitions Program was designed to enhance care transitions across the health system for the Northeast PHO chronic condition patient population by improving patient education, engagement in self-care, primary care communication and follow-up, with an overall goal of reducing readmissions as well as improving the quality and continuity of care. The program had four major goals:
- reduce readmission rate by 2% at the Northeast PHO home hospitals  
- improve patient/caregiver satisfaction with the discharge plan communication and coordination  
- Improve physician satisfaction with the discharge plan communication and coordination  
- Improve compliance of diabetic and asthma patients encountered in the program with HEDIS quality measures

5. **Key project components**

- Target unplanned admissions with 6 chronic conditions that drive utilization: COPD, CHF, Diabetes, Asthma, CAD and CKD  
- Provide patient encounter by PCP case manager  
- Complete comprehensive discharge checklist addressing important transition components  
- Use evidence-based education tools for patient education  
- Coaching to improve patient self-management of chronic condition  
- Physician follow-up appt. coordination prior to discharge set within 5-7 days of discharge  
- VNA and other community services facilitation  
- Post discharge call by PCP case manager to assess compliance with treatment plan, reinforce self-management education and intervene with urgent access to care as needed  
- Pharmacist call on select cases to address adherence or financial concerns  
- Electronic transmission of transition checklist to PCP at discharge via secure messaging to communicate plan and address patient follow-up concerns
6. Key project outcomes to date

2010 Enhanced Care Transitions Program
Summary of Goals Met

- Goal to improve patient/caregiver satisfaction with the discharge plan communication and coordination measured through 90% of surveyed patients/caregivers satisfied with program was met
- Goal to improve physician satisfaction with the discharge plan communication and coordination measured through 90% of surveyed physicians satisfied with program was met

2010 Inpatient Outcomes

- 242 Northeast PHO patients enrolled in program and received enhanced care transitions program support to home in the hospital setting. (58 additional patients received enhanced care transitions program support in 2011).
- All program patients received a patient encounter by the PCP case manager with comprehensive transition components addressed such as discharge instructions, medications, advance directives, support system, transportation, VNA and physician follow-up appt. coordination prior to discharge
- All program patients received coaching and education regarding chronic condition self-management with evidence-based educational tools provided
- 95% coordinated with physician follow-up appt. within 7 days
- 84% kept follow-up appt. with their physician compared to 57% in 2009
- Days between discharge and follow-up with physician reduced to 7 days compared to 14 days in 2009
- 81% reached on post-discharge calls compared to 78% in 2009
- 97% reported being satisfied with care plan
- 40% coordinated with VNA services
- 90% of patients/caregivers surveyed reported satisfied with program
- 90% of physicians surveyed reported satisfied with program
- Readmission rate decreased to 9.7% compared to 11% in 2009, representing a 1.3% reduction in readmissions as a result of the program across 5 health plans

2010 SNF Outcomes

- 96 additional Northeast PHO patients received enhanced care transitions program support to home in the skilled nursing facility setting
- 92% coordinated with physician follow-up appt. within 7 days
- 91% kept their follow-up appt. with their physician
- 96% reached on post-discharge calls
- 100% reported being satisfied with care plan
- 97% coordinated with VNA services
- Readmission rate at 5.2% for patients discharged with VNA that kept physician f/up appt.

Total Northeast PHO patients supported through Enhanced Care Transitions Program to date: 396

7. Identify any goals not achieved

The readmission rate reduction goal of 2% was not achieved but readmission rate reduction came within .7% of the aggressive readmission goal. The goal to improve the compliance rate by 5% of asthma and diabetes patients encountered in the program was difficult to measure based on the HEDIS results. We measured individual patient compliance before and after program enrollment which showed a positive impact in HbA1C reduction in over 60% of diabetic patients. Asthma patients encountered in the program were generally on controllers so we could not measure impact but there was opportunity found in lack of written asthma action plans for which work continues.
8. **Plan for extending and sustaining achievements beyond the grant year**
Northeast PHO will continue the Enhanced Care Transitions Program focusing on provision of quality, cost effective services for the chronic condition patient population that drives utilization and incurs high costs. Northeast PHO plans to build on the valuable work and lessons learned through the program by focusing on improving care coordination and patient self-management for the chronic condition population while strengthening relationships with the primary care practices.

9. **Lessons Learned/ Words of Wisdom**
**Lessons Learned**
- the need to involve all stakeholders from the start on such a wide-scale transitions project across the health system is critical
- the need to work closely with the primary care offices to identify and overcome barriers in setting up timely follow-up appt. especially for the higher risk patients such as those with COPD and CHF
- a face to face patient encounter in the hospital or other setting by the PCP case manager is critical in building relationships
- the need for setting measurable outcomes since it was difficult to measure asthma and diabetes outcome changes based on the HEDIS criteria over a short timeframe
- the importance of working on small tests of change and remaining flexible but not straying from the original program criteria in hopes of extending reach to a larger patient population
- the need to improve completion of written action plans for the asthma, COPD and CHF patient population as an area of opportunity since more than 60% of patients encountered in program did not have one and requires ongoing education which is underway at present
- the need to stratify the “higher touch” chronic condition patient population that requires ongoing support at regular intervals by case management to reduce readmission risk