Improving Care Transitions

California Improvement Network

Improving Care Transitions Project in Sonoma County

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Presenters

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Major Factors in Readmission

- Age greater than 65
- Discharge diagnosis of CHF or COPD
- Low patient activation
- Medication related complications
- Inadequate transfer of information
- Inadequate community support

Quality Impacts Outcomes

- One example: Hospital readmission rate within 30 days of discharge

Patients with identified discrepancies in discharge medications	14.3%
Patients with no identified discrepancies in discharge medications	6.1%

Coleman EA, et al. Arch of Int Med 2005;165(16)1842-1847.

Healthcare Redesign

- Handoffs will matter
- It's about the patient's journey
- Seamless transitions
- Developing partnerships
- Respect for resources
- Potential redistribution where needed

Healthcare Redesign

"The aim is to reward value instead of volume and intensity by making providers eligible to share in savings resulting from steps that reduce overall healthcare costs while improving quality of care."

Donald Berwick, Administrator
Centers for Medicare and Medicaid Services (CMS)

What Does This Mean for Community Agencies?

- New opportunities for partnerships with hospitals and physician's groups
- Opportunities for creative programs that benefit overall health of the community
- Non-traditional services may be incorporated into overall continuum of care
- Wellness and proactive interventions

"It helped us to be a lot better prepared to take care of my dad. The social worker (transitions counselor) gave us good advice.."

Client's daughter

Key Findings in Care Transitions Research

Patients who participated in CTI were:

- Significantly less likely to be readmitted (12% versus 19% national rate)
- More likely to achieve self-identified personal goals around symptom management and functional recovery
- Sustain benefits for as long as six months after the program ended

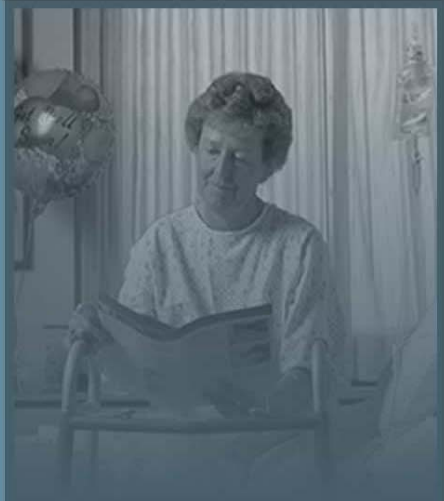
The Care Transitions Model

- 4-week intervention for low-income seniors with complex medical conditions and few supports

- Coaching and empowering model

- Fidelity is important

- Tools include:
  - Personal health record
  - Medication self management
  - Red flags
  - Follow-up with physician



"I have a few medications that I have taken for years that I didn't know the purpose of and now I understand."

Client

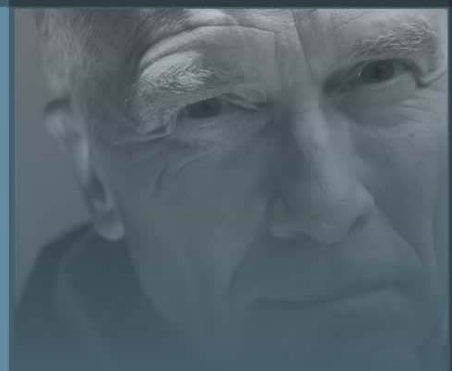
So How Do Care Transitions Help?

- Evidence-based research shows that this model significantly reduces hospital readmissions
- Sonoma County data showed that seniors felt more empowered to take charge of their own healthcare after this intervention
- This model significantly reduces costs for both hospitals and government agencies

"At 85, I deserve to know what is going on with my health. My voice was shaking, but I had [the doctor] sit down with me and answer all my questions."

Partnership Development

- Rapport and relationship with partner
- Vision and leadership for community initiatives
- Trust and willingness to take risks
- Flexibility in approach to service delivery



"When I showed my doctor my personal health record, he sat down and answered all my questions."

Client

Client Enrollment Process

Hospital or SNF identifies patient

D/C Planner determines eligibility

D/C Planner discusses with patient

Patient accepts program

D/C Planner phones in referral to A&A Intake

D/C Planner faxes medical records to A&A Intake

Transitions supervisor determines appropriateness & assigns patient to Transitions Counselor

Transitions Counselor contacts D/C Planner by phone to arrange hospital visit

"I feel like I know how to take care of my own health better."

Client

Care Transitions Conference

- Both Santa Rosa Memorial Hospital and Adult & Aging spoke at conference
- Physician champion spoke about need for intervention
- More than 100 attendees
- Increased awareness and community receptiveness to intervention

Lessons Learned

- A simple intervention can make a profound difference
- Education for partners and clients is important to successful implementation (Community Forum)
- Transitions Counselor training on the "coaching" model is essential to a successful intervention

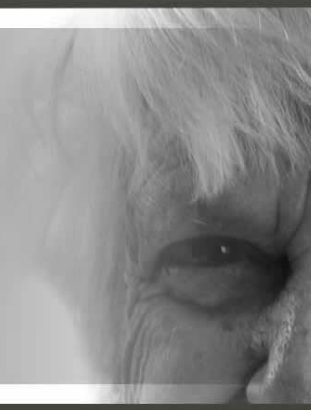
"When I showed my doctor my personal health record he said, 'I wish everyone had one of these.' "

Client

4 Years Later = CCTP

- CCTP = Community Care Transition Project through CMS
- 6 months of planning with expanded list of partners
- 'Health Action' – Sonoma County healthcare coalition
- Goal is to include all hospitals, clinics, and other partners to create

Thank You!



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