Providing feedback to the community-based care transitions program

Health & Medicine, Nursing

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It is definitely a problem when patients end up coming back for readmission, due to the same problem that they were there for the first time, in this case, heart problems. The Community-based Care Transitions Program (CCTP), which is under Section 3026 of the Affordable Care Act (ACA), seeks to improve how patients will transition from their hospital to another point of care, including how to manage their own care while at home (CMS, 2014). This is particularly true of those elderly patients who are covered by Medicare, which has incurred $26 billion for readmissions that could have been prevented. The CCTP is connected with the Partnership for Patients, whose focus is on improving patient experience and reducing the costs of hospital readmissions by 20 percent (Partnership, 2014). Those included in the partnership are the Hospital Engagement Networks there are 26 state, regional and national hospital system organizations that help identify solutions for protecting against hospital-acquired conditions; the Community-based Care Transition Program (CCTP) which seeks to incorporate social service providers, pharmacies, primary care practices, nursing homes and home health agencies to provide patients with care; and the Patient and Family Engagement (PFE) system which connects relationships between patients, their families and the health care system, so that outside care can continue, rather than returning to the hospital (Partnership, 2014).

The New York Methodist Hospital provides a coordinator who assists each patient during the first 30 days to assist patient needs, decipher discharge paperwork and care instructions, oversees follow-up medical appointments

for the patient, along with prescription fillings, and will also connect the patient with community services, such as Meals on Wheels (NYM, 2014). As this whole process is still relatively new, it is a work in progress, particularly as the ACA moves into gear in this past year.

Obviously, hospitals want to reduce costs, but it should never be at the expense of the public's health, particularly when concerning older people. As of January 2013, New York State's Medicare Quality Improvement Organization (QIO) showed reduction rates for Medicare patients in re-admissions within the first 30 days of implementing the program (PR, 2013). Those rates were compared to those from an intervention pilot program during 2009 to 2010, as part of the CMS 9th Scope of Work (SOW) Care Transitions initiative, covering 14 communities nationwide. Each had their own partnership arrangement to facilitate transitions for Medicare patients from hospital to their secondary place of medical care (PR, 2013). It proved to be very successful in reducing readmissions to hospitals by a marked percentage.

More information on statistics may be found by using the following search term: " statistics on hospital transition program for frail older adults," " statistics on hospital transition programs," and " hospital readmission statistics 2013." Research should also include what the fines are for hospitals that allow readmissions. This is a very crucial area that may cause problems in the future for both patients and the medical system. Hope this will help you with your initial research for this issue.

Resources

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