The York/Adams Community-based Care Transitions Program

Presented by the York County Area Agency on Aging
Deanna Ruff, CCTP Project Manager
June Main, CCTP Clinical Supervisor
Objectives

• Understand background of Community-based Care Transitions initiative, its parameters, and eligibility criteria

• Understand our community’s model of intervention

• Understand the program’s benefits and how it differs from other initiatives and services

• Understand who is appropriate for services

• Know about future directions of the program and how to become involved.
“Not Another Acronym!”

- The Community-based Care Transitions Program or **CCTP**
  - A Readmission Reduction Initiative under Affordable Care Act
  - Tests Evidenced-based Models
  - Targets High-Risk Medicare Fee-for-Service Beneficiaries
  - We are 1 of only 102
Program Structure

• Program Structure and Goals:
  o Supported by Partnerships between Community-based Organizations and Acute Care Hospitals
  
  o Coordinate efforts to provide the Care Transitions Intervention™ to beneficiaries
  
  o Sites must meet performance goals by the end of 2-year agreement period:
    • Reduce 30-day, All-cause, Medicare Fee For Service (MFFS) hospital readmissions by 20%
      • 1-a-Day Campaign
    • Demonstrate measureable cost savings to Medicare program
The Care Transitions Intervention™

• How does it work?
  o 30-day intervention
  o Schedule of Contacts
    • Hospital visit
    • Home Visit within 48 hours of discharge
    • 3 follow-up phone calls

• Why does it work?
  o Four Pillars: Medication Management, Red Flags, Follow-up Care, and a Personal Health Record
  o Patient centered, goal oriented
Important Things to Know

• It is NOT Home Health
  o It is not skilled care!
  o Focuses on Patient Activation and empowerment through skill transference

• Referrals and Patient Identification
  o Targeting those at moderate to high risk for readmission
  o Patient must be...
    • MFFS A and B
    • Not enrolled in Hospice as of hospital discharge date
    • Be an inpatient at one of the participating hospitals
    • Not have participated in CCTP in last 180 days.
  o Patients who are discharged to SNFs for rehab less than 30 days are eligible.
  o Patient must be able to benefit from program
Successes and Lessons Learned

• Coordination with Health Coaches

• Patients of all education levels and socioeconomic backgrounds can benefit

• Added benefit of using Area Agency on Aging trained Care Transitions Coaches
  o Address of barriers and identification of community resources

• Can be a successful model for prevention
Metrics

• Patient Experience Surveys
  o Patient Activation Measure
  o Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS)
  o Care Transitions Measure 3

• Process Measures
  o Acceptance, retention, completion rates

• Outcomes
  o Successful PCP follow-up visits within 7-14 days of discharge
  o CCTP Participant readmission rates
  o All-cause 30 day MFFS readmission rates
  o Emergency Room and Observation Stays Utilization

• Key Performance Measures
How You Can Become a Part of the CCTP Team?

• Become an Active Collaborator
  o Does your organization participate in community meetings?

• Help improve our Acceptance Rates!
  o Discuss CCTP with your patients ahead of time, make it a part of the discharge planning.
  o Send referral to CCTP Coach

• Share Your Resources
  o Available Trainings
  o Educational Materials
Future Directions for CCTP

• On-Going Root Cause Analysis and Quality Improvement Efforts

• Higher Intensity Intervention for Patients with Behavioral Health comorbidities

• Expansion to Medicaid and Medicare Advantage Plans
CCTP Contacts

For general program information:

Deanna Ruff, CCTP Project Manager
(717)852-4902 or DJRuff@yorkcountypa.gov

To make a referral or ask a specific question related to patient participation:

June Main, CCTP Clinical Supervisor
(717)858-3151 or JEMain@yorkcountypa.gov
with a cc to Mark Hargreaves, CCTP Coach
(717)417-8522 or MSHargreaves@yorkcountypa.gov