Care Transitions Programs
Transforming Care Across the Continuum

Live Well, San Diego!
Information and Assistance (I&A)
Short Term Service Coordination
Options Counseling
Care Transitions
AIS Care Transitions Activities

— 2010 ADRC Enhancement
— 2010 CMS/AoA ADRC Care Transitions Grant
— 2011 Tech4Impact Grant
— 2011 Beacon Community Award
— 2012 Community-Based Care Transitions Program (CCTP)
Care Transitions Intervention (CTI) Model

- Evidence based program
- Patient and caregiver centered
- 4 week program
- Patients are supported by a coach
- Patients with complex care needs receive specific tools - can choose electronic or paper
- Patients learn self-management skills
Key Elements of CTI

- Referral Process
- Hospital Visit
- Phone call to patient after discharge from hospital
- Home visit within 2 days after discharge
- Phone calls to patient 7 days and 14 days after the home visit
CTI- Focus on 4 Pillars

Medication Management

Patient Centered Record

Physician Follow up

Knowledge of Red flags
Community-Based Care Transitions Program (CCTP)

- $500 M CMS funding under Sec. 3026 of ACA
- Improve quality, reduce cost and improve patient experience for Medicare beneficiaries (including duals) through partnerships
- Target Medicare beneficiaries with multiple chronic conditions including CHF, AMI, PNEU and at high risk for readmission
- Preferred Applicants:
  - AoA funded ADRCs partnering with multiple hospitals
  - Hospitals with high readmission rates partnering with CBOs
- Program runs for 5 years-2 year agreement initially
- Rolling application process began April 12, 2011
San Diego Care Transitions Partnership (SDCTP)

• Partnership between the County HHSA AIS and Palomar Health, Scripps Health, Sharp HealthCare and UC San Diego Health System-11 hospitals with 13 campuses
• Planning began in October 2011- application submitted on April 16, 2012
• Planning Team- HHSA/AIS, Hospitals, HSAG, Dr. Joanne Lynn and Grant Writer
• Planning Process
  – Each hospital system completed an RCA
  – Each hospital system identified interventions
  – Each hospital system established a blended rate
  – SDCTP blended rate was created
  – Implementation Plan was created
• Establishing a LAN
SDCTP Program

Primary Causes of Readmissions and Planned Interventions

1. Inadequate and inconsistent continuity of care coordination and hand-off to downstream providers within hospital systems
   – Re-engineer discharge and post-discharge practices
     • Project BOOST and Project RED; Bridges Program – Advanced Care Planning

2. Lack of patient or caregiver activation
   – Implement an evidence-based care transition model
     • Care Transition Intervention (CTI)
     • Pharmacy Intervention
SDCTP Program

Primary Causes of Readmissions and Planned Interventions Cont.

3. Insufficient connections to social supports and services
   – Provide short term intense care coordination
     • CTI Care Enhancement

4. Need for medication education and reconciliation
   – Implement a comprehensive Pharmacy Intervention
     • Pharmacy Intervention
SDCTP Proposal

• benefit approximately 23,828 Medicare fee-for-service (FFS) patients each year within the four hospital systems

• reduce the number of readmissions by at least 845 (20%) each year

• based upon an average cost of readmission in San Diego ($14,226), will result in annual readmission savings of $12,020,666

• requesting up to $10,276,954 per year from CMS - an overall blended rate of $431.30
Benefit of SDCTP to CMS

• opportunity to learn what is required to scale up CCTP to large, medically and socially complex, and diverse populations

• prospect to test care transitions improvements for Medicare FFS beneficiaries in a predominantly managed care market

• chance to innovate with clinical and social service partners who endorse a shared vision and have made a commitment to ongoing learning
Questions
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[Image of a group of people with their hands raised, smiling, and cheering]