

# TRANSITION ACCESS PROGRAM (TAP)



*Genie Pritchett, MD*  
*Senior Medical Director*  
*Colorado Access*

# About Colorado Access

- Non-profit, safety net sponsored health plan
- Founded 1994
- Sponsors
  - University of Colorado Hospital/University Physicians, Inc.
  - The Children's Hospital
  - Colorado Community Managed Care Network (FQHCs)
- Lines of business
  - Colorado Access Advantage (Medicare)
  - Behavioral Health managed care
  - SCHIP
  - Medicaid (non-dual disabled adults)

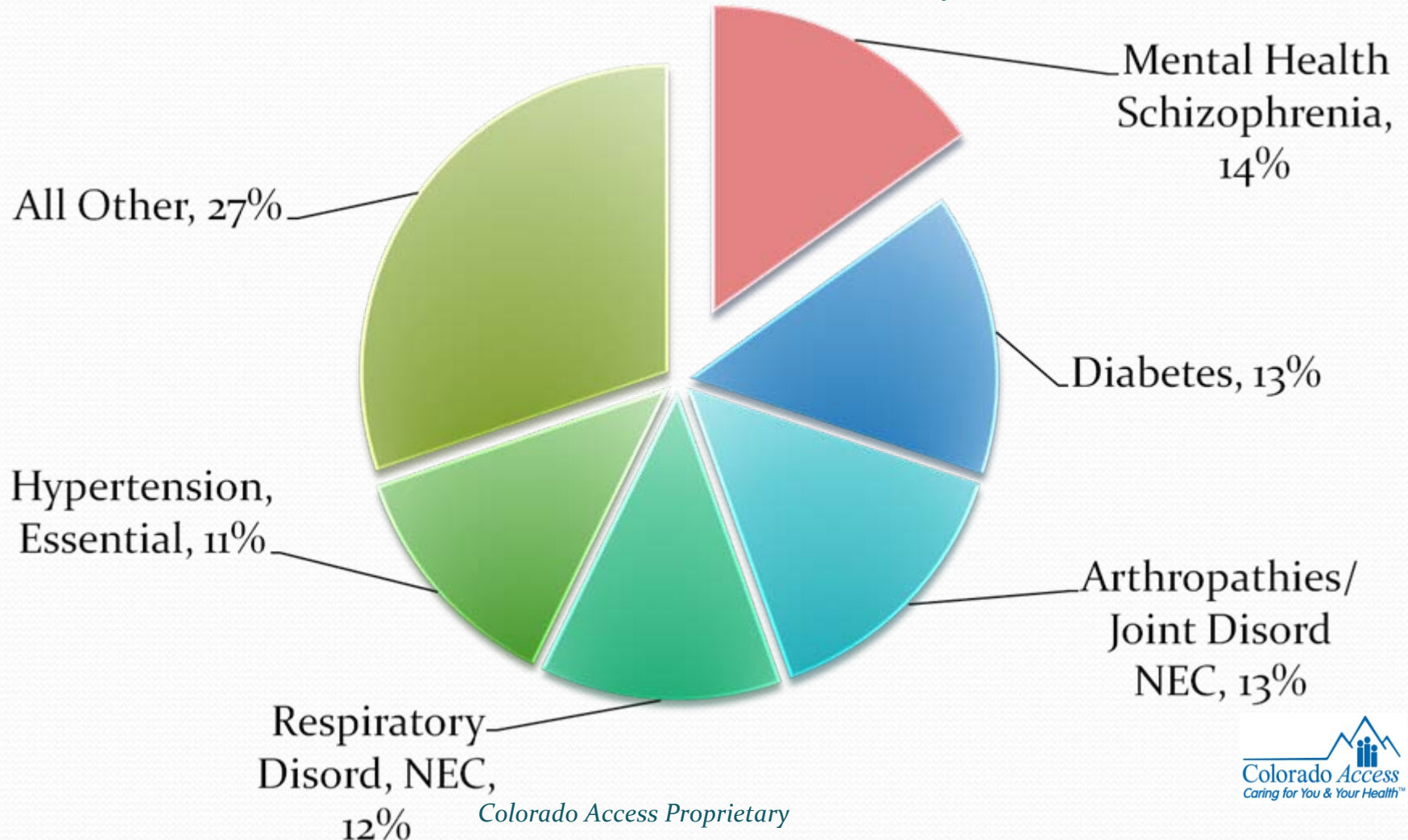
# Medicare members

- Total membership
  - 3,600
    - 75% in Special Needs Plans (SNPs)
- Member characteristics
  - Average age 58 yrs
  - High acuity (CMI = 2.5)
  - High cost (annual average = \$12,225)



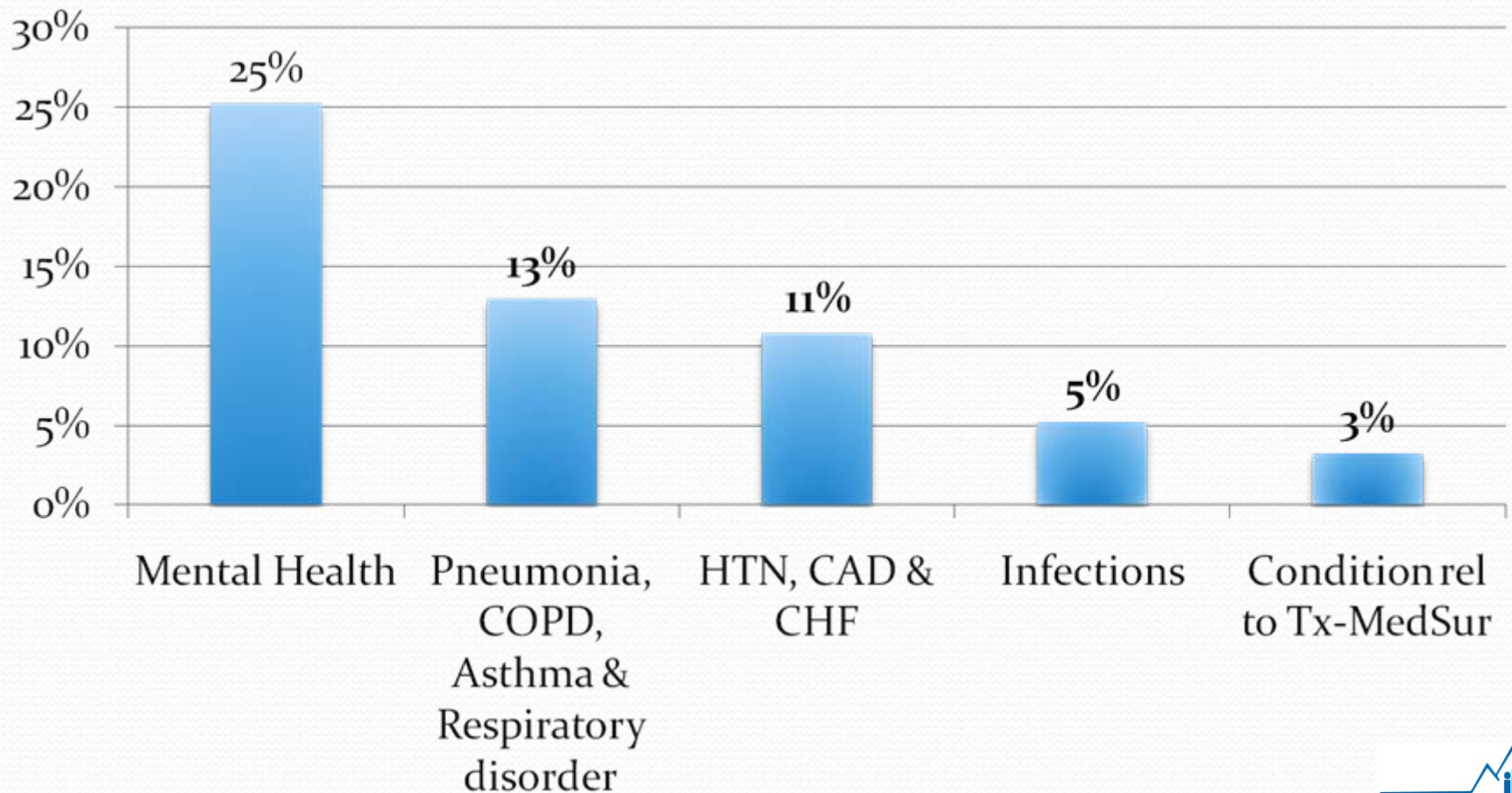
# Clinical Conditions

*all Medicare members CY09/IV*



*Colorado Access Proprietary*

# Principal Diagnosis: Medicare admissions, 2009





# The Evolution of Transition Interventions

- Our response to growing national attention to care transitions and readmissions

2008

- Post-discharge calls to members with a mental health admission

Mid 2009

- Expanded to all admissions
- Inpatient visit by transition nurse at high volume hospitals

Fall 2009

- Transition Access Program (TAP) developed for January 1, 2010 implementation

## Baseline data:

- Colorado Access Advantage 30-day readmission rate (CY09 = 19%)
- Similar to U.S. Medicare fee-for-service rate (20%)

# TAP Overview

- Colorado Access TAP is modeled after the work done by Eric Coleman, MD
- Patient-centered intervention designed to:
  1. Improve continuity of care between settings
  2. Improve member safety
  3. Improve member outcomes
  4. Decrease avoidable hospital readmissions
- Intervention lasts approximately 30 days



# Program Components

- **Personal Health Record (PHR)**

- Patient understands and uses the PHR to facilitate communication and ensure continuity of care plan across providers and settings.
- The patient or the informal caregiver manages the PHR.

- **Medication Self-Management**

- Patient is knowledgeable about his/her medications and has a medication management system.
- Use the PHR to update any changes in medications and share that information with his/her healthcare providers.



# Program Components (cont'd)

- **Follow-up Visit with PCP or Specialist**
  - Patient schedules and completes a follow-up visit with the PCP or specialist and is empowered to be an active participant in these visits.
  - Encourage use of PHR.
- **Understanding “Red Flags”**
  - Patient is knowledgeable about indications that their condition is worsening and how to respond.

# “High Touch” Interventions

A 5-step process:

In-hospital nurse visit (discontinued in March)

One or more post-discharge calls by a transitions care manager

Home visit by the nurse practitioner

- Focus on the diagnoses that triggered the hospital visit
- Education about their condition

Follow-up call after home visit by the transitions care manager

Program discharge when goals are met or the program is interrupted (usually within 30-days of discharge)



# Transition Access Program



# TAP Preliminary Evaluation

- **Objective:** Assess processes and outcomes of startup phase (Jan-Mar 2010)
- **Process measure:**
  - Hospitalized members receiving one or more of the TAP interventions
- **Outcome measure:**
  - 30-day readmission rate
    - Members receiving and not receiving TAP interventions



# Data Source and Study Population

- **Data source:** Program database (*not claims*)
  - Admissions known to TAP staff within 7 days of discharge
  - Program staff documentation of patient information and program interventions
- **Study population:**
  - Discharges between 1/1 – 3/31/10 in program database
    - Discharges classified as “mental health” ***excluded***

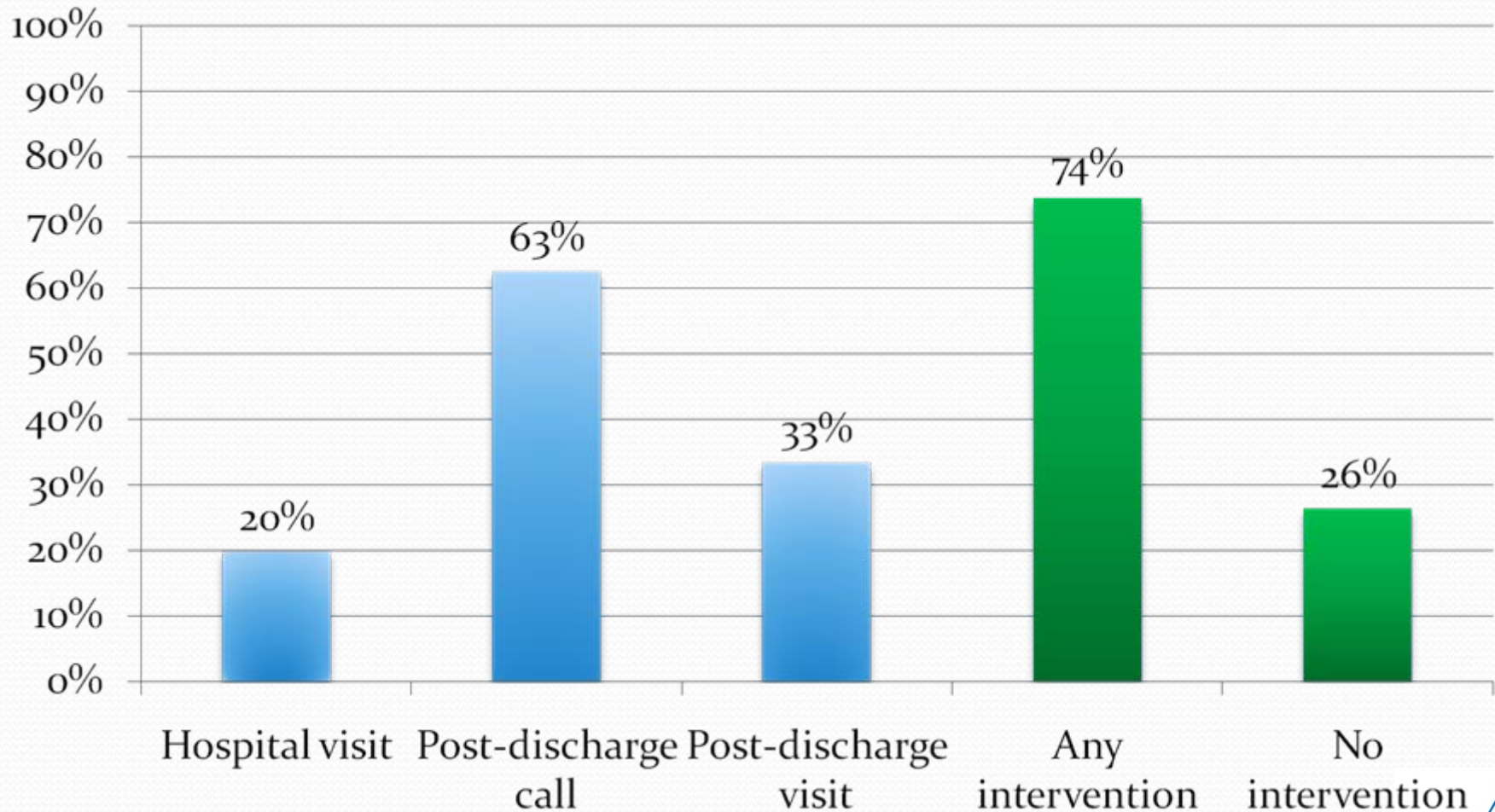
# Study Population Characteristics



- 171 Medical discharges
- 149 distinct patients
- Average length of stay = 4 days
- 49% of discharges in 5 target hospitals



# Process Measure: TAP Interventions

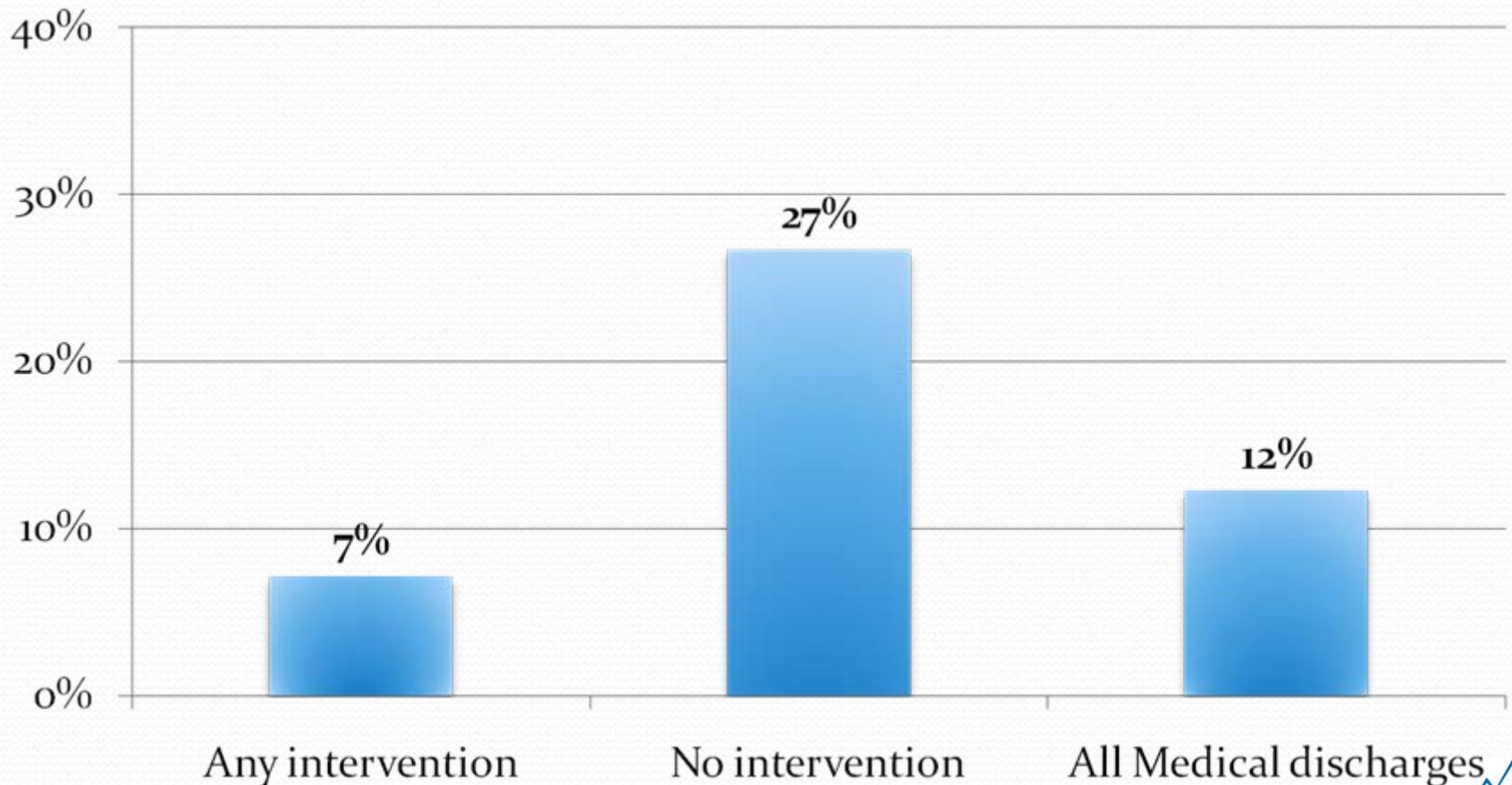


# Outcome Measure: Readmissions

- 21 readmissions within 30 calendar days of a discharge between 1/1/10 and 3/31/10
- 30-day overall readmission rate = 12%



# The Impact: 30-day readmissions

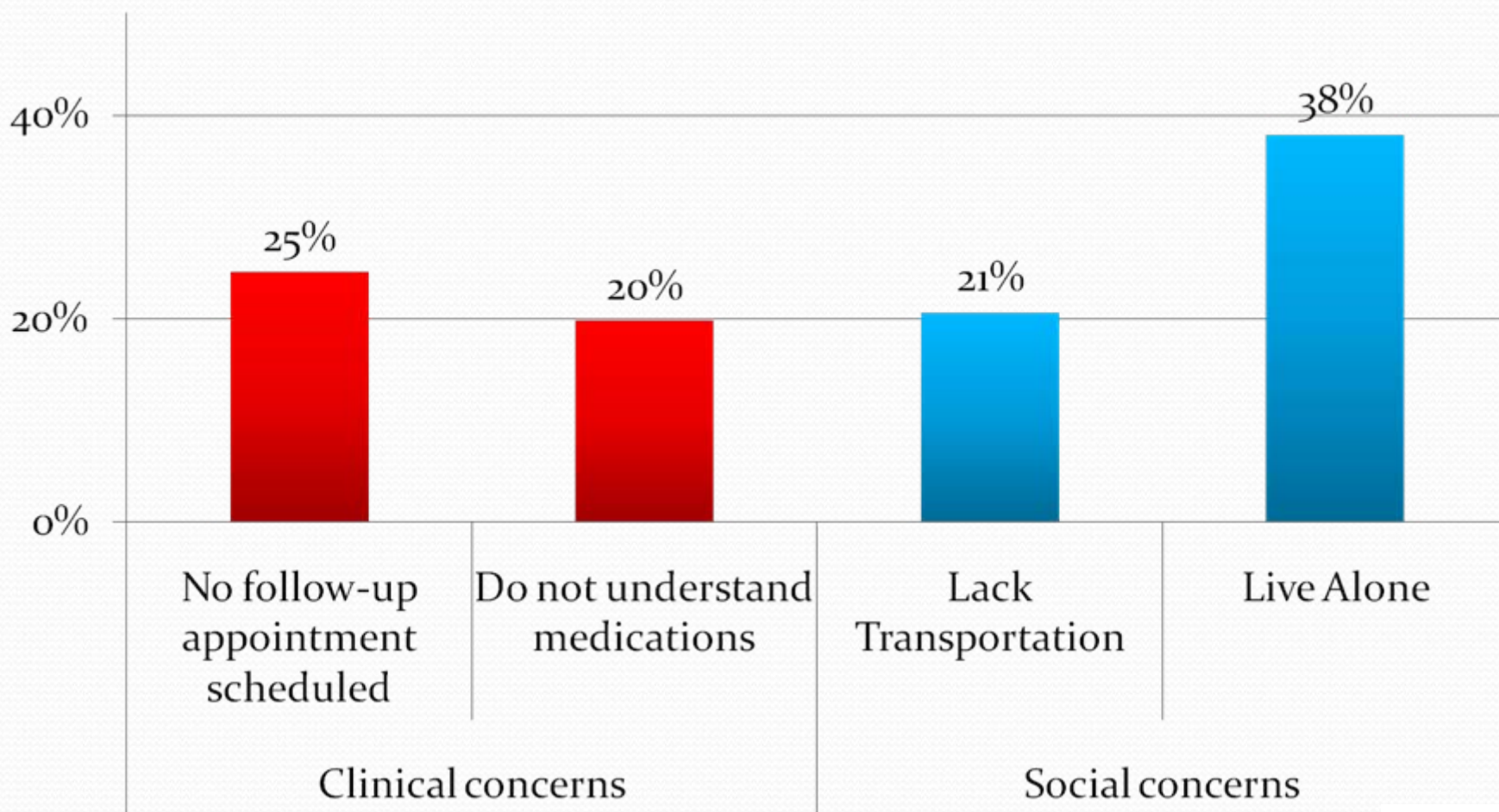


# Study Limitations

- **Small number of cases:**
  - 171 discharges
  - 21 readmissions within 30 days
  - “Treatment” and “No Treatment” groups of unequal size (126 and 45 respectively)
- **Potential selection bias:**
  - Discharges included in program database may be unrepresentative of all discharges
  - Discharges receiving intervention may be at lower risk of readmission
  - Mental health discharges are excluded
- **Lack of severity adjustment:**
  - Readmissions *with* an intervention had a shorter ALOS than those *without* (3.1 vs. 5.5 days)



# Concerns Identified through TAP Intervention



# TAP Continues to Evolve

- Expand to other lines of business
  - Medicaid disabled adults added 3/1/10
  - Mid-March discontinued in-patient visits
- Process and outcomes assessment underway
- Planned improvements
  - Interventions targeted to patients with psychiatric conditions



# Thank you

Genie Pritchett, MD

Colorado Access

[www.coaccess.com](http://www.coaccess.com)

(800) 511-5010

