Expanding Transitional Home Care Visits: Scalable Model Development

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Abstract:

The purpose of this project is to expand the capacity of the transitional care program at Indiana University Health (IUH) Bloomington. The project uses Indiana University (IU) nursing and medical student “navigator” teams to conduct home visits on patients who are deemed high risk for readmission upon discharge from IUH Bloomington Hospital. Working with the Kara Bierbaum, the Transitional Care Manager (TCM) from the Integrated Health Management department, student teams are provided with patients who are either in the hospital for a 30-day readmission or at risk for a 30-day readmission as identified by case management.

The intent of the project is to demonstrate that the combined 50% effort of the Project Manager and Research Assistant will be offset through readmission or through lower cost health care usage of the patients that are seen by the student navigational teams. For this offsetting to happen, an additional readmissions would need to be avoided. Based on a conservative average of $10,000 per patient per admission, the raw number reduction would need to be minimally further reduced by 3.5 readmissions per year. This does not include the offset of the potential penalty through the Affordable Care Act Readmission Reduction Program. The TCM program, prior to the student navigation teams, has already shown its effect, reducing the readmission rate from 19% in 2Q12 to 9.4% in 4Q14. The raw number of 30 readmission cases for 2014 was 852. Given this number of readmission, a reduction by at least 3.5 per year is highly probable.