Care Transitions Programs

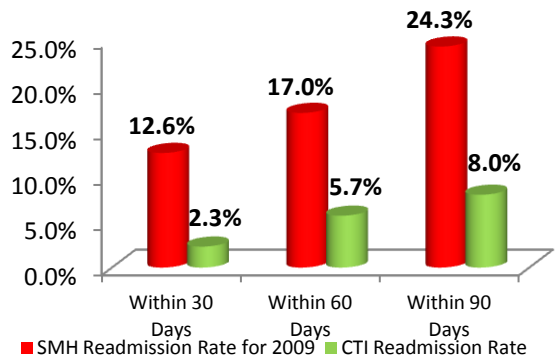
San Diego Care Transitions Partnership

Transforming Care Across the Continuum

Live Well, San Diego!

Care Transitions Experience

The County of San Diego, Health and Human Services Agency, Aging & Independence Services (AIS) is the Area Agency on Aging (AAA) and a federally designated Aging and Disability Resource Connection (ADRC). AIS/ADRC received funding in 2010 from the Administration on Aging (AoA) and CMS to implement Eric Coleman's Care Transitions Intervention (CTI) Program. Through one hospital visit and one home visit, and a series of follow-up phone calls by a trained Transitions Coach whose primary role is "to coach, not do", patients with chronic health conditions develop improved capacity in the areas of medication management, personal health record keeping, knowledge of "Red Flags," and follow-up care with primary care providers and specialists. A partnership was established with Sharp Memorial Hospital. The CTI Pilot successfully reduced readmission rates.



CTI Pilot Outcomes

- Comparison groups: 88 patients who completed CTI and were at least 90 days post discharge and Sharp Memorial Hospital patients admitted during the 2009 calendar year with the same diagnoses as the CTI patients
- A readmission was defined as an inpatient readmission for the same diagnosis to the same hospital
- Seven out of the 88 CTI patients were readmitted; for a total of 9 readmissions
- Expected number of readmissions would have been 21

Recognizing the success of the CTI Program, the San Diego Beacon Community has funded the continuation of CTI at Sharp Memorial Hospital and expanded CTI to UCSD Medical Center and Scripps Mercy Hospital. Certified Transition Coaches who are Public Health Nurses employed by AIS will enroll over 1,000 patients before March 31, 2013 into CTI who over the age of 18, have chronic conditions and are at high-risk for readmission at the three hospitals. Underserved, chronically ill patients are the primary target population served by this project. Readmission rates and cost saving data are being tracked throughout the project to determine the impact of this evidence-based practice on this high-risk target population.

CTI patients are also engaged by the Transition Coaches in using the AIS Network of Care Web resource to support health self-management. They are coached to establish an electronic medication list and personal health record (PHR) and to use the online library to learn more about their health conditions, locate needed services through the service directory and engage their formal and informal caregivers in improved communication and care coordination through their personal health record (PHR). AIS also educates healthcare and social service professionals about how they can establish virtual teams with social service providers, use the Network of Care site to activate patients to self-manage their health, communicate better with one another, and better coordinate care.

Community-Based Care Transitions Program (CCTP)

The Community-based Care Transitions Program (CCTP), mandated by section 3026 of the Affordable Care Act, provides $500M in funding for community-based organizations (CBOs) partnering with hospitals to test models for improving care transitions for high risk (FFS) Medicare beneficiaries. Partnerships are awarded two-year agreements that may be extended annually through the duration of the 5-year program based on performance. AIS, as the lead applicant, collaborated with Scripps Health, Sharp HealthCare, Palomar Health, and University of California San Diego Health System (UCSD) (11 hospitals with a total of 13 campuses) to design the San Diego Care Transitions Partnership (SDCTP). The goals of the SDCTP program are to:

- test models for improving care transitions for high risk Medicare beneficiaries
- improve transitions of beneficiaries from the inpatient hospital setting to other care settings
- improve quality of care
- reduce readmissions for high risk beneficiaries by 20%
- document measureable savings to the Medicare program

The San Diego Care Transitions Partnership (SDCTP) Design

Each hospital system completed a comprehensive Root Cause Analysis (RCA) to determine why FFS Medicare patients were being readmitted, and based on that information identified the target population and the interventions that would be implemented to address the root causes. The SDCTP will serve approximately 21,000 FFS Medicare patients with various interventions that include: using assessment tools to conduct risk screening, using a high-risk health care coach to coordinate care and handoff to other providers upon discharge, using a pharmacist for medication education and reconciliation, transitioning patients into palliative care and hospice, and activating patients and their caregivers to better manage chronic health conditions through CTI.

The SDCTP is a hybrid model in which partnering hospitals will provide direct care transition interventions to support broader system change and will be reimbursed for each eligible patient they serve with one or more interventions. AIS will provide CTI to patients within UCSD Health System and Palomar Health, and Scripps Health and Sharp HealthCare will staff and deliver CTI to their patients. AIS will provide intense, short-term, care coordination to CTI patients at all hospitals who are at high risk for a readmission because they lack essential social supports. Patients will be supported with in-home care, transportation, home delivered meals, and other critical needs. AIS will purchase these services for the patients for a short period of time after discharge if there is no other means to provide the supports. The goal will be to link CTI patients as quickly as possible to ongoing home and community based services both within and outside of AIS.

The SDCTP planning was supported by the Health Services Advisory Group (HSAG), the Quality Improvement Organization (QIO) for California, as well as Dr. Joanne Lynn, a renowned care transitions expert who assisted CMS with the design of the CCTP. The SDCTP application was approval by CMS in November 2012 and CCTP services began on January 22, 2013.