Neighborhood House
Care Transitions Program

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What are Care Transitions?

- When a patient visits the ER and/or has an inpatient stay at a facility, transitions of care is the process of being discharged into the appropriate care setting
  - Transitioning from one level of care (i.e. hospital) to another (i.e. home, care facility etc.)
- The care team and patient decide where they will go when they discharge, how they will get there, who will assist them, and what they need to be successful
- The care team may include:
  - doctors, nurses, PT/OT, pharmacists, SW/discharge planners, family, established caregivers, other facilities (skilled nursing, adult family homes, assisted living)

The Identified Problem

- Hospital discharge planners are overwhelmed and not always able to meet the needs of each patient *during* discharge
  - Discharge can seem straightforward in the moment, but confusing/forgotten instructions once you leave the hospital setting
- The hospital-based care team has limited capacity to follow up with the patient *after* discharge
  - After discharge the patient is responsible for following up to schedule appointments, get needed DME, care for themselves, fill prescriptions ect.

How Do We Fit In?

- Patients that have been identified as a **medium to high risk of readmission** are referred to Neighborhood House's CT Program Coordinator for short-term case management
- We work with the patient to address health, social, and economic factors/needs which make their transition difficult and may lead to readmission
  - Encouraging and scheduling PCP and specialist follow up visits
  - Referring for caregiving services
  - Assisting with access to basic needs: food, shelter, medical equipment and supplies, etc.
  - Financial: provide information about where to get assistance, assist with applications
  - Helping get prescriptions filled
  - Assistance with needed/prescribed DME

Why is This Important?

- About 17% of Medicare beneficiaries readmit to the hospital within 30 days
  (HCUP Statistical Brief #248, 2019)
- In a study spanning 2.5 years in Washington State, using light touch case management and transition of care services decreased Medicaid/Medicare costs by $67.5 million
- Many people who are elderly, high risk, and/or low income are more likely to readmit to the hospital
  - This increases healthcare costs and creates instability in a person's life
  - Overwhelms hospitals/hospital staff

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Program Eligibility

- Current in-patient status OR
- Recent Emergency Room Visit (within last 7 days) OR
- Recently discharged from a facility (within last 7 days)

AND

- Risk of readmission due to:
  - Condition/diagnosis
  - Cultural/linguistic barriers at discharge
  - Discharged to wrong level of care
  - Short term needs not being met

How to Make a Referral

- Contact with Eligibility/Referral Questions
  - Email transitionsofcare@nhwa.org
  - Emilie Laik, Program Coordinator
    - 206-532-6920
    - emiliel@nhwa.org

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Questions!?

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