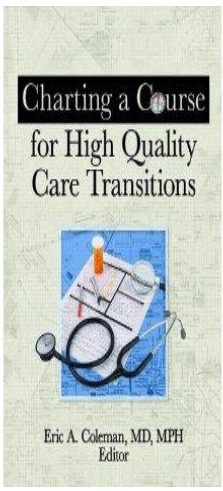
The San Diego Care Transitions Partnership (SDCTP)

Transforming Care Across the Continuum

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY
Aging & Independence Services

Aging & Disability Resource Connection

AIS Care Transitions



—**2010/2011** CMS/AoA ADRC Care Transitions Grant

—**2011** Tech4Impact Grant-Center for Technology and Aging

—**2011** Beacon Community Collaborative Award

Community-based Care Transitions Program (CCTP)

- Section 3026 of the Affordable Care Act
- CCTP provides $500 million to test models for improving care transitions for high risk FFS Medicare patients

– Preferred Applicants:
  - – Hospitals with high readmission rates who partner with an eligible community-based organization (CBO)
  - AoA/CMS funded AAA/ADRCs partnering with multiple hospitals

Community-based Care Transitions Program (CCTP) Goals

- Improve transitions of beneficiaries from the inpatient hospital setting to home or other care settings
  - – Improve quality of care
  - – Reduce readmissions for high risk beneficiaries -goal is to reduce readmissions by 20%
  - – Document measureable savings to the Medicare program

The San Diego Care Transitions Partnership (SDCTP)

- Partnership between the HHSA/AIS and Palomar Health, Scripps Health, Sharp HealthCare and UCSD Health System-13 hospitals
- Planning began in October 2011 with HHSA/AIS, Hospital Teams, and Consultants
- Planning Process:
  - Each hospital system completed an RCA and identified interventions based on RCA
  - Each hospital system established a single rate for hospital-based interventions
  - HHSA /AIS established a single rate for CBO interventions
  - Combined blended rate was established and is paid to AIS
  - Proposal was submitted to CMS in April 2012, CCTP Award received and Program Agreement executed in November 2012
  - CCTP roll out January 22, 2013-April 15, 2013

SDCTP Program

Primary Causes of Readmissions

1. **Inadequate or inconsistent continuity of care coordination and hand-off to downstream providers within hospital systems.**
2. **Inadequate medication education and reconciliation.**
3. **Lack of patient or caregiver activation.**
4. **Insufficient connections to social supports.**
5. **Lack of disease management for patients with advanced chronic illness.**

Total patients served=2,879

Palomar Health

INTERVENTION: High-Risk Healthcare Coach (HC Coach) – 2,879 patients

Identified High Risk patients will receive referral to HC Coach by Case Management to receive the following initial services:

- Hand off of identified high risk patients to HC Coach from Case Manager
- Conduct review of High Risk pt record (H&P, SW notes, other clinical notes)
- Round with hospitalists and facilitate communication with PCP and/or specialist

To facilitate disease management/ patient education the Healthcare Coach will perform the following:

- Daily visits with pt/family to assess health-literacy, language barriers and other obstacles to learning. Pts to do teach back of learning (20 min x3)
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- Confer with CNS and other pt educators addressing learning barriers.
- Conduct 3 pre-discharge sessions with staff nurses to reinforce disease-specific education and teach back. (15 min x 3)
- Facilitate development of coordinated Care Plan at D/C (hospitalist, PCP, Specialist, CNS)

Verbal Hand-off to CTI

Phone calls to pts not requiring or receiving CTI or SNF. Follow up on cases that may have unresolved issues/questions.

INTERVENTION: Pharmacist (Pharm) – 1,200 patients

Pharmacist will:

- Assess barriers in patient compliance to drug therapy (financial, ADR, regimen, social)
- Provide patient education on home medications including OTCs, herbal dietary supplements.
- Resolve pharmacy- specific barriers for safe discharge including:
  - Create an affordable and convenient medication discharge plan with MD.
  - Utilize low-cost generic plans if/where available.
  - Fax or calling outpatient pharmacies to ensure plan coverage and medication availability.
  - Work with insurance to arrange authorization.
  - Arrange financial assistance for medications via Pharma Assistance Program or other community resources for indigent patients.
- Provide consultation to Home Health nurses as needed.
- Gather necessary documentation and review AVS, DC Summary, and medication lists for appropriate dosing, interactions, and major side-effects.
- During phone call, assess health status, medication check, clarification of physician appointments and lab tests, review post-discharge home services, problem triage, and review patient options if problems arise.

Follow-Up Phone Call to 180 Unique Patients that Refuse CTI

- Gather necessary documentation and review AVS, DC Summary, and medication lists for appropriate dosing, interactions, and major side-effects.
- During phone call, assess health status, medication check, clarification of physician appointments and lab tests, review post-discharge home services, problem triage, and review patient options if problems arise.

Total patients served=9,877

Scripps Health

INTERVENTION: Inpatient Navigator (IN) – 8,396 patients

- For these at-risk patients, Inpatient Navigator will coordinate specific risk-reduction interventions including:
  - Reinforce disease-specific education using teach-back. (RED)
  - Access health-literacy, language barriers. Ensure patient / family receive d/c material they can comprehend.
- High-risk patients will have a follow up appointment scheduled. Review teaching materials and discharge instructions to insure patient comprehension.
- The IN will provide these additional care transition services:
  - Ensure prompt transmission of discharge summaries to PCPs and specialists. Provide call-back number for verbal handoff for PCP office.
  - Provide verbal hand-off to SNF case mgr with detailed risk-assess and interventions needing follow-up at SNF + upon discharge from SNF (11% pts discharged to SNF).
- The Inpatient Navigator will provide follow-up phone call for those patients not requiring CTI or MTM services or those deemed appropriate but refused CTI service.

INTERVENTION: MTM Pharmacist (Pharm) – 2,741 patients

- Pharmacist assesses barriers in patient compliance to drug therapy ($, ADR, regimen, social).
- Pharmacist provides patient education on home meds including OTCs, herbal & dietary supplements.
- Pharmacist will resolve pharmacy-specific barriers for safe discharge including:
  - Creating an affordable and convenient medication discharge plan with the physician.
  - Utilizing low-cost generic plans if/where available.
  - Arranging delivery of discharge medications at bedside or at home to ensure compliance.
  - Faxing or calling outpatient pharmacies to ensure plan coverage and medication availability.
  - Working with insurance to arrange authorization.
  - Arranging financial assistance for medications via Pharma Assistance Program or other community resources for indigent patients.
- Pharmacist creates comprehensive DC med list ("My Med List" for each patient).
- Pharmacist will provide patient medication discharge education.
- Pharmacist will provide 30 day post discharge follow up (phone and/or home visit) that includes:
  - Assessing patients medication understanding and literacy (Comprehension, Compliance, Potential side/adverse effects, Medication related issues or questions).
  - Contacting the patient's PCP for intervention as needed.

INTERVENTION: Care Transitions Intervention (CTI) – 2,518 patients

- Transition Coach conducts visit with patient/caregiver in the hospital prior to discharge and arranges home visit within 48 hours after discharge, completes social support risk assessment and makes referral to AIS for CTI Care Enhancement if triggered by risk assessment.
- Transition Coach maintains fidelity to the Coleman Model. The Four Pillars are addressed through a combination of visits and follow-up calls by the Transition Coach and the use of Care Transitions Intervention tools. The schedule of visits and follow-up calls represent the "stages" of the Care Transitions Intervention over the four-week intervention period and include the following:
  - One home visit scheduled 24-72 hours post-discharge (within 48 hours preferred).
  - Weekly follow up phone calls to the patient designed to reinforce the home-visit, re-assess patient activation and determine whether any new barrier to effective outpatient management of chronic disease have arisen.

Sharp HealthCare

Total patients served=5,632

INTERVENTION: Sharp CTI Only – 4,106 patients

- Beneficiary evaluation by CTI Coach (includes referral review if applicable, record review, risk screening tool completion, discussion with Hospital Case Mgr and Attending Physician on patient appropriateness for CTI program).
- CCTP introductory hospital visit w/ patient and consent to participate - f/u home visit scheduled at this time when possible and PHR given to patient.
- Initial CTI Home Visit (includes completion of CTM-3, PAA and travel time to and from home & documentation time post-visit).
- 1st, 2nd and 3rd follow-up CTI phone call - includes documentation time post-call.

INTERVENTION: Post-Acute Navigation Program – 1,226 patients

- Beneficiary evaluation by CTI Coach (includes referral review if applicable, record review, risk screening tool completion, discussion with Hospital Case Mgr and Attending Physician on patient appropriateness for CTI program).
- CCTP introductory hospital visit w/ patient and consent to participate.
- 1st follow-up Navigation phone call (will follow "CTI Model" phone call guidelines - includes completion of CTM-3 and PAA).
- 2nd f/u Navigation phone call - includes documentation time post-call.
- 3rd follow-up CTI phone call - includes documentation time post-call.

INTERVENTION: Hospice & Palliative Care Bridges Program – 300 patients

- Beneficiary evaluation by CTI Coach (includes referral review if applicable, record review, risk screening tool completion, discussion with Hospital Case Mgr and Attending Physician on patient appropriateness for CTI program).
- Bridges introductory hospital visit w/ patient and consent to participate.
- Bridges program includes:
  - minimum 1 home visit by Bridges RN or Palliative Physician
  - minimum 1 home visit by Bridges SW
  - up to 4 phone calls within 30 day post-DC period
- Note that visits and calls include various activities aimed at Advanced Care Planning and setting realistic goals of care with patients.

University of California San Diego Health System

Total patients served=3,002

INTERVENTION: High-Risk Healthcare Coach (HRHC) – 1,651 patients

Patient/Family Interview

- Intensive Review of Complex risk factors/barriers.
- Engage Patient/Family in promoting goal setting around the identified risk factors and barriers.
- Based on interview process, get agreement on bridging process for the Patient/Family from acute care to outpatient setting.

Direct Patient Teaching

- Review teaching materials and discharge instructions to insure patient comprehension.
- Enhance electronic communication with verbal communication to post-acute providers to insure successful hand-off.
- Verbally confirm care continuity with providers, including hand-offs and f/u appointments.
- Teaching tailored to the unique disease state and risk factors of the patient.

INTERVENTION: Pharmacist – 1,150 patients

In Depth Review of Medication Lists Upon Admission

- Interview patient for medication history; corroborate information with records and other available information.
- Screen patients for previous nonadherence, lack of efficacy and side effects to medications.
- Identify barriers to learning and ability to access medications.
- Review findings with patient.

In Depth Review of Medication Lists Upon Discharge

- Compare and reconcile 3 medication lists: previous to admission, inpatient medication list, and post-acute medications.
- Resolve issues in medication lists with physicians, pharmacys, family, etc..

Development of Medication Action Plan (MAP)

- Creation of customized medication list (with pictures of each medication) using software for MedActionPlan.
- Creation of supporting documents for teaching including: special instructions, weekly medication checklist, health care monitoring record, patient education.
- Direct patient teaching on medications and usage.

Facilitation of Outpatient Medication Requirements

- Discuss patient options for fulfillment of prescriptions.
- Ensure patient has required medications, including new prescriptions and refills for existing Rx.
- Verify compliance between insurance, formulary, and medications prescribed for the patient; make necessary changes to optimize patient's health and acquisition of medications.

INTERVENTION: Follow-Up Phone Calls – 2,432 patients

Follow-up phone calls for patients not receiving CTI

- Gather necessary documentation and review AVS, DC Summary, and medication lists for appropriate dosing, interactions, and major side-effects.
- During phone call, assess health status, medication check, clarification of physician appointments and lab tests, review post-discharge home services, problem triage, and review patient options if problems arise.

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Aging & Independence Services

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY Aging & Independence Services

Total patients served=3,457

INTERVENTION: Care Transitions Intervention (CTI) – 1,282 patients

CTI Coach = Nurse:

- Hospital Visit (case referral and review, chart assembly, patient assessment, follow-up with hospital staff).
- Hospital Discharge Verification (notification of discharge, review hosp census for patient status, review D/C notes, obtain patient D/C Summary, Fax d/c paperwork to CTI Supt Spec and charting).
- 2-Day Follow-up Phone Call to Client.
- 7-Day Follow-up Phone Call to Client.
- 14-Day Follow-up Phone Call to Client.
- Case Closing, Review, and Supervision.
- SNF Transfer Procedures (review SNF transfer check-list with hospital CM/SW, phone call with SNF, notification of planned D/C, patient visit at SNF, charting).

INTERVENTION: CTI Care Enhancement – 2,615 patients

CTI Social Worker:

- Hospital Visit (referral from CTI Coach, visit patient at hospital, update with PMD, follow-up with CTI Coach, follow-up with hospital D/C CM, SW, charting).
- Support Services Coordination (verify with CTI Coach that patient is being discharged, review D/C notes, verify with patient that support services are still needed, arrange for in-home services upon discharge, follow up with patient on support services that have been ordered, charting).
- Home Visit.
- Follow-up Phone Calls to Client and Providers (1 - 5, Avg = 3).
- Coordination of Service Providers.
- Case Closing and Review.
- CTI Care Enhancement Purchase of Services ($350 average per client, $500 maximum).

Questions?