

VA Coordinated Transitional Care (C-TraC) Program

This model of care shows promise to increase rural Veterans' access to care and services, and is recommended for replication at other facilities.

Medical Issue

Hospital readmissions are associated with poor health care transitions occurring when a patient moves from one health care setting to another (e.g., from a hospital to a home). This often results in fragmented care, patient dissatisfaction, rehospitalizations, and/or serious medication errors. Many of these hospital readmissions are avoidable and are often related to hospital-acquired infections and other complications, lack of medication reconciliation, inadequate communication among critical stakeholders, and poor planning for care transition.¹

Access Challenge

Research demonstrates that patients over the age of 75 have a higher risk of experiencing negative health outcomes associated with poor transitional care due to the increased prevalence of chronic conditions, physical disability, cognitive impairments, and polypharmacy.² Rural Veterans are more likely to be rehospitalized within 30 days compared to their urban counterparts and are more likely to be readmitted to a non-VA hospital within 30 days, resulting in fragmented care.³

Solution

To help, the Madison VA Geriatrics Research and Education Clinical Center (GRECC), in partnership with the Madison VA Medical Center in Wisconsin, established the VA Coordinated Transitional Care (C-TraC) program to provide coordinated care for high-risk, aging, and rural Veterans as they move from hospital to community settings.

The protocol involves a nurse care manager:

- ☑ preparing for transition within a multidisciplinary team by identifying program candidates and offering transitional care/outpatient advice;
- ☑ meeting with the Veteran/caregiver prior to discharge to discuss the program;
- ☑ conducting a follow-up phone call with the Veteran within 48 hours from discharge to reconcile any medication discrepancies and review "red flags," follow-up plans, and contact information;
- ☑ following up weekly with the Veterans for up to a month; and
- ☑ coordinating with caregivers, community support, and primary care providers to arrange services with local community agencies.

The C-TraC program has been implemented at VA and non-VA facilities across the U.S. C-TraC has been tailored to meet the needs of vulnerable individuals living in rural communities, and has reduced rehospitalizations within 30 days by one-third for elderly Veterans across multiple settings. Since its initial development in 2010, the C-TraC program has enrolled tens of thousands of Veterans, increased access to post-hospital care and decreased costs (cost savings of ~\$1,500 per Veteran enrolled).

¹ Berenson, R.A., Paulus, R.A., & Kalman, N.S. (2012). Medicare's readmissions-reduction program — a positive alternative. *New England Journal of Medicine*, 366, 1364-1366.

² Storm, M., Siemsen, I.M.D., Laugaland, K., Dyrstad, D.N., & Aase, K. (2014). Quality in transitional care of the elderly: Key challenges and relevant improvement measures. *International Journal of Integrated Care*, 14, e013.

³ Weeks W.B., Lee R.E., Wallace A.E., West A.N., & Bagian J.P. (2009). Do older rural and urban Veterans experience different rates of unplanned readmission to VA and non-VA hospitals? *Journal of Rural Health*, Winter,25(1), 62-69. doi10.1111/j.1748-0361.2009.00200.x

Office of Rural Health

The Office of Rural Health (ORH) works to see that America's Veterans thrive in rural communities. To support the health and well-being of rural Veterans, ORH and its Veterans Rural Health Resource Centers establish and disseminate initiatives that increase access to care for the 2.7 million rural Veterans enrolled in the U.S. Department of Veterans Affairs' health care system. Key focus areas include programs that address workforce shortages, transportation, primary care, mental health, telehealth and specialty care. To learn more, visit www.ruralhealth.va.gov.