



AGING & INDEPENDENCE SERVICES  
COUNTY OF SAN DIEGO ■ HEALTH AND HUMAN SERVICES AGENCY  
LONG TERM CARE INTEGRATION PROJECT

**Friday, December 12, 2014**



**AGING & INDEPENDENCE SERVICES**  
COUNTY OF SAN DIEGO ■ HEALTH AND HUMAN SERVICES AGENCY  
**LONG TERM CARE INTEGRATION PROJECT**

## **Brenda Schmitthener**

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**Long Term Care Integration Project Website**

[www.sdltcip.org](http://www.sdltcip.org)



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## MEETING AGENDA

### The San Diego Care Transitions Partnership (SDCTP)

A Two Year Journey to Transform Care Across the Continuum through the  
Community-based Care Transitions Program (CCTP)



- |                      |                                 |
|----------------------|---------------------------------|
| Brenda Schmitthenner | - Aging & Independence Services |
| Regina Carrillo      | - Palomar Health                |
| Joseph Parker        | - Palomar Health                |
| Sue Erikson          | - Scripps Health                |
| Cecile Davis         | - Sharp HealthCare              |
| John Tastad          | - Sharp HealthCare              |
| Eileen Haley         | - UCSD Health System            |
| Carol Castillon      | - Aging & Independence Services |



# THE SAN DIEGO CARE TRANSITIONS PARTNERSHIP

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*Transforming Care Across the Continuum*

Brenda Schmitthenner



# Background

A strategic partnership between Palomar Health, Scripps Health, Sharp HealthCare, the UCSD Health System

– 11 hospitals/13 campuses, and AIS/County of San Diego



Scripps



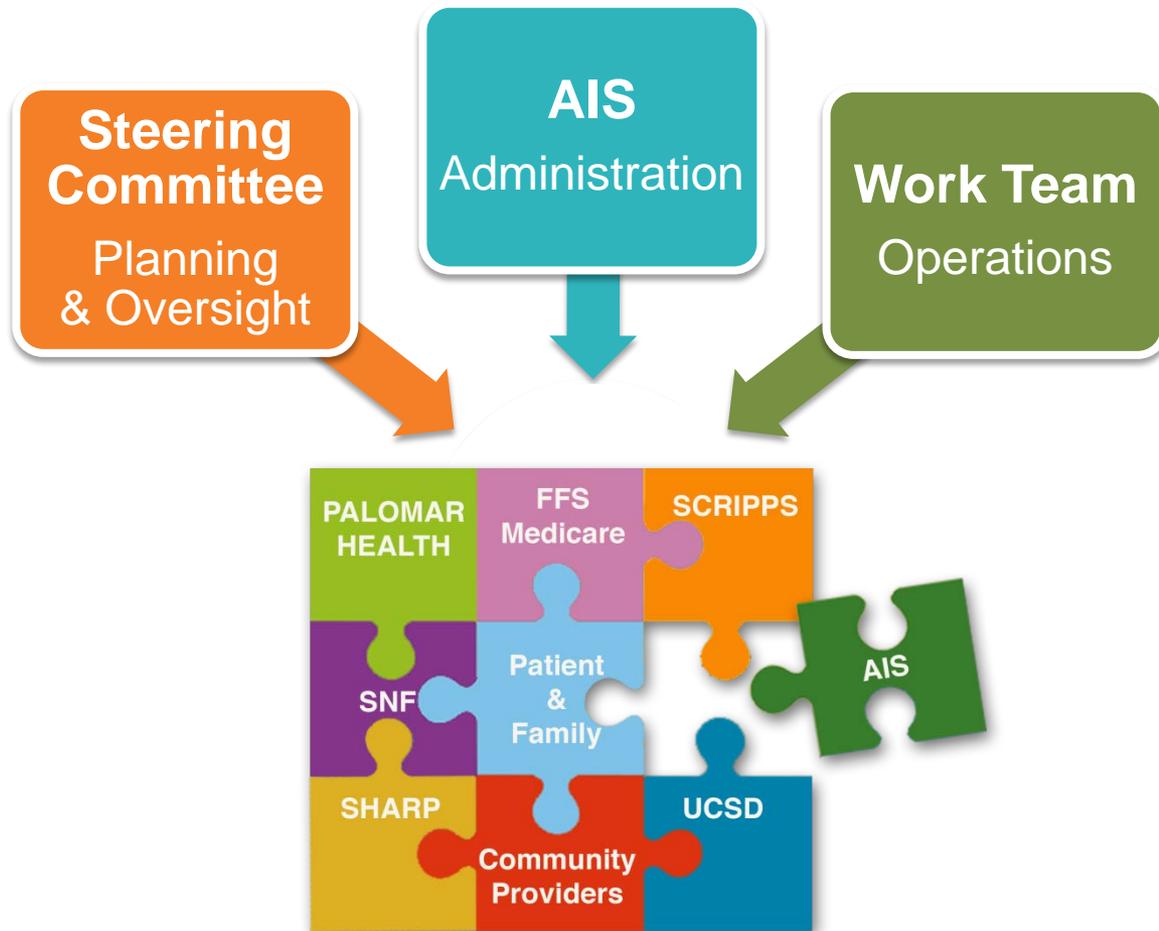
UC San Diego  
HEALTH SYSTEM



Goals of the Community-based Care Transitions Program (CCTP):

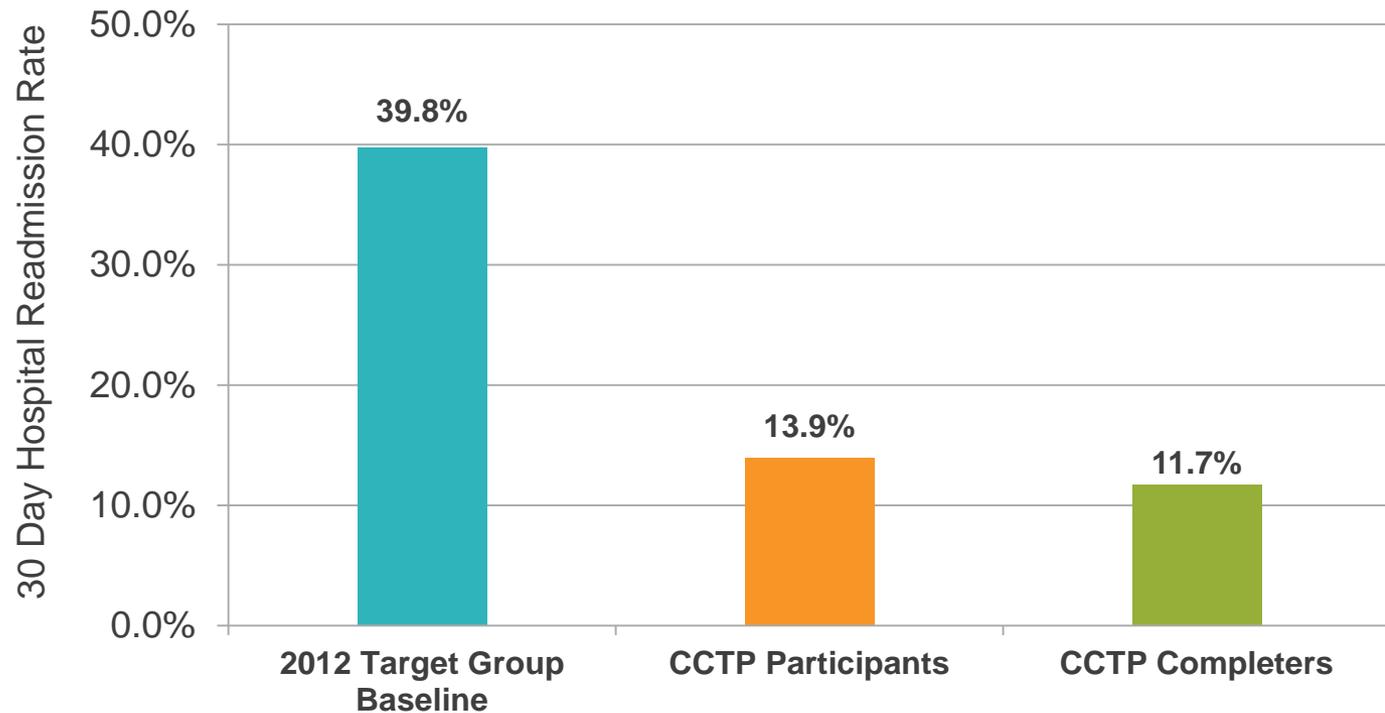
- Improve transitions from the inpatient hospital setting to community
- Improve quality of care
- Reduce readmissions for high risk beneficiaries, and
- Document measureable savings to the Medicare program

# Structure



# CCTP: Impact of Readmission Rates

## Community-Based Care Transitions Program (CCTP) Reduction in 30 Day Hospital Readmission Rates January 2013 to January 2014



Target Group baseline: CCTP participants 30 day readmission rate from 2012

CCTP Participants: Those who completed services (CCTP Completers) and those who did not complete all aspects of the program

CCTP Completers: CCTP participants who completed all aspects of the program

## Trends and Outcomes

- An increase in the San Diego FFS population by 8.6%
- A decrease in hospital admissions from 2010 to 2013 of 3.4%
- Readmission rate per 1,000 beneficiaries
  - 2010: 11.02/1000 benes/quarter
  - 2013: 8.99/1000 benes/Q4 (seasonally adjusted)



## What's Next?

- Improvements in screening / patient selection process
- Better understanding of why patients readmit and how/if we could have intervened
- Increased collaborations with community health agencies and SNFs
- Training the next generation of health care practitioners
- Expanding CCTP to other patient populations
- Sustaining the partnership and seeking new opportunities for partnership

# CCTP PHARMACIST INTERVENTION

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Joseph Parker, RN, MSN, CNL



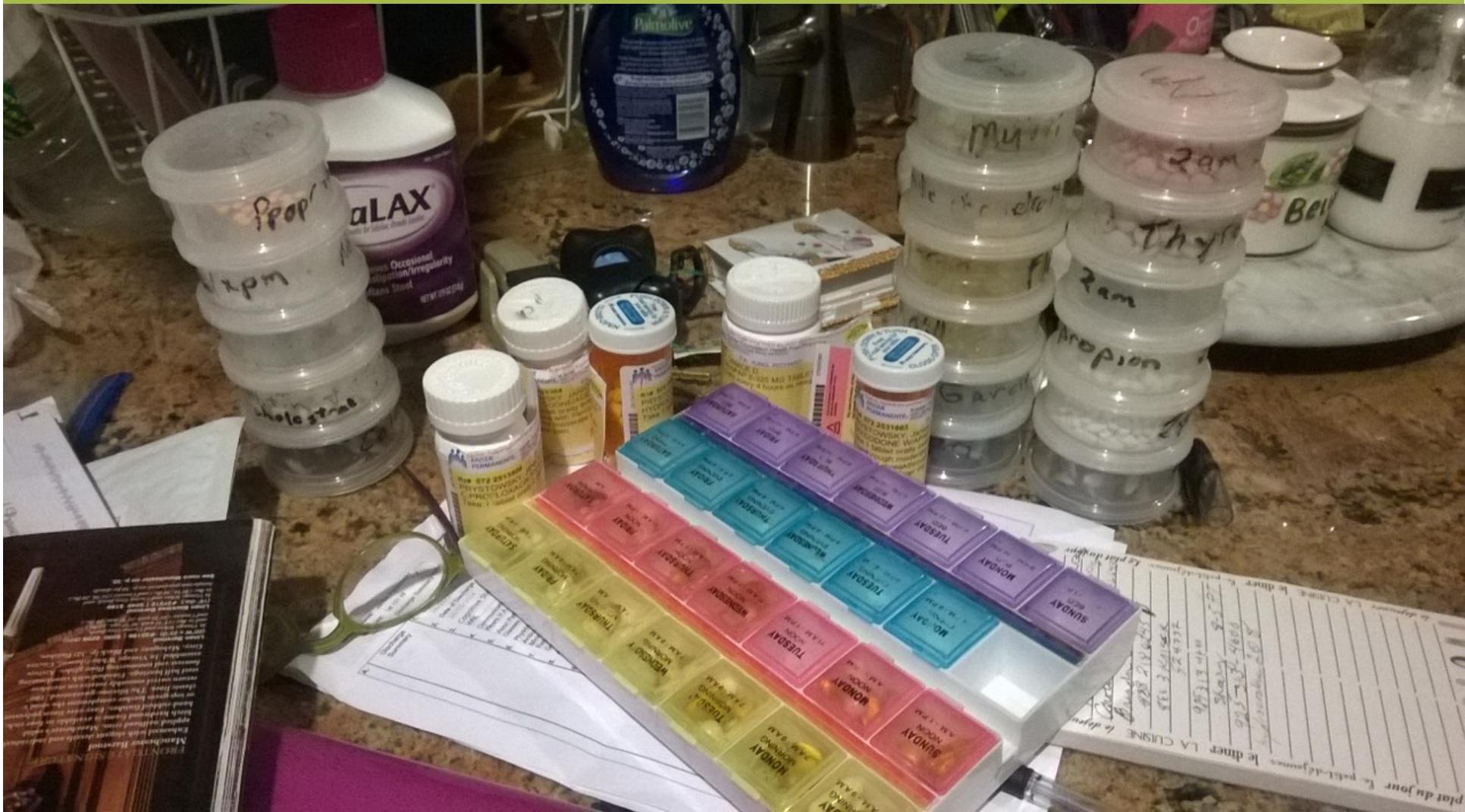
# Reconciliation vs. Management

- Medication Reconciliation--the process of comparing a patient's medication orders to all of the medications that the patient has been taking; done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.
- Medication Management--monitoring of medications that a patient takes to confirm that it is appropriate for their disease process and that he or she is complying with a medication regimen, while also ensuring the patient is avoiding potentially dangerous drug interactions and other complications.

# Standard Hospital Medication Reconciliation

Upon	Process	Risk Factor
Admission	<ul style="list-style-type: none"><li>• Provider (non-pharmacist) reviews prior to admission (PTA) medications – <i>should</i> review this list with patient or caregiver.</li><li>• This does not typically get verified with the patient's pharmacy.</li><li>• These meds are imported into a med list by an EMR system.</li><li>• Provider enters any missing PTA medications.</li></ul>	Medications are often not verified with the patients or the patient's pharmacy.
Discharge	<ul style="list-style-type: none"><li>• Provider reviews all medications listed in EMR and determines what to keep, stop, or change.</li><li>• If PTA meds were incorrect, discharge medications will follow suit.</li></ul>	The discharge provider is typically different than the admitting provider.

# Importance of Medication Management at Home



# Pharmacist Involvement

- CCTP Patients (Polypharmacy, HR Meds, MTM)
- Orthopedic Patients

## MedActionPlan for Healthcare Providers

Discharge Planning Tool—Advance patient safety, patient education, and adherence to medication therapy

[Watch a Demo ▶](#)

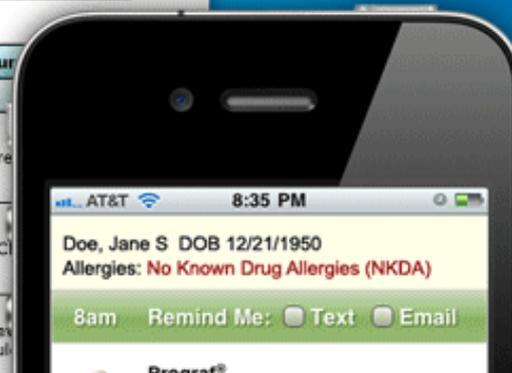
Morristown General Hospital  
Transplant Department  
908 555-5555

MedActionPlan®  
**My Daily Schedule**

10/03/11 1:26:00 PM  
Revised by: Tim Peters

Doe, Jane S DOB: 12-21-1950 MRN: B93-228-776  
Allergies: **No Known Drug Allergies (NKDA)**

Take These Medications	At These Times			Purpose
	8am	8pm	10pm	
 <b>Prograf®</b> (Tacrolimus) 1 mg Capsule(s) By mouth	<b>3</b> Capsule(s)	<b>3</b> Capsule(s)		Prevents re
 <b>Valcyte®</b> (Valganciclovir Hydrochloride) 450 mg Tablet(s) By mouth	<b>1</b> Tablet(s)			Prevents CI
 <b>Nexium®</b> (Esomeprazole) 40mg Capsule(s) By mouth	<b>1</b> Capsule(s)			Treats/pre



# Medication Reconciliation



**Communication**



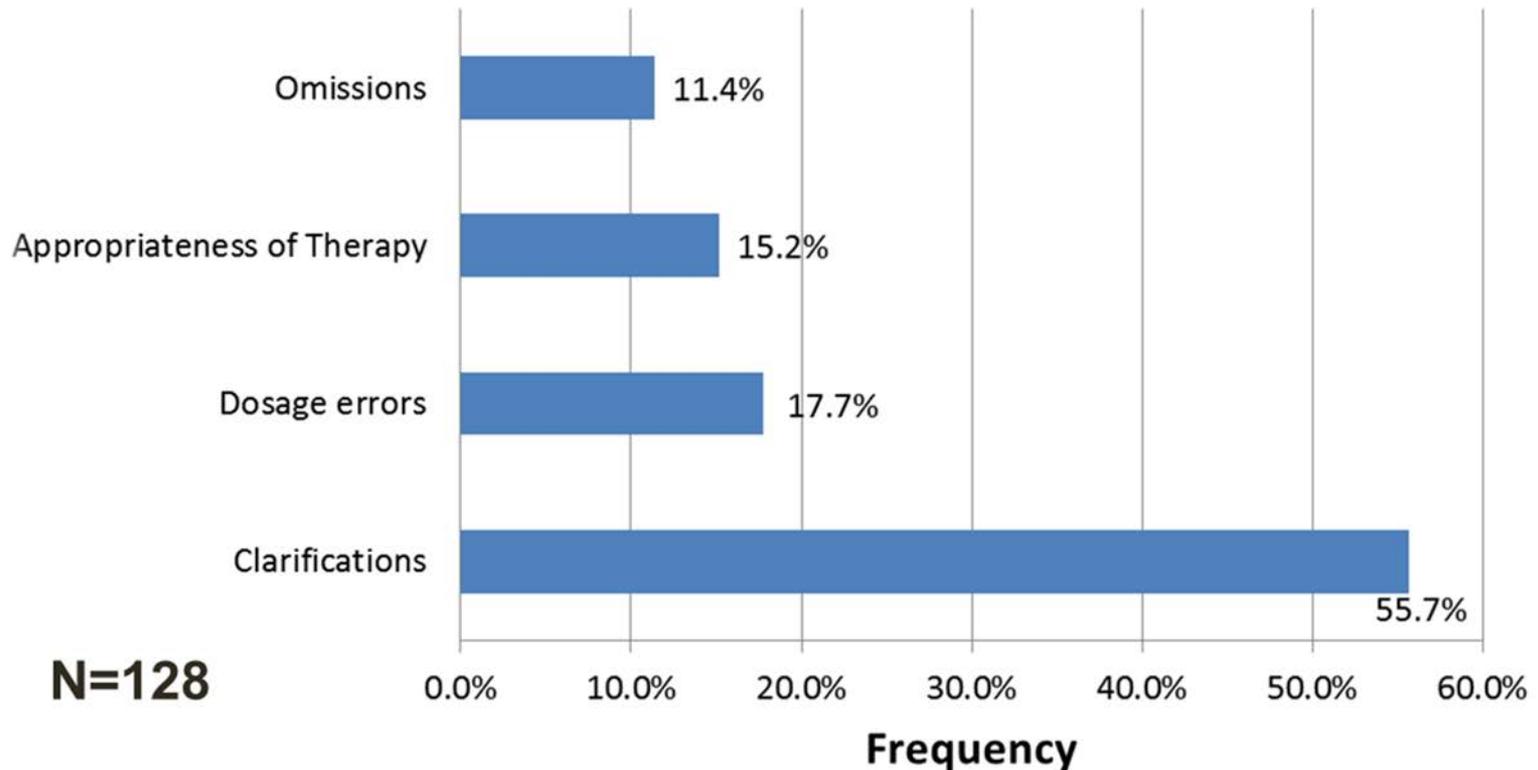
**Reconciliation**



**Medication History Documentation**

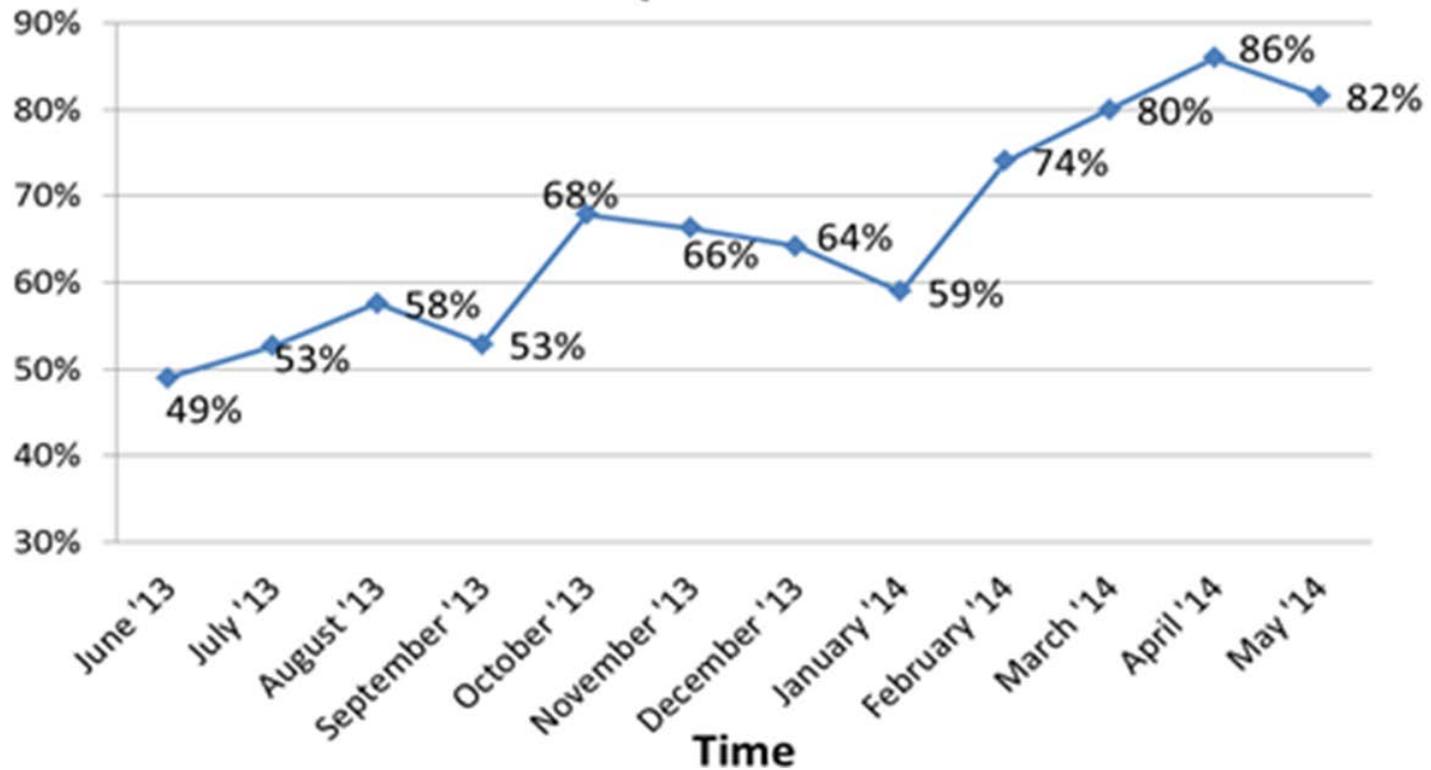
# What Interventions are the Pharmacists Doing?

**Frequency of Interventions Performed by Palomar Health's Pharmacists in May 2014**



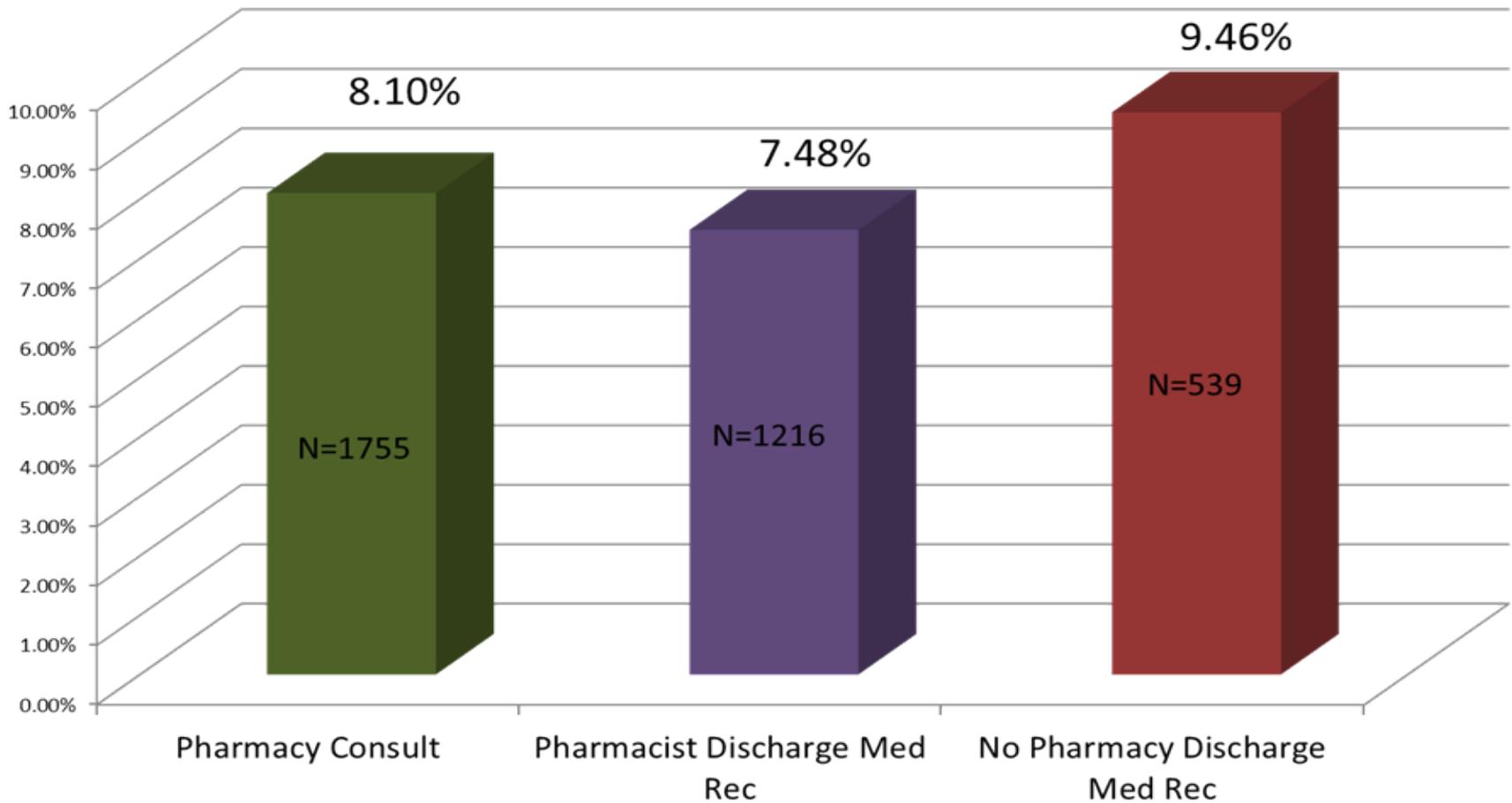
# Pharmacy Impact

## Discharge Medication Reconciliation Completion Rate



# Pharmacy Impact

**Pharmacy Intervention Readmission Rates June 2013- May 2014**



# **Scripps Health CCTP Program**

Susan Erickson RN, MPH  
Senior Director Patient Navigation

December 12, 2014

Not for Profit  
Integrated Health System  
13,000 Employees  
2600 Physicians

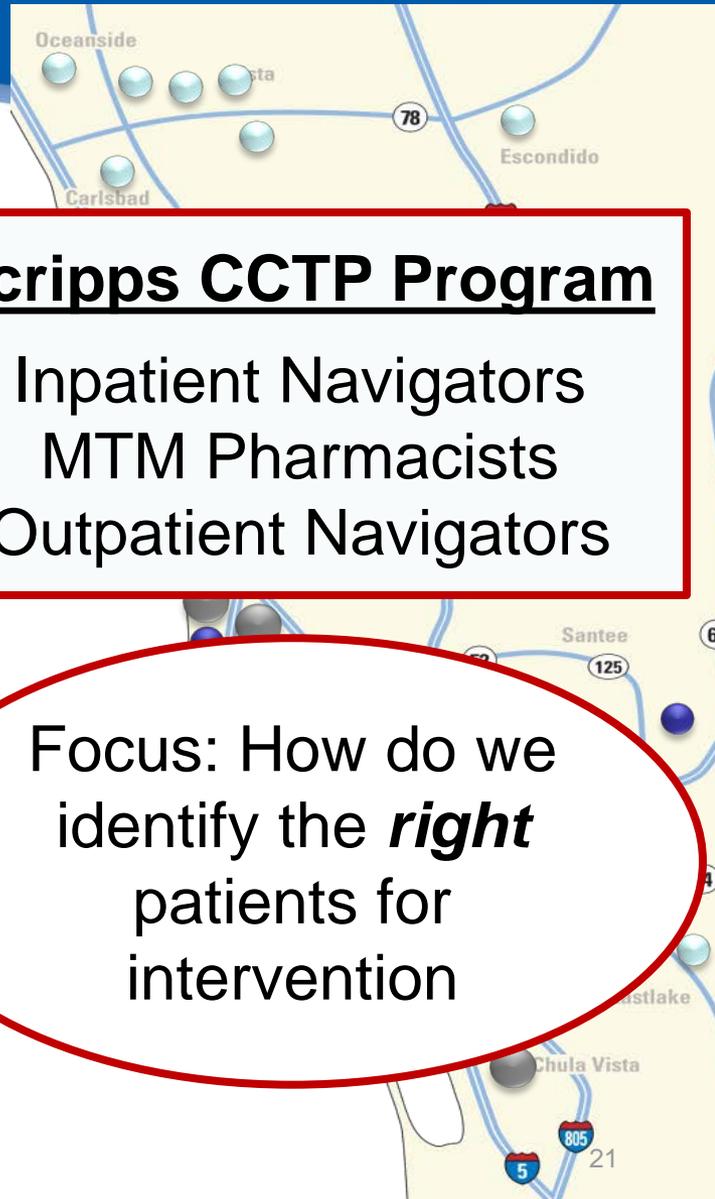
Scripps Hospital Campuses

Scripps Clinic

Scripps Coastal Medical Center

Well Being Centers

Scripps Home Health / Hospice Care



The map shows the service area of Scripps Health Care System, covering parts of San Diego County. Key locations marked include Oceanside, Carlsbad, Escondido, Santee, Chula Vista, and San Marcos. Major highways shown include I-5, I-805, SR-78, SR-67, and SR-125.

## Scripps CCTP Program

Inpatient Navigators  
MTM Pharmacists  
Outpatient Navigators

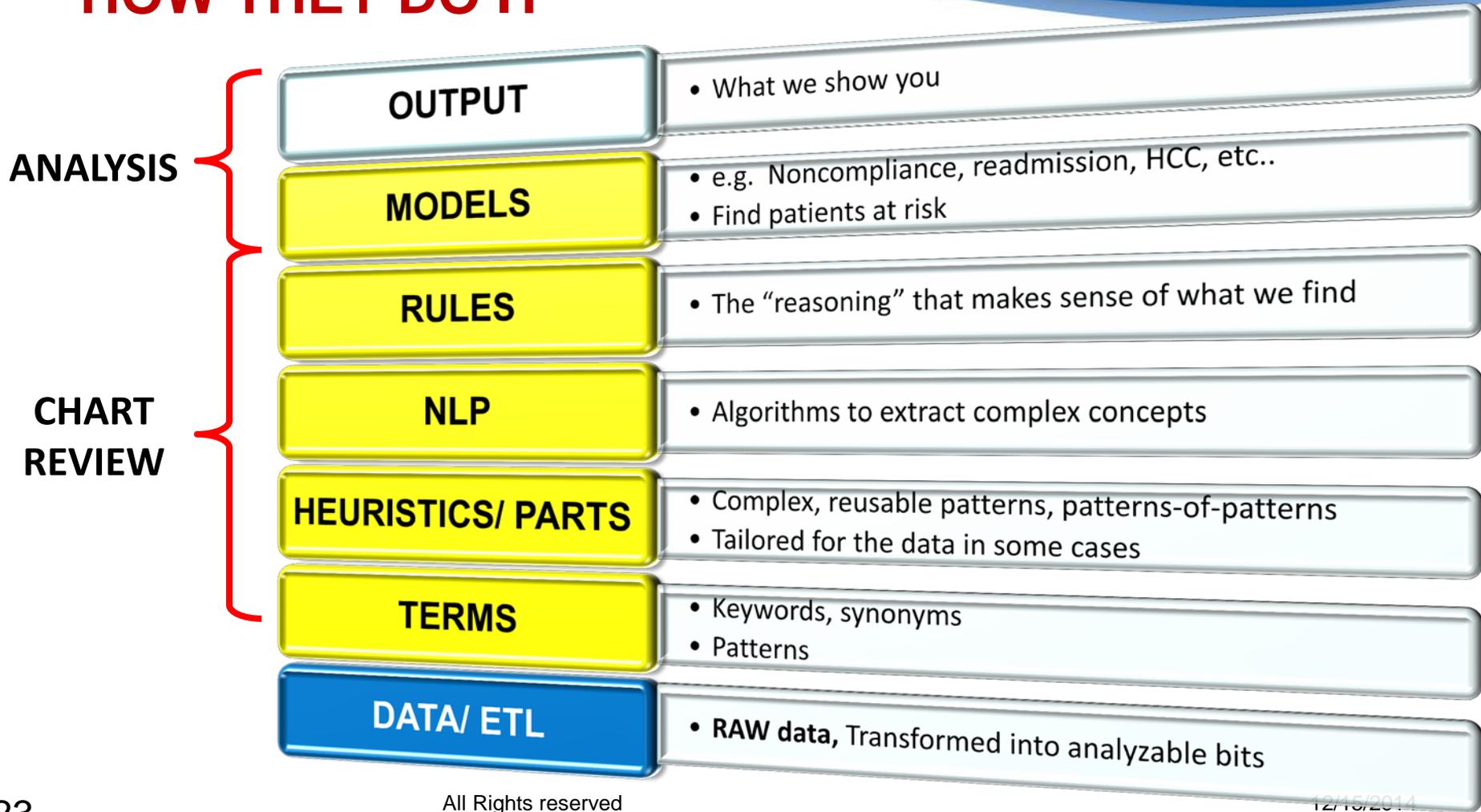
Focus: How do we  
identify the *right*  
patients for  
intervention

**Crimson Real Time:** Natural Language Processing

## How it works



## HOW THEY DO IT



# A Glimpse Into the Technical Process

**Intake** of a variety of clinical data [1], transforms[2, 4] then using robust, proprietary dictionaries [3], rules [6], analytics [5] and mathematical models [7.9] drive targeted interventions [10] and outcomes

- LABS
- ORDERS
- CLINICAL NOTES
- TEST RESULTS
- NURSING NOTES
- OTHER DATA

Heterogeneous Health Data



360Fresh Dictionaries

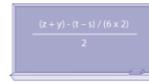


Extract and Cleanse

Clinical Analytics Warehouse



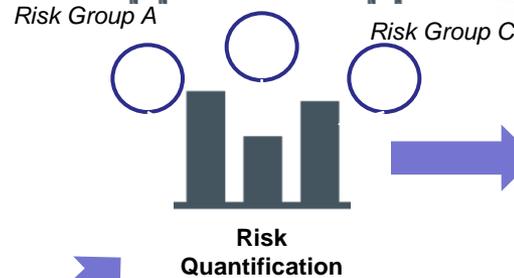
Rules



Models



Analytics



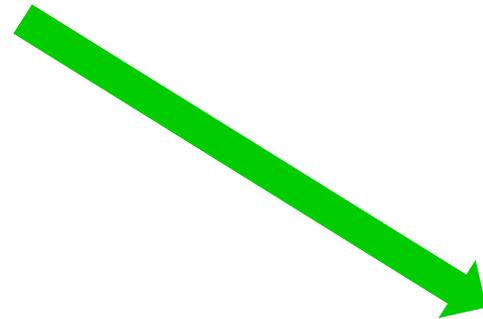
Risk Quantification

PATIENTS @ RISK	
PEREZ	
LU	
WEISS	
SMITH	

Risk Stratification



Targeted Intervention and Alerts



**HISTORY OF PRESENT ILLNESS:** The patient is a 41-year-old African-American male previously well known to me. He presents with dyspnea, weakness, and confusion. He has a history of aortic valve disease, status post aortic valve replacement on 99/99/9999, for which he has been on chronic anticoagulation. There is a previous history of paroxysmal atrial fibrillation and congestive heart failure, which has been rather unstable prior to this admission. He has a previous history of transient ischemic attack with no residual neurologic deficits.

The patient has undergone surgery by Dr. X for attempted nephrolithotomy. The patient has experienced significant postoperative bleeding, for which it has been necessary to discontinue all anticoagulation. The patient is presently seen at the request of Dr. X for management of anticoagulation and his above heart disease.

**FAMILY HISTORY:** There are no family members with coronary artery disease. His mother has congestive heart failure.

**SOCIAL HISTORY:** The patient is widowed, living alone. He has "a friend" who helps with care "once in a while". He is employed as a barber. He does not use alcohol, tobacco, or illicit drugs.

**MEDICATIONS PRIOR TO ADMISSION:**

- |                             |   |
|-----------------------------|---|
| 1. Clonidine 0.3 mg b.i.d.  | 9. Amlodipine 10 mg daily.                  |
| 2. Atenolol 50 mg daily.    | 10. Lantus insulin 50 units q.p.m.          |
| 3. Simvastatin 80 mg daily. | 11. KCl 20 mEq daily.                       |
| 4. Furosemide 40 mg daily.  | 12. NovoLog sliding scale insulin coverage. |
| 5. Metformin 1000 mg b.i.d. | 13. Warfarin 7.5 mg daily.                  |
| 6. Hydralazine 25 mg t.i.d. | 14. Levothyroxine 0.2 mg daily.             |
| 7. Diovan 320 mg daily.     | 15. Folic acid 1 mg daily.                  |
| 8. Lisinopril 40 mg daily.  |   |

**ELECTROCARDIOGRAM:** Normal sinus rhythm. Right bundle-branch block. Findings compatible with old anteroseptal and lateral wall myocardial infarction. Nonspecific ST-T abnormality.

**HEART FAILURE** is **UNSTABLE**. Risk factor for 30-day readmission.

Potential **COMPLICATIONS** (TIAs)

**LITTLE OR NO SUPPORT:** strong risk factor for noncompliance & 30-day readmission

**LIVES ALONE:** strong risk factor for noncompliance

**SOCIOECONOMIC RISK:** can't afford care, afford transportation to come to clinic visits, etc.

**POLYPHARMACY, DOSAGE VARIATION / FREQUENCY, DRUG COST:** risk factors for noncompliance, 30-day readmission, adverse events





**Identified Patients**

Facility: All Payor: [X]

Visits:  All  Current  Discharged

Disease:  HF  AMI  Pneumonia

Age:  all  <65  65+  65-71  72-79  80+

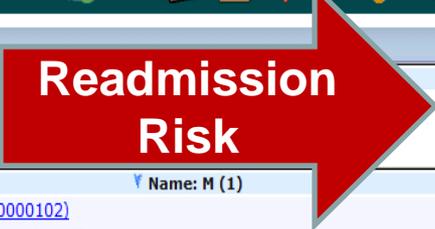
Name: [X] Selection:  Selected Named:  All

- Rules**
- Case Finding Screens
  - Chronic mental illness
    - Dual Diagnosis: Mental Illness & Substance Abuse
    - Mental illness (alone)
  - New Diabetes
  - Diabetes
  - Advanced Age or meets socioeconomic criteria
    - Advanced age
    - Socioeconomic criteria
  - Altered level of consciousness
  - Any mental illness
  - Cellulitis or IV infusion on DC
  - Chronic CHF, COPD, or DM
  - comorbidity form
  - Conservatorship
  - CVA / TIA
  - Funding challenges
  - History of 30d HOSPITAL readmission
  - History of frequent ED visits
  - HIV



**Patients**

Admitted:	Name:	Details	Readmission Risk
Admitted: Sat, Aug 3 (1)	WILE, Coyote (000000001)	Loc:EICU, Gender: M	High Risk
Admitted: Sun, Aug 4 (2)	MAN, Super (000000102)	Loc:EICU, Gender: M, Age: 83yo	High Risk
	BULLWINKLE, Moose (300000003)	Loc:5-11-7, Gender: F, Age: 103yo	High Risk
Admitted: Mon, Mar 11 (1)	SMITH, Biggy (700000007)	Loc:EICU, Gender: F, Age: 76yo	High Risk
Admitted: Wed, Feb 13 (1)	MCDONALD, Fona (900000009)	Loc:EICU, Gender: F, Age: 63yo	High Risk
Admitted: Fri, Mar 1 (1)	PACER, Roxane (10460008261000023067)	Loc:EICU, Gender: F, Age: 69yo	High Risk
Admitted: Tue, Aug 6 (1)	LANE, Lois (400000004)	Loc:103-2, Gender: F, Age: 73yo	High Risk
Admitted: Fri, Aug 2 (3)	MOUSE, Mickey (000000106)	Loc:EICU, Gender: M, Age: 71yo	Medium Risk
	DUCK, Daffy (000000101)	Loc:EICU, Gender: M, Age: 81yo	Medium Risk
	MAN, Spider (000000104)	Loc:EICU, Gender: M, Age: 51yo	Medium Risk
Admitted: Sat, Aug 3 (1)	RUNNER, Road (000000110)	Loc:EICU, Gender: M, Age: 75yo	Medium Risk



## Demo - Readmissions UI



### Identified Patients

Status:  Name/EID:   
 Facility:  Payor:

Visits:  All  Current  Discharged  
 Readmit:  Readmit  
 Visit Type:  Inpatient  ER  Outpatient  Other  
 Disease:  HF  AMI  
 Age:  al  <  
 Sort:  Admission

**Individual Patient Detail**

- Admitted: Sun, Feb 3 (3)

1 [BULLWINKLE, Moose](#)  
 Id:300000003, Gender: F, Age: 103yo  
 Score: high risk (1)
- 2 [LOIS, Lane](#)  
 Id:400000004, Gender: F, Age: 72yo  
 Score: very low risk (1)
- 3 [BUGS, Bunny](#)  
 Id:100000001, Gender: M, Age: 87yo  
 Score: very high risk (1)
- 4 [MAN, Super](#)  
 Id:000000102, Gender: M, Age: 83yo  
 Score: medium risk (1)
- 5 [DUCK, Daffy](#)  
 Id:000000101, Gender: M, Age: 80yo  
 Score: medium risk (1)
- 6 [DUCK, Donald](#)  
 Id:000000105, Gender: M, Age: 70yo  
 Score: medium risk (1)

### Patient Review and Enrollment

1-Screen 2-Contact CM 3-Contact TH 4-Completed On Hold Removed  
**BULLWINKLE, Moose** (300000003, F, 103yo, 731, Feb/3/2013 22:13, Pending)

Screen Enroll Forms History Patient Wall

#### Patient

EID: 300000003  
 Patient: Bullwinkle, Moose (F)  
 Birth Date: Oct 11 1909 (103yo)  
 Allergies: N/A  
 Insurance: N/A  
 Home Address: 4 Pine Tree Pass  
 Mooseport, Hunt  
 MS, 10937  
 Home number: 888-333-3333

#### Visit History (details...)

Hospitalizations: 4  
 ER 1  
 Readmissions: 14-days: 1, 30-days: 1

#### Current Visit (details...)

VisitId 330000334  
 Visit Type: I  
 Admission Date: Feb 3 2013, 22:13PM  
 Discharge Date: N/A  
 LOS: 25  
 Location: Room: 731; Bed: 3  
 Readmission: Yes   
 Disease Class: HF, Pneumonia  
 Risk Score: 0.87

*This information was last updated Feb 19 2013, 22:35PM*

[Risk Details](#)

[Care Plan](#)

#### Classification

Tier:

Intervention:

[Next...](#)

[Hold](#) [Remove](#)

**Utilization - Disease - Age  
Rules Pinged - Payer**

## Risk Summary Report

Owner: *[Redacted]*

Generated: *[Redacted]* 2014, 09:52:06

### Selection Criteria

Status: current Visits: current Readmissions: N/A Visit Type: Inpatient,Other

Disease: N/A Age: all Risk Type: REA30 Rules: Pharmacy Screens Tier 1: Med Acquisition  
Inpatient Navigation Screens

Payor: N/A Facility: GR Team: all Unit: N/A

### Risk Summary Report

Patient Info	Risk Score	Model Risk Factors	Case Findings
<b>EID:</b> <i>[Redacted]</i> <b>Name:</b> <i>[Redacted]</i> <b>Gender (Age):</b> <i>[Redacted]</i> <b>Location:</b> <i>[Redacted]</i> <b>Team:</b> <i>[Redacted]</i> <b>Admit date:</b> <i>[Redacted]</i>	0.95 VeryHigh	<ul style="list-style-type: none"> <li>Inpatient Visits: 3 visits</li> <li>Current LOS: 103 days</li> <li>Chest Pain: Diagnosed with 'ACUTE RESPIR FAILURE' Code 51881 (I9) Type A</li> <li>Depression Symptoms: Note ID: 771158715 ...RVICE: 09/27/2014 INPATIENT PROGRESS NOTE SUBJECTIVE: Mr. Alcasar reports passing a fairly comfortable day and a quiet night. He reports ongoing generalized fatigue and (#DX_DETECT_diminiss...</li> </ul>	<b>Pharmacy Screens Tier 1: Med Acquisition</b> Medications needing assistance Methylaltraxone : _MEDS_2014.07.02_19.19.15   METHYALTRAXONE BR 12MG/0.6ML VIAL SQ   6   mg   SUBCUT    . <b>Inpatient Navigation Screens</b> 30 Day Readmission : _ANALYSIS_READMIT_30_CUMUL   1.

**Demographics**

**Risk Score**

**Model Risk Factors**

**Discipline Specific Case Finding**

# Are Risk Scores Actionable?

Risk scores are a relative number – how does the score correlate to readmission risk?

Review of patients with heart failure 2013:

- **Top Tier – Risk Score Band > 0.922**
  - 58% of patients had a readmission within 30 days
- **Second Tier - Risk Score Band = 0.806-0.923**
  - 41% of patients had a readmission within 30 days

- **Inpatient and outpatient navigators**

- Case finding and triaging for services
- Earlier referrals internally and to community resources
- Retrospective review and refinement of practice: Did we target the “right” patients?

- **Social work**

- Case finding and triage patients

Heart Failure Program  
Diabetes Program

- **Pharmacy**

- Identify patients for enrollment into the system-wide MTM program

**BEGIN  
WITH  
THE END  
IN MIND**

Covey 1989

# What is Advance Care Planning?

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Advance Care Planning is a process aimed at allowing competent adults to guide their medical care at times when they are unable to speak for themselves.

**Advance Directive** = The Outcome – Noun  
A document, a tool for healthcare decision making.

**Advance Care Planning** = A Process – Verb  
A journey, honoring patient autonomy or self-determination.

# What are the benefits of planning?

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- A person's voice can be heard. (Even when they cannot speak!)
- Family and health care providers can be relieved of a challenging moral burden.
- Planning and preferences can align with treatment and care.
- A reliable document can guide health care decision making and is consistently stored and retrieved as needed.

# Why is Advance Care Planning Important?



**It helps protect against back seat drivers making uninformed decisions.**

# Why are People Hesitant to Begin the ACP Process?

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*I'm not THAT sick.*

*It is confusing.*

*I've already talked to my lawyer about it.*

*It won't happen to me,*

*It might be bad luck.*

*I don't like difficult conversations.*

*Later!*

*I'm sure that my loved one's know what I would want.*

*I don't want to talk about my mortality.*

# Advance Health Care Planning

## What it is not...

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- The “*Death Panel.*”
- Legal Counsel.
- Forced upon people.
- Gloom and doom!
- Specific medical advice.
- An inducement to hospice services.

# The Five Key Components of Advance Care Planning

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**Select** a qualified, informed health care agent.

**Explore** personal values and beliefs regarding health care.

**Understand** your current health status, and the expected course of any illness.

**Document** the health care agent and specific health care preferences.

**Inform** the health care agent, and others as needed, of health care preferences.

# Care Transitions and Advanced Care Planning

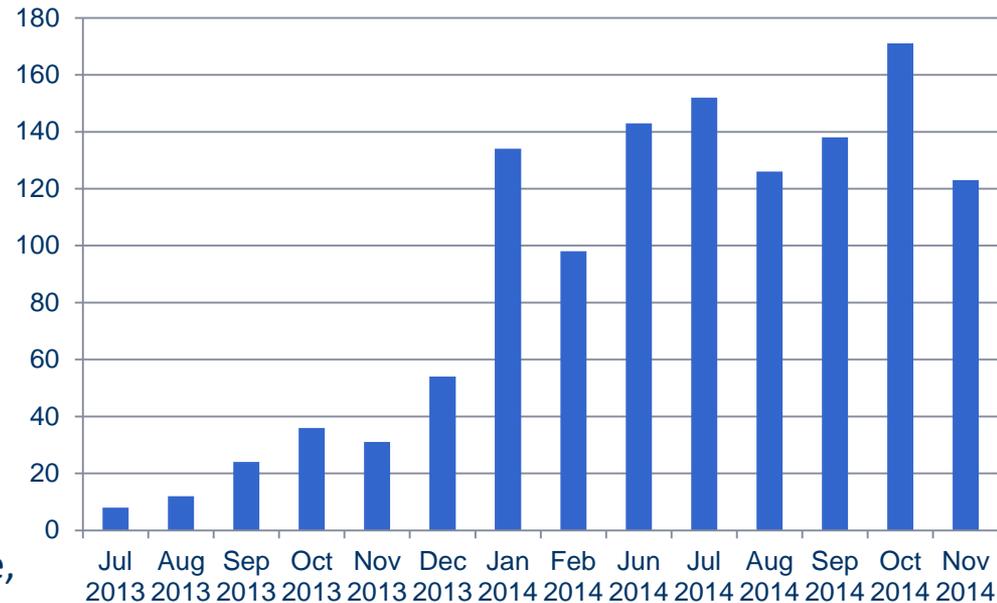
The majority of population that is targeted by the Community Based Care Transitions Program are the elderly with chronic conditions. These patients not only are experiencing an acute event in the hospital, they continue to experience progression in their illness that Advanced Care Planning can assist with their decision making in regards to their care. Advanced Care planning ultimately has the same goal as the Care Transitions Intervention.

“Empowering the patient with tools that will help them manage their lives/health and their wishes as the patient dictates – putting the patient in the driver’s seat in the decision making process needed to navigate through changes in their health”.

# How do the coaches have this conversation, what tools do they share with the patient?

Tools given to patient:

- 5 Wishes booklet – Coaches offer to review during home visit or at a future home visit
- Advanced Directives if requested by patient
- Contact information for patient should they want to speak to someone from the Advanced Care Planning department at Sharp HealthCare (referral)
- Second home visit offered to continue discussion (usually questions regarding Hospice, POLST)



*“Conversations matter”*



*What we're talking about here is self-determined care -- every individual's inalienable right to determine, in advance, how they will be cared for near the end of their lives.*

-Allen S. Lichter, M.D., American Society of Clinical Oncology

# Health Resources & Services Administration (HRSA) Grant for Advanced Practice Nursing Students Care of Vulnerable Populations with Multiple Chronic Conditions with an emphasis on Inter Professional Approach

## UCSD / CSUSM Partnership

Eileen M. Haley, MSN, RN, CNS, ACM

Annemarie Degen DeCort, MSN, RN, PHN, ACM

# OBJECTIVES

- Understand Need for Education on Providing Patient Centered Care Planning Across the Continuum,
- Review Draft of CSUSM Program Overview and Timeline.
- Identify Opportunities for Hospitals and Community Participation

# CCTP Highlighted Gaps in Transitions of Care Knowledge : handoff between hospital and upstream providers and lack of patient centered planning and knowledge transfer.

- Hospital Systems
  - Qualifying Stay / Appeals / Denials
  - Trajectory of Acute Illness & Post Discharge Patient Options
  - Pace of Transitions within a Hospital
  - Communication / Handoffs variable, inconsistent
- Payers
  - Benefits- What they are and mean & they keep changing
  - Maximizing Resources: Prescription Assistance Programs, Chronic Disease Management Programs, AIS opportunities
- Patient Centered Planning
  - Advocacy
  - Cultural Humility
  - Resilience: characteristic and outcome
  - Patient / Family Education: Teach Back and Patient Engagement
- Inter Professional team – no one filling in the gap. High risk pt = readmission
- Upstream Provider Awareness: Changes / Practices

# Why Develop Undergraduate and Graduate Nurses Trained in Transitions of Care (TOC)

- Decreased Length of Stay = rapid transitions within hospitals
- Discharge planning needs to start with nurses who know TOC and can anticipate LOS and Post DC Needs
- Higher Acuity of Patients going home
- Less Resources / Payer Changes
- Greater Demands on Hospital Staff – Multiple Priorities of Teams
- Penalties for Readmission / Red Census
- Increase in hiring staff / lack of consistent competence, on the job training
- Aging Nurse Case Management Workforce with high degree of knowledge variation
- Limited SW hospital training on TOC

# HRSA Grant Highlights

- Focus on advanced practice nursing education with an inter professional approach for vulnerable populations with multiple chronic conditions –
  - NP Fellowship in Underserved Health and Clinical Nurse Specialist specializing in Adult-Gerontology with special emphasis in Transitions of Care.
- CSUSM / UCSD partnership open to all nurses / entities
  - Principal Investigator UCSD Free Clinic: Ellen Beck, M.D.
  - Principal Investigator CSUSM: Denise Boren, Director of Nursing
- NP Fellowship – clinical primarily at UCSD free clinics with opportunities for clinical rotation
- UCSD Care Coordination Leadership & Transition Nurse Specialists will be preceptor of undergraduate & graduate nurses
- Collaborating with area hospitals and community clinics for clinical

\*Pending approval from CSUSM Academic Senate

# HRSA Grant Focus with added RN Tracks

## ➤ Areas of Concentration:

### ✓ Transitions of Care

- TOC Certificate I – Standards & Practices of Case Management with emphasis on hospital case management
- TOC Certificate II – Emphasis on Evidenced based Practice Tools and Research, Adult Learning Theories, Care Across The Continuum, Patient Engagement: Education & Coaching, Program Development and System Integration, Acute, Chronic and Population Health Focus

### ✓ Inter Professional Practice – Transdisciplinary Approach

### ✓ Integrative Medicine

## ➤ 4 Tracks:

- Post BSN Certificate: 12 units with 6 units hybrid classroom and 6 units clinical (270 hours)
- MSN to CNS
- BSN to CNS ( 44 Units)
- NP Fellowship: One year of part time study with clinical
- emphasis at UCSD Free Clinics / vulnerable populations

# Draft of Introduction to Integrative Healthcare Syllabus Objective

- This seminar course introduces the student to the history and foundations of a Trans-disciplinary Modeled of Evidence-based Integrative Healthcare (IH) to include the influence of the environment on healthcare. This introductory course presents an overview of nutrition and health, micronutrients and supplements, spirituality, mind body practice, and traditional whole body practices to effect positive health-related changes.
- Integrative medicine (IM) or healthcare (IH), as defined by the National Center for Complementary and Alternative Medicine (CAM) at the National Institutes of Health (NIH, 2009), "combines mainstream therapies and CAM therapies for which there is some high-quality scientific evidence of safety and effectiveness". Complementary generally refers to using a non-mainstream approach together with conventional medicine and Alternative refers to using a non-mainstream approach in place of conventional medicine.

\*Pending approval from CSUSM Academic Senate

# Excerpts from Draft of Inter Professional Practice: A Transdisciplinary Approach to Care Syllabus

- This course introduces concepts, knowledge, and skills in transdisciplinary practice with underserved communities.
  - Define the terms inter-professional and trans-disciplinary.
  - Describe key elements of a transdisciplinary approach
  - Describe how these skills/approach is used in the clinical setting
  - Describe three key behaviors of a humanistic approach and how to integrate these behaviors into all encounters.
  - Describe key areas of overlap in the work of different professions.
  - Identify areas of controversy and/or prejudice between different fields
- Term Definition & Interdisciplinary Approach
  - Empowerment, Humanistic Approach [including terms: empathy, congruence/self-awareness, positive regard/respect], Transdisciplinary Approach, Community as Teacher, Vulnerable Populations , “Cultural Humility”, Health Literacy, Social Determinants of Health, Teach back

# Timeline

- January 2015: Submit curriculum for final approval through CSUSM curriculum approval process
  - Expected Determination 4 months / Spring 2015
- Continued course development
- Enrollment Winter 2016
- Identify expert teams as preceptor sites
- Share updates on status with partners - ongoing



# AGING & INDEPENDENCE SERVICES

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*Care Transitions and Care Enhancement*

Carol Castillon



# CARE ENHANCEMENT MODEL

- Intense short-term care coordination
- Initial focus on immediate needs to transition home
- Move to long term services and supports
  - I. Access to expedited services
  - II. Long term case management
  - III. Purchase of DME, Med copays
- 30 day intervention
- Typical response ~11 hours



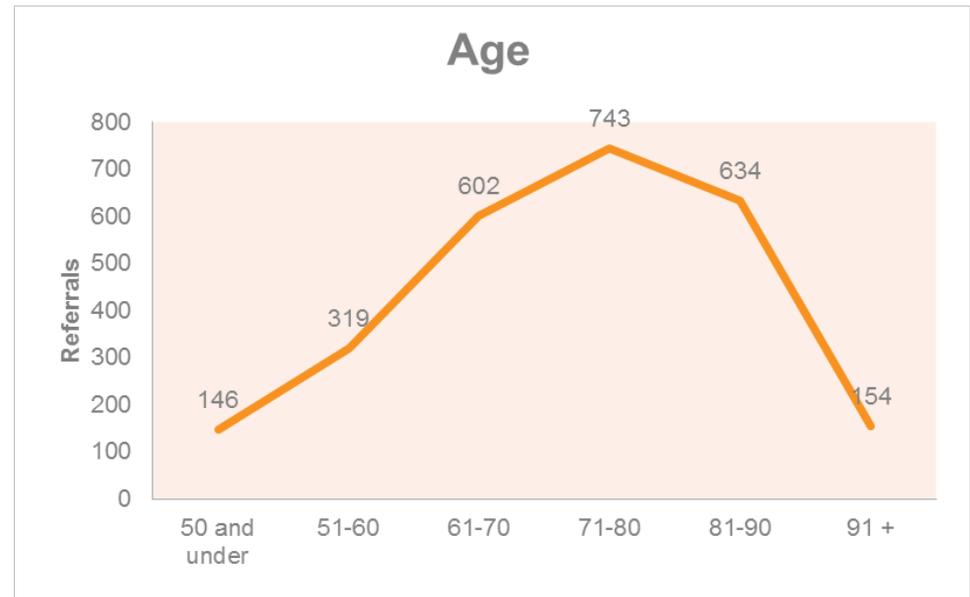
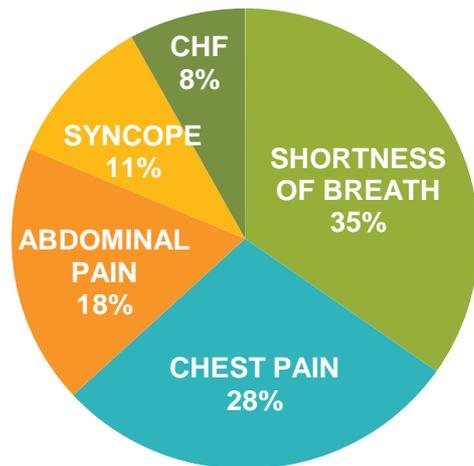
# MEDICAL AND SOCIAL SERVICE WORLD



- Not your typical “Social Service” program
  - Constantly looking at ways to improve quality and efficiencies
  - Quick response time
- Pushing the envelope
  - New breed of social work
  - Processes vary per system
  - Oversight by both organizations
- Patient centered care
  - Based on risk identified by chart review, clinical expertise and patient interviews

# WHO ARE OUR PATIENTS?

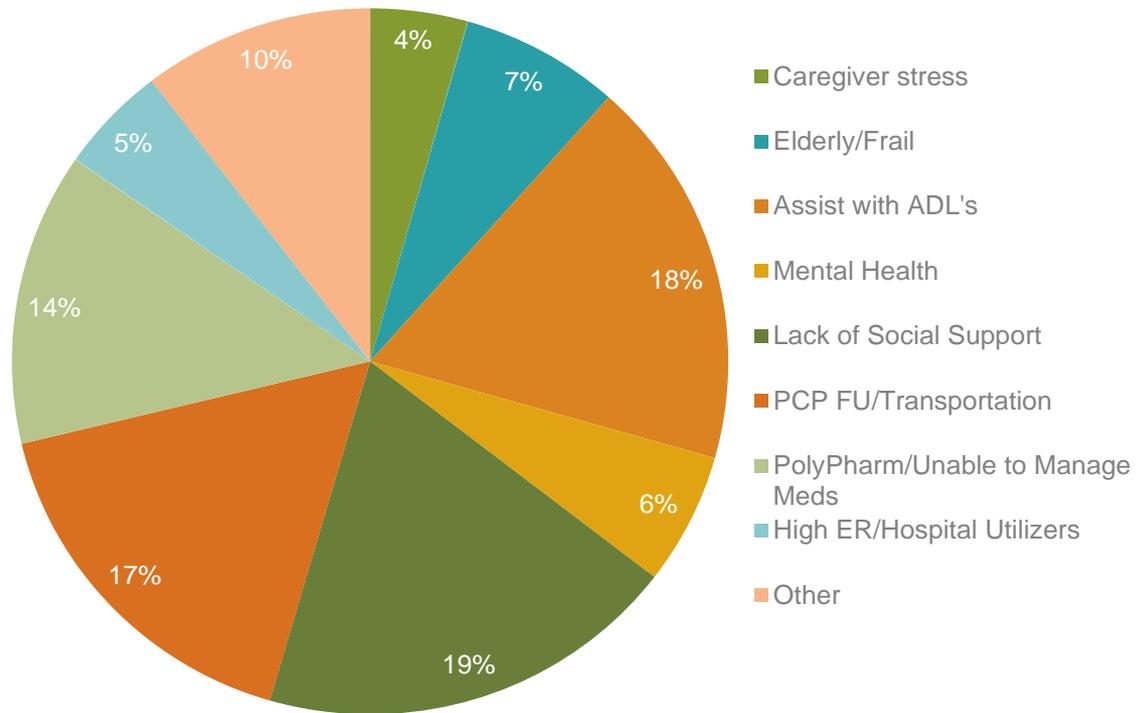
## Top Admitting Diagnosis



- 55% of Care Enhancement patients are female
- 38% Fall at or below the FPL
- 34% receive SSI
- 24% Spanish only

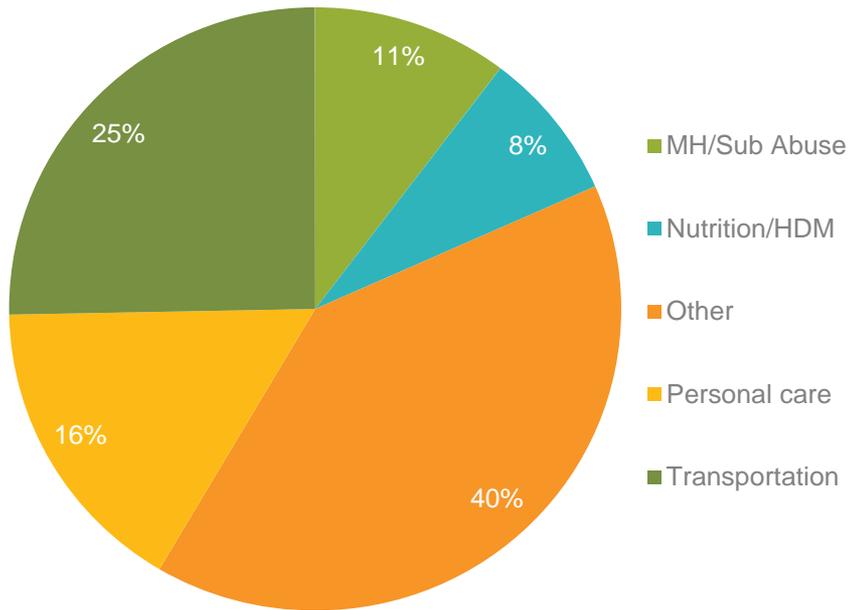
# WHY WERE PATIENTS REFERRED?

## ASSESSED RISK

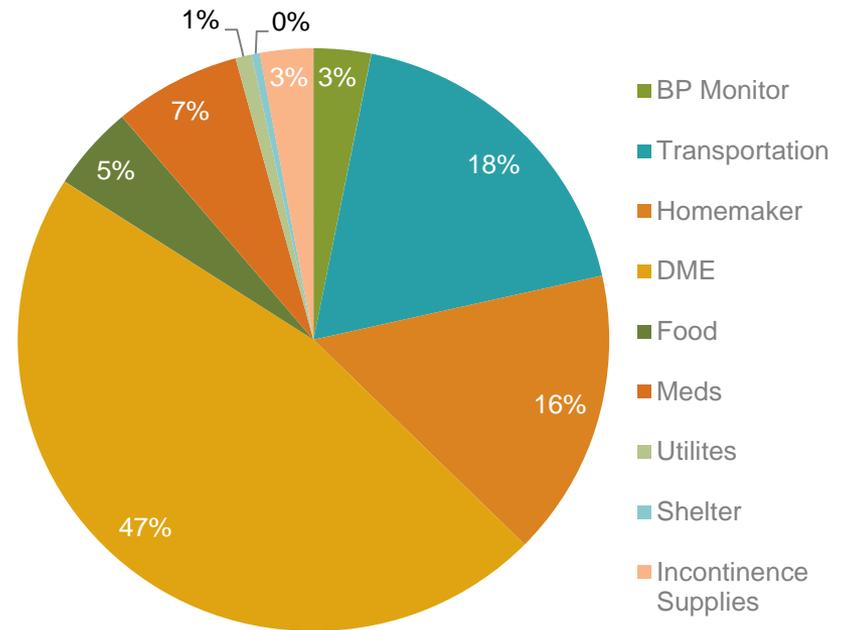


# SERVICES PROVIDED

## COORDINATED



## PURCHASED



# RESULTS!

- In system readmission rate is currently at 13.2%
- **Quality of Life Assessment**
  - Showed 30% improvement in 82% of patients assessed
  - Most noted improvement involved ADL functioning and social activities
- **Common concerns found post D/C**
  - Medication Education
  - Lack of Meds
  - Medication Discrepancies
  - Lack of tools



QUESTIONS??