JFS and Scripps Memorial Hospital Care Management Transition Program

Reducing Hospital Readmissions through Care Management

Craig Lambert, LCSW
Senior Director, Older Adult Services

Stated Problem

Jewish Family Service
one source for a lifetime of help

- For Seniors:
  - 20% of US seniors readmitted to hospital within 30 days of discharge
  - Isolated seniors over twice as likely to be readmitted
- For Society:
  - $17.5 billion cost to Medicare for unplanned hospital readmissions in 2009
- For Hospitals:
  - Current pressure on hospitals to decrease readmission rates'
  - Health Care Reform – fines for readmissions
  - Reduced reimbursements for hospital readmissions

Program Goals

Jewish Family Service
one source for a lifetime of help

- Improve transition from hospital to home
- Develop a strong relationship with Scripps Memorial Hospital
- Expand use of a model of care that shows efficacy and will eventually serve all Scripps Hospitals

Program Outcomes

Jewish Family Service
one source for a lifetime of help

- Show direct connection between in-home care management and reduced rates of hospital readmission
- Social worker will provide assistance to 200 discharged patients
- Improve the client's ability to access community resources
- Increase the client's ability to manage condition

Implementation

Jewish Family Service
one source for a lifetime of help

- Staffing:
  - 1 Medical Care Manager (.57FTE)
  - Care Manager will work with Scripps Memorial Hospital discharge planners to connect with older adults being discharged
- Scope:
  - Provide short-term care management and/or information and referral to 200 patients discharged from hospital

Eligibility Criteria

Jewish Family Service
one source for a lifetime of help

- 65+
- Diagnosis of congestive heart failure
- Discharged to home
- Resides in one of the following zip codes: 92037, 92111, 92117, 92121, 92122

Intervention Method

Jewish Family Service
one source for a lifetime of help

- Care Management services provided within 48 hours of discharge
  - Follow up in the form of telephone calls or in-person sessions, as determined by client needs
- Intervention:
  - Complete Care Management assessment
  - Assess ability to manage medications
  - Perform In-home safety check
  - Discuss/implement discharge orders (ensure follow up care with physician and specialty care)
  - Connect patient and family with community resources
  - Evaluate ability for self care, using an instrument to measure confidence and ability

Evaluation Component

Jewish Family Service
one source for a lifetime of help

- Independent evaluator to analyze the data
- Dr. Susan Enguidanos – worked with JFS - LA
  - Design intervention
  - Identify outcomes measures
  - Evaluation tests and database
  - Training of staff
  - Analysis of data collected

Sustainability

- Prove the model and ask the hospital to pay for it