

#### BLUEGRASS TRANSITIONAL CARE PARTNERSHIP





#### The Facts

- •1 out of 5 discharged from a hospital return within 30 days.
- One in three are readmitted within 90 days
- 76% of these readmissions could be avoidable.
- •\$26 billion is spent on avoidable readmissions annually.
- •40% to 50% of readmissions are linked to lack of community resources and social issues
- •50% of those discharged do not attend their required follow-up visits with their physicians

"MedPAC 2007"



#### Addressing the Need Bluegrass Transitional Care, "TLC", Partnership

The "TLC" partnership targets services to address specific needs. The Partnership will improve patient care, patient health, bridge the gaps between the medical and community services, reduce or prevent unnecessary admissions, readmissions, ER use, and reduce overall health care cost.



#### A Partnership Because...

- BAAAIL has an array of in-home and community based services and supports to seniors, persons with disabilities, caregivers and family members (40 years)
- BAAAIL expanded services and offers programs to individuals of all ages targeting assistance in the community including the Aging and Disability Resource Center – Information Assistance and Access to public and private services and the Medicaid Consumer Directed Options Program.
- Serves 17 counties



#### **Transitional Care "TLC" Services**

"Transitional Care (TLC)" services, provides an evidence-based model of care to assist the patient with post hospital discharge and their transition back home. "TLC" staff is there at a time when the patient is most in need of assistance, when transitioning from hospital to home, and to assist the patient with their healing process. These services can either be implemented for the short-term

(30 days), or extended-term (up to 90 days). These models, in coordination with the care management models, have been proven to reduce or prevent hospital admissions, readmissions and emergency department use.





#### **Transitional Care "TLC" Services**

Services are coordinated by a Care Management Coach working in partnership with the Hospital's Discharge Team. Services target five focus areas, Medication Management, Personal Health Record, Medical follow-up, Recognizing Potential Issues, and Patient and Caregiver Education.





#### **RESULTS**

**MAY Through July 2014** 

175 Referrals

25 Withdrawn

83 in the program

8 Readmissions



#### **Key Takeaways**

- Improvement of social assessment
- Better Treatment of many chronic diseases Chronic Disease Self Management
- •Program and community services are necessary for patient/caregiver support
- Communication is paramount
- Education (Patient and Caregiver)
- Creative follow up "must think out of the box"
- •On July 9<sup>th</sup>, TLC program was notified of receiving the "Innovations" award from the National Association of Development Organizations, one of the national organizations of which the ADD is a member.