

Care Transitions–Cutting Edge Intervention

Presented by Stacy Bjerke, M.S., and Melissa Thun, RN, PHN
Aging & Independence Services
County of San Diego Health and Human Services Agency

Care transitions model:

- ❖ 4 week program
 - ❖ Patients with complex care needs receive specific tools
 - ❖ Patients are supported by a coach
 - ❖ Patients learn self-management skills
- 

Overview of Care Transitions Program

- ❖ Evidence based program
 - ❖ Developed in response to fragmented care
 - ❖ Patient and caregiver centered
- 

Care transitions model consists of:

- ❖ Transitions Coach
- ❖ Focus on 4 Pillars
 - Medication Management
 - Patient Centered Record
 - Physician Follow up
 - Knowledge of Red flags



In San Diego County the Care Transitions Program focuses on the following individuals:

- ❖ Patients with primary admitting diagnosis of CHF, COPD, Pneumonia, and/or other chronic disease processes
 - ❖ Cognitively able to participate in program or have a care giver able to assist
 - ❖ Be at risk of re-admission within 30 days
 - ❖ Being discharged home with or without a caregiver
- 

The Care Transition Process

A four week program that encourages patients to take a more active role in their health care



Four pillars

- ❖ Medication self-management
- ❖ Patient-centered record
- ❖ Follow up Care
- ❖ Red Flags



Key Elements of program:

- ❖ Referral Process
 - ❖ Hospital Visit
 - ❖ Phone call to patient after discharge from hospital
 - ❖ Home visit within 2 days after discharge—personal health record completed and 4 pillars reviewed
 - ❖ Phone calls to patient 7 days and 14 days after the home visit
- 

Hospital Visit

Transition coach meets with patient in the hospital to explain CTI, enroll patient, and provide personal health record.

Second day phone call

Transition Coach calls patient within 2 days of discharge from hospital to arrange for the home visit. Home visit should ideally be scheduled within 2 days of discharge.



Home visit

- ❖ PHR reviewed
- ❖ Medications reconciled with discharge medications, medication list completed, and education provided.
- ❖ Red Flags discussed
- ❖ Follow up primary care doc and specialists appointments reviewed



7 day and 14 day Follow up phone calls



Accomplishments:

❖ CTI enrollments

Since 8/12/2010:

Total # of referrals.....	55
Total # of enrollments.....	42
Total # of cases completed.....	17
Total # cases in process.....	17
Total # declined to enroll.....	13
Total # closed prior to completion.....	9

❖ Hospital buy-in

❖ Referrals provided through CTI process



QUESTIONS

