Long Term Care Integration Project Stakeholder Meeting

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UC San Diego Health System

UCSDHS Overview

- Three hospitals (soon to open Jacobs center) one license, academic Level 1 trauma center
- 594 beds
- 23, 706 inpatient discharges
- 60,160 emergency room
- 533,480 out patient visits
- Approx. 13.2% of patients come from outside San Diego
- We provide 8.5% of care in SD County, 13% are for County's total undercompensated (including MCAL) and 36.5 % are for the County's indigent patients
- CCTP = 3,002 projected annual enrollees
- First to start enrolling CCTP patients in 1/1/13

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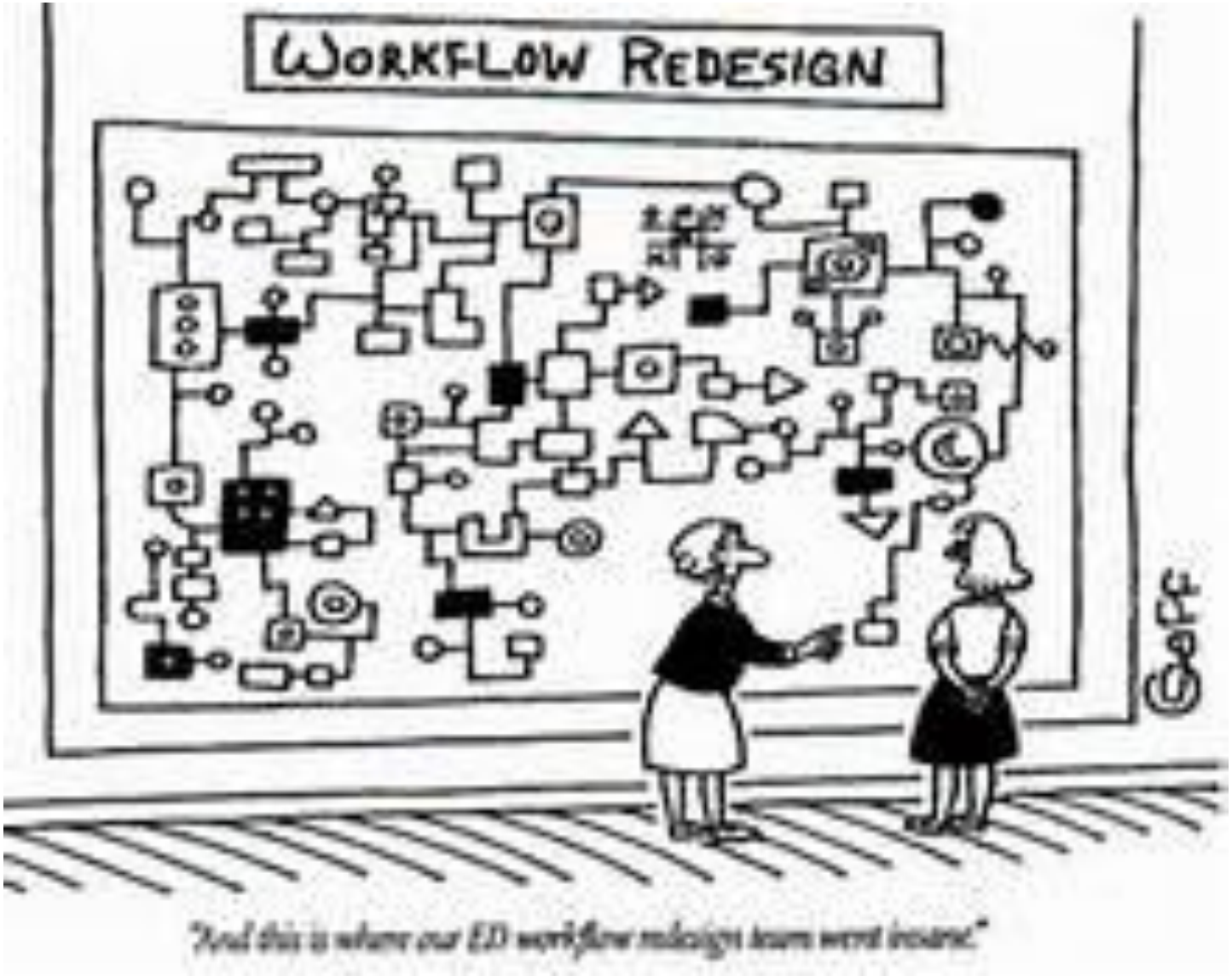
Totals & Future Plans

- 1,041 CCTP patients discharged/invoiced through 10/30/13
- Need to increase footprint
- Process improvement projects internally – develop integrated model for system.
- Project Link pilot site – community clinic PCP/ Medical Home Linkages and post d/c appointments
- Improved relationships with community and downstream providers
- Shared knowledge for cross learning – internally and through partnership



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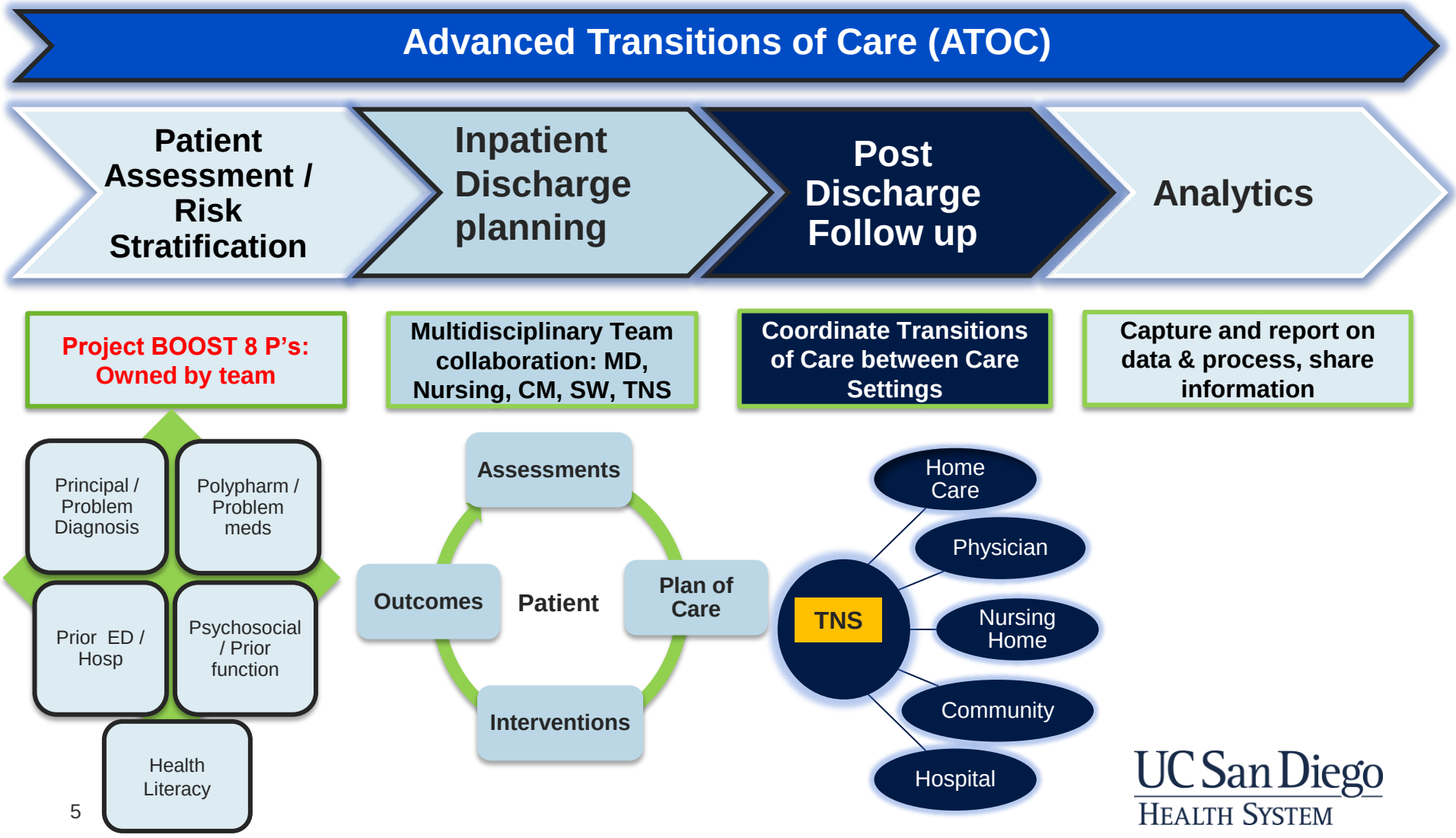
Care Coordination Process



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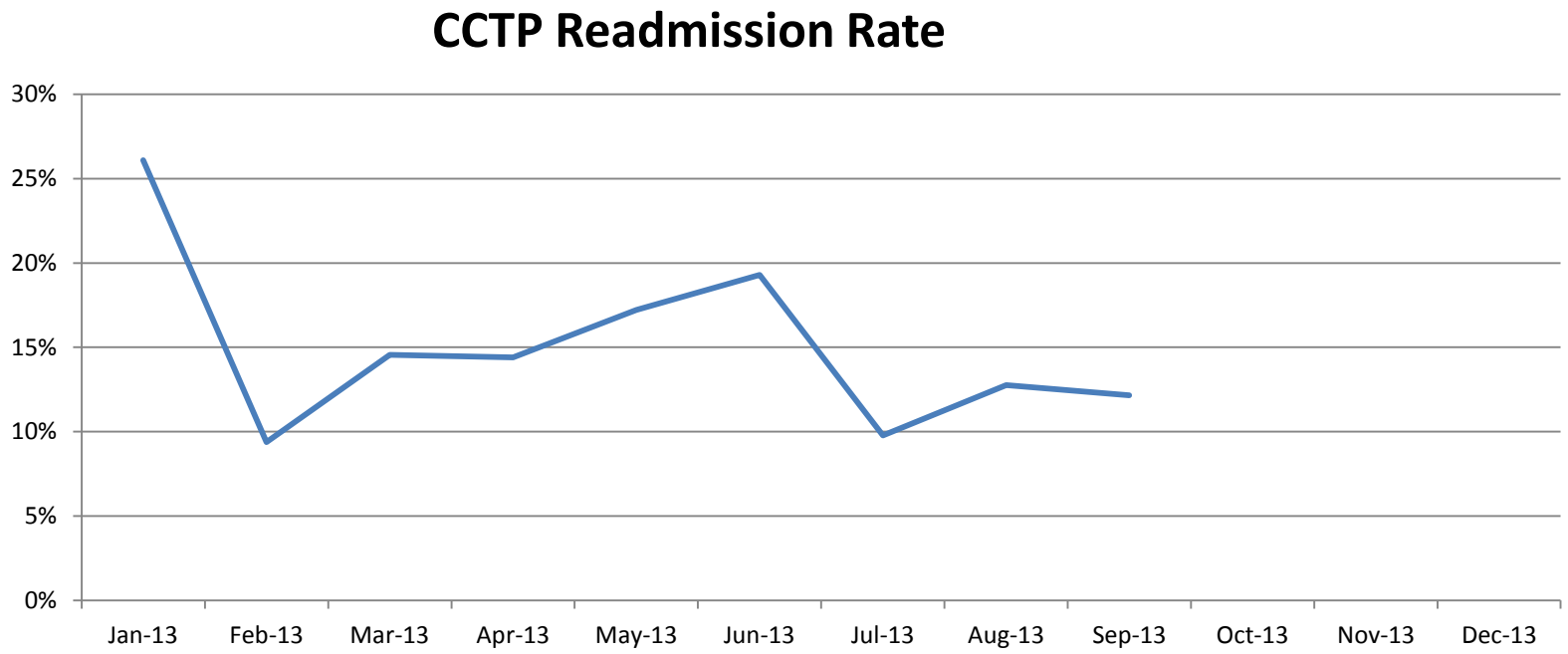
Project BOOST 8 P's
Risk for Readmission Tool

- Principal Diagnosis (HF, DM, COPD, PNA, Stroke)
- Problem Medications >8
- Poly Pharmacy
  - anticoagulants
  - hypoglycemics/insulin
  - narcotics
- Psycho-social (patient support)
- Prior Hospitalizations / ED visit (past 6 months)
- Poor Health Literacy
- Prior Functional status (decline)
- Palliative Care

Advanced **T**ransitions **o**f **C**are

- **Process Improvement / Reduce Readmissions**
- **T**ransition **N**urse **S**pecialists (TNS)
  - Select *High Risk Patients* who have a *Modifiable Risk*, provide patient education/resources – self management support, review red flags, PHR, follow up appointments prior to discharge, follow up calls post discharge, and possible home visits. Goal behavior modification – patient sets the goals
- **TNS** screens for additional possible interventions inpatient and outpatient:
  - Pharmacy
  - Care Transitions Intervention, CTI Enhanced
  - Community resources/linkages

CCTP Readmission Rate (30-day all cause)



	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
CCTP Readmission Rate	26%	9%	15%	14%	17%	19%	10%	13%	12%			

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As of July 2013

- 6 UCSDHS TNS positions – APN's
- 2 in La Jolla – CVC and Thornton: following patients from admission to post discharge
- 3 in Hillcrest
  - 1 TNS: HIV AIDS population
- 1 TNS – employed by UCSDHS following CTI model targeting underfunded/underserved with home visits, community linkages
- 2 Transition Coaches following CTI model for Medicare FFS, part of CCTP: post discharge home visits

Methodology

Interventions:

- TNS
  - Teach Back
  - Screen, assess, enroll
  - Indepth interview, follow inpatient, planned education & patient/family case conferences
  - Personal health record
  - Medication Action Plans
  - Follow Up calls within 72 hours & as needed after
  - Task to Pharmacy medication reconciliation
    (4 interventions max. during inpatient stay)
  - Task to CTI & CTI enhanced home visit follow up / complex social service plan

Process Improvements:

- Warm Handoffs
- Sending Appropriate & Prompt information to clinics, SNF and other downstream providers
- Scheduling

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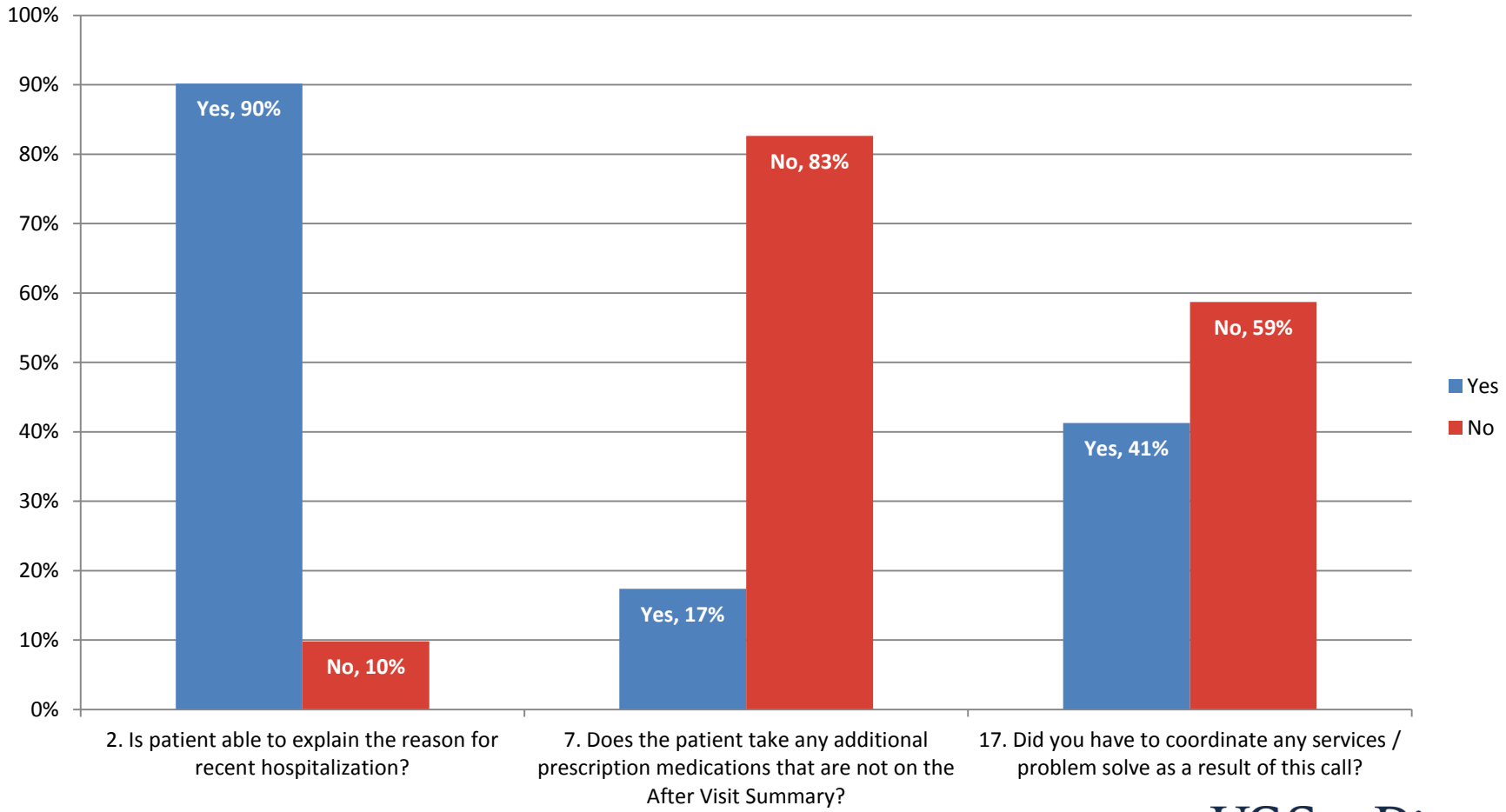
Transitions Nurse Specialist Post Discharge Follow Up call through 11/30/2013 (Assessment Created Date) – 568 Assessments



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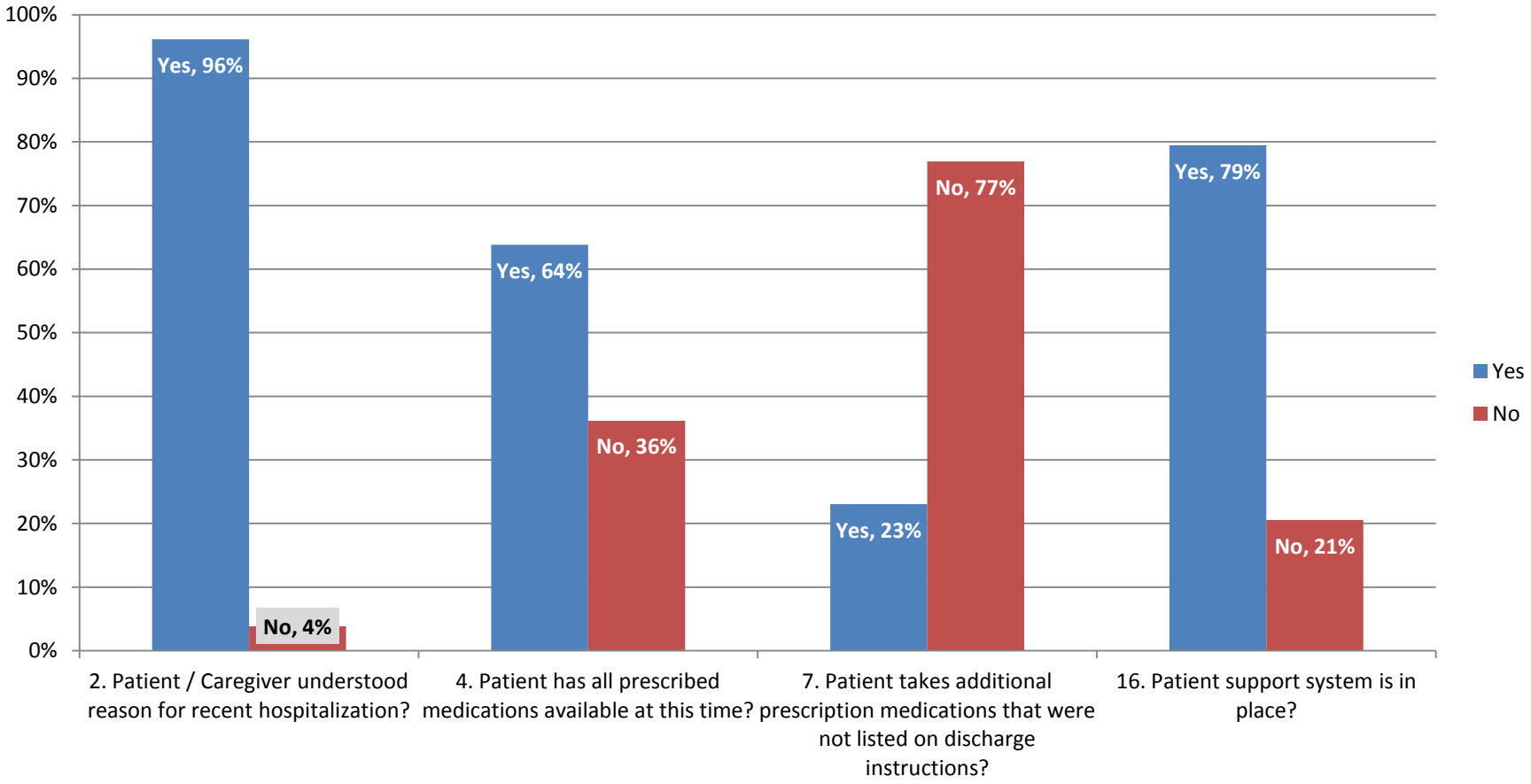
CTI Home Visit Summary Through 11/30/2013 (Assessment Created Date) – 260 Assessments



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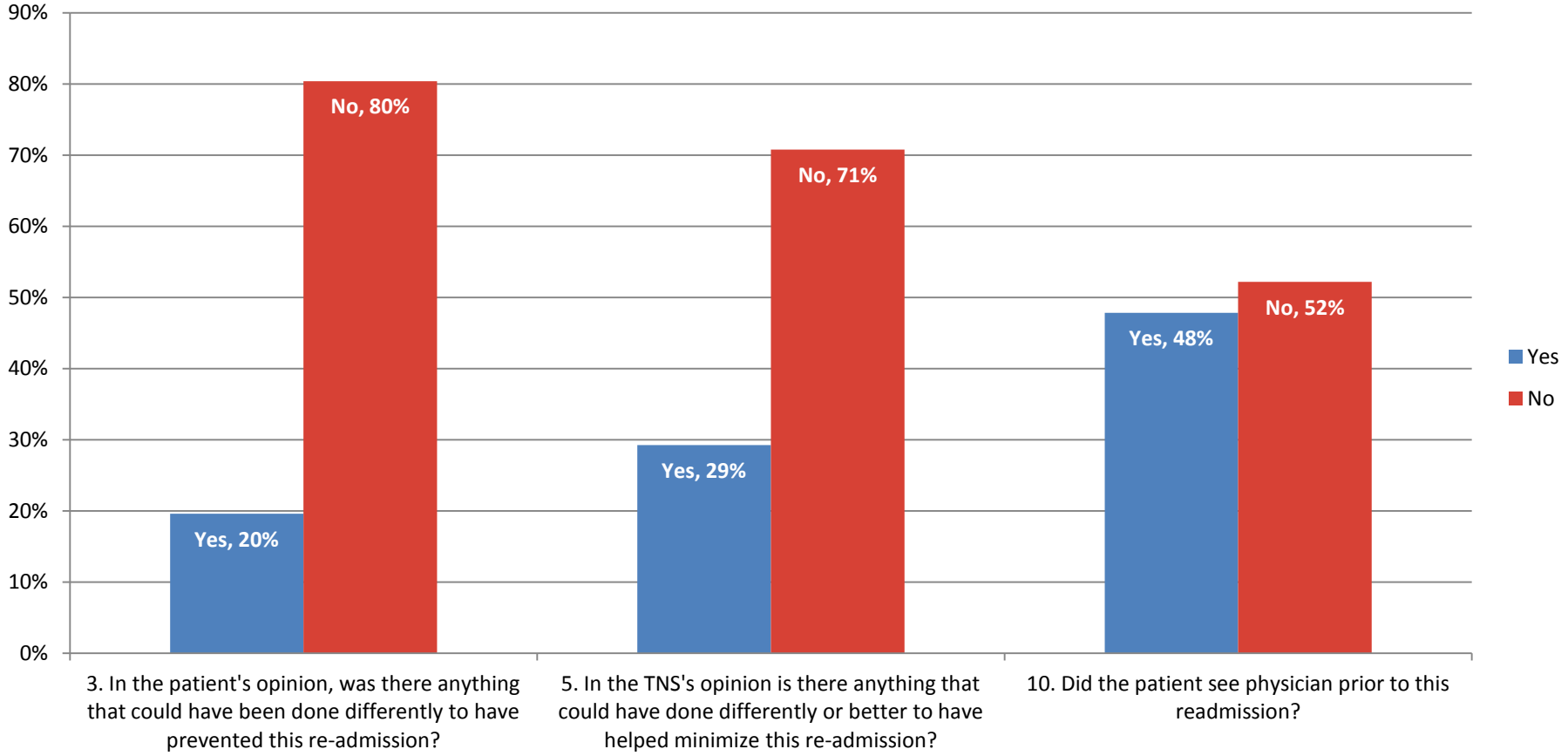
Transitions Nurse Specialist Re-Admission Questionnaire Through 11/30/2013 (Assessment Created Date) – 184 Assessments

Of the 184 assessments, 31 were scheduled readmissions and 153 unscheduled. The following data is for the unscheduled readmissions.



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