Intro to Sharp HealthCare Community Care Transitions Program

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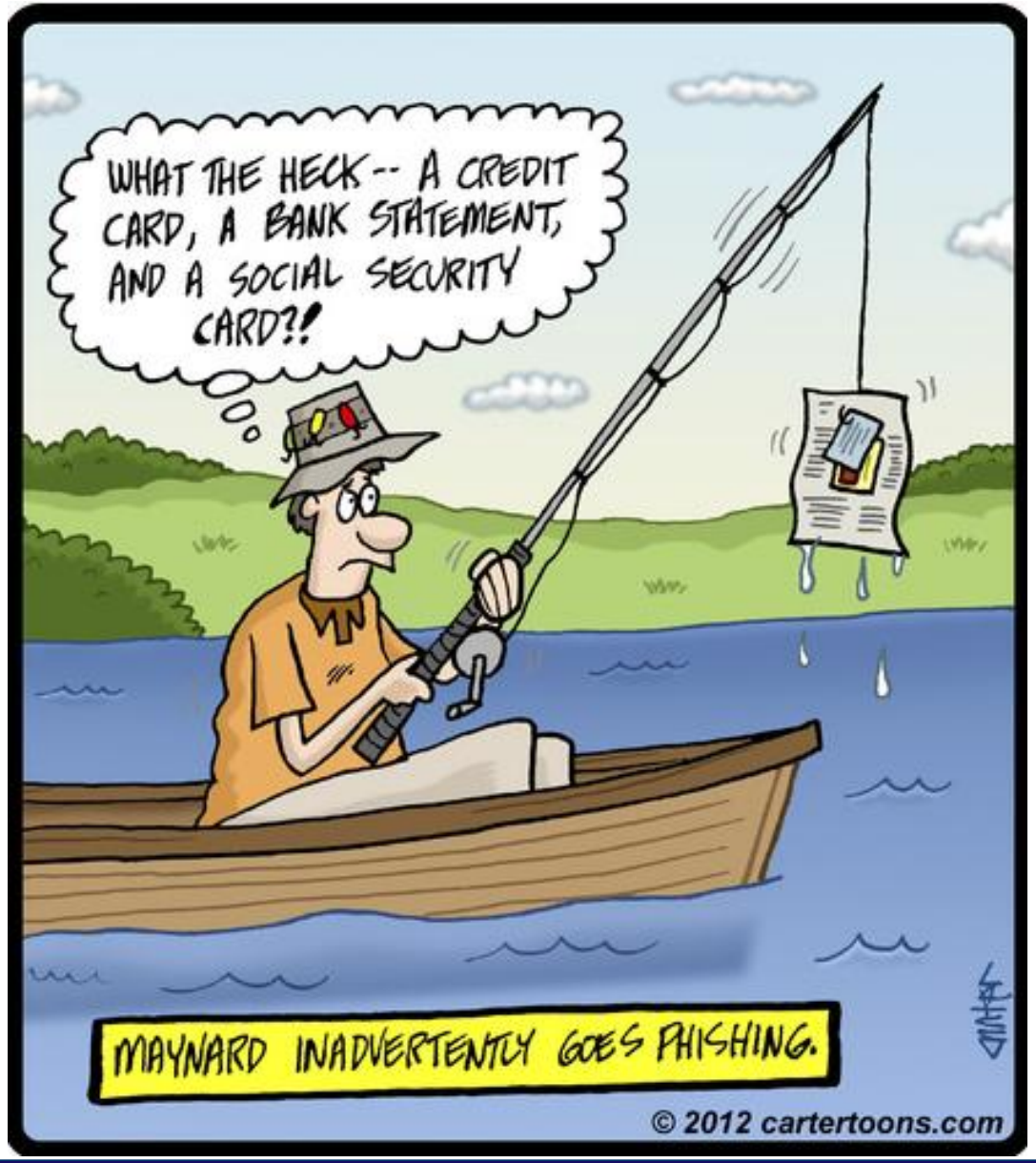

GIVE A MAN A FISH, HE EATS FOR A DAY….. TEACH A MAN TO FISH, HE EATS FOR A LIFETIME.

Sharp's CTI Program Timeline

- Spring/Summer 2012 – joint application with SD County, Scripps, UCSD and Palomar/Pomerado for a CMS CCTP Program Award
  - Sharp's program includes 4 possible intervention options:
    1) Full CTI
    2) Full CTI w/ Care Enhancement support from SD County Social Services
    3) Post-Acute Navigator Services
    4) Referral to Bridges
- April/June 2012 – 2 SHC staff attend CTI Coach training in Denver, Colorado
- July 2012 – "Test phase" of CTI begins at Sharp Grossmont Hospital using (2) of the (4) possible interventions – 30 patients enrolled as of mid-September

The intervention options

1. CTI
   - 1 home visit
     - ✓Set personal goal
     - ✓Complete PHR
   - 3 to 4 telephone follow ups
2. Post-Acute Navigation Services
   - 4 post-DC telephone calls
   - Follows CTI path w/o home visit
3. CTI w/ Care Enhancement
   - All items in #1
   - AIS Care Enhancement Svcs
4. Bridges
   - 2 home visits
   - 4 telephone follow-ups
   - Advanced Care Planning
   - Medical prognostication

The Workflow

See separate pdf document

Eligibility Criteria** for Sharp's CTI Program

Inclusion

- High risk for readmission
- Medicare FFS primary / MediCal secondary ok
- Independent (able to actively participate in their own care)
- Can have caregiver
- Chronic disease diagnosis
- Willing to accept home visit from CTI coach

*** Criteria is being revised and adapted to new findings on a regular basis so check with your facility's CTI Coach for questions*

Exclusion

- Dialysis (facility- or home-based)
- Hx substance abuse within one year
- Hx non-compliance
- Hospice-eligible end-stage disease
- Lives in or is DCd to Nursing Facility or Board & Care
- Active Cancer
- Post-surgical patients (at this time)
- Active Mental Health dx
  - Bipolar
  - Schizoeffective disorder

Eligibility for Post-Navigation Services Program

Inclusion

- Pt elig for CTI but refuses home visit, agrees to telephone follow-up …OR…
- Moderate risk of readmission
- Medicare FFS primary / MediCal secondary ok
- Independent (able to actively participate in their own care)
- Chronic disease diagnosis

Exclusion

- Dialysis (facility- or home-based)
- Hx substance abuse within one year
- Hx non-compliance
- Hospice-eligible end-stage disease
- Lives in or is DCd to Nursing Facility or Board & Care
- Active Cancer
- Post-surgical patients (at this time)
- Active Mental Health dx
  - Bipolar
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Sharp's Bridges Program

Target Population:

- Patients with advanced chronic illness with a diagnosis of CHF, COPD or dementia and/or other End of Life dx.
- Not "ready" or eligible for hospice

The Model:

- Proactive model of disease management focused on EOL
- Comprehensive proactive in-home patient and family education about their disease process.
- Evidence based prognostication.
- Professional proactive support of the caregiver.
- **Advanced care planning**

Questions???