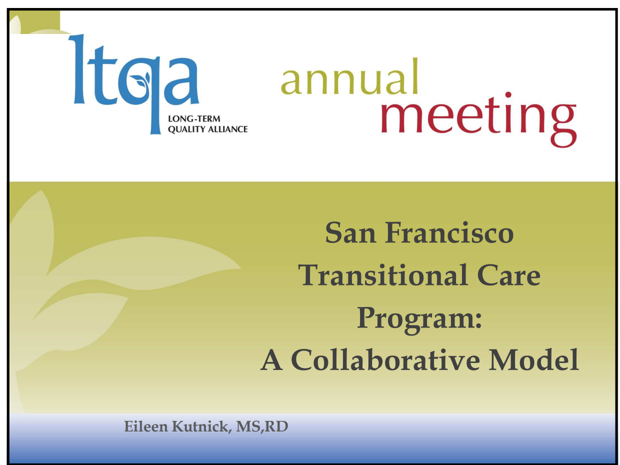

Historical Overview

- Program history
  - Started – 2002
  - Partnership - SF Senior Center & Saint Francis Memorial Hospital
  - Purpose - to refer at-risk patients to a dedicated community case manager
  - Target population - isolated, low income seniors
  - Initial study – demonstrated readmission rates were reduced

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Historical Overview
cont

- 2008
  - Grant funding to implement a central transitional care referral system
  - Expand from 1 to 7 community partners
  - Expand citywide
  - Provide service to all hospitals

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2008 Expansion Hospital

» Centralize referral process for discharge planners for all SF hospitals
» Provide training and orientation for hospital staff
» Create a presence at the hospital that built familiarity and trust
» Feed-back of outcomes to discharge planners to increase job satisfaction and ongoing relationships

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2008 Expansion Community

» To create a collaboration among AAA community agencies to provide transitional care services
» To create a system to improve training and communication
» To establish lead agency for fiscal and administrative oversight to maximize the leverage public and private funds

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Dedicated Community Case Management Transitional Care Model Review

- February 1, 2010 – November 30, 2010
- Purpose
  - Evaluate the effectiveness of a dedicated case management model
  - Assess the social services that are most needed and/or utilized
  - Identify the optimal structure for a hospital-to-home community-based transitional care program
- 4 community agencies were funded for .5 FTE transitional care case manager
- 4 hospitals participated

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Referrals

- 404 eligible patients to transitional care services
  - 87 refused the service (21.5%).
  - 317 clients served
  - 142 were over 65 years of age
  - 165 referrals, 102 were younger disabled under 60
- Acceptance rate was 41.5% for referrals from their assigned hospital

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Population Served

- 70% lived alone
- 54% were at 150% of poverty
- 53% were on Medi-Cal or Medicare/Medi-Cal
- 76% had no caregiver
- 64% were taking five or more medications
- 27% had multiple discharges in the last 6 months
- Average age of all clients served was 65.6 years
- Average age of clients over 65 years was 78
- 4% passed away while on program

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Dedicated Case Management

- Cases were open an average of 32 days
- Number of client interactions by the case managers:
  - 0.21 hospital assessments/ client
  - 1.7 home visit /client
  - 1.5 service arrangement visit/client,
  - 1.9 telephone contacts/ client contacts
- 4.9 hours /client (not including travel time and administrative client record management)
- Medication assistance - 61% of clients

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Client Assessment Issues

- Unmet needs were:
  - physical health, mental health, food, finances, mobility, medications, in-home supportive services (IHSS).
- The 6 top services utilized were
  - IHSS, Food
  - Medication
  - Medical appointment
  - Transportation
  - Housing
  - Home Care

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Key Successes

- Clients reported
  - Improved health status
  - Clearer understanding of medications, equipment and health care needs
- Identified key service needs to target funding and build community capacity
- Profiled the demographics of this at-risk population
- Formalized CBO agency oversight committee
- Developed a database and implemented standardized forms
- Improved communication systems between hospitals and CBO's
- Streamlined centralized referral process

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2011- 2012

- Expanding participation in the Oversight Committee
  - 8 SF hospital
  - 9 community based organizations
  - Area Agency on Aging
  - DPH Clinic
  - Consumer
- Expanding service
  - Care Transitions – coach model of care
  - Support services package
- Developing a joint funding request

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Root Cause Analysis 30 Day Readmission

- 8 Hospitals participated
- 46% psycho-social issues
  - Housing instability
  - Mental illness, Substance use
  - Social isolation, Transportation barriers
  - Unstable family situation
  - Food instability
  - Low literacy/low health literacy
- 58% readmitted prior to follow up Physician appointment
- 53% return home with no services
- 83% with polypharmacy issues
- Understanding discharge instructions
  - 56 % of clients reported the client understood discharge instructions
  - 40% indicated that a family member was present
  - 38% of clients surveyed once home understood discharge instructs

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Recommendations

1. Select community partners with like vision
2. Assess partnership capacity and needs of unique communities served (language, housing, homelessness, veterans, etc)
3. Develop MOU for commitment and units of service goals
4. Build a process for funding (Area Agency on Aging, Hospitals, foundations)
5. Create Transitional Care case manager specific training and oversight process
6. Track transitional care services

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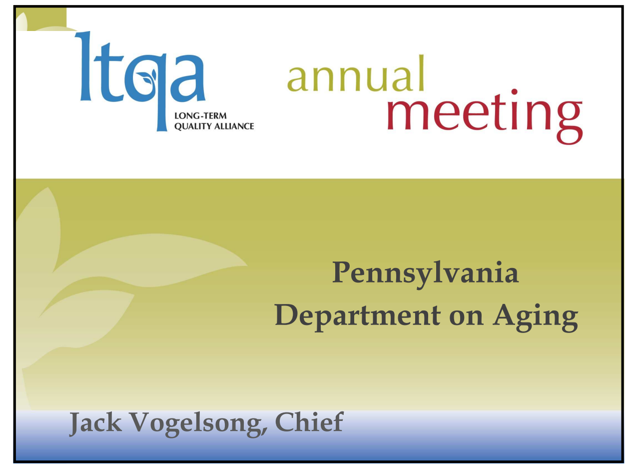

Pennsylvania Department of Aging

- Role of Care Transition in the Department of Aging's Mission
  - "Enhancing the quality of life of all older Pennsylvanians by empowering diverse communities, the family and the individual."
- Delivering Services at the Right Time, Right Place, Right Intensity built with Private / Public Partnership.

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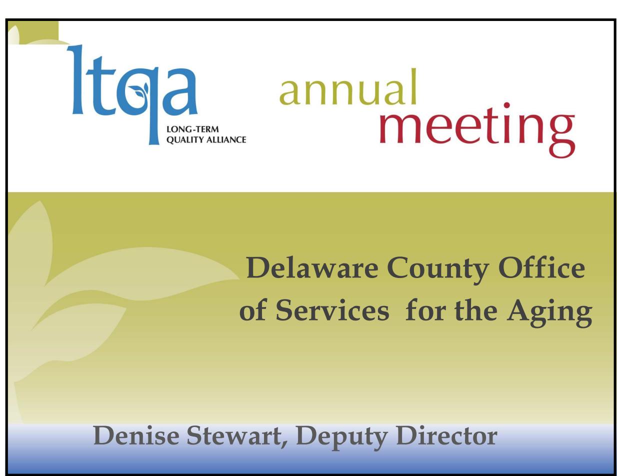
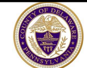


COSA – Transitional Care Service Report



» Aging Waiver consumers – 26

Personal Care	11
ADC	1
Personal Assistance Service	2
PERS	10
Meals	6
Stair Ride	3

» Options consumers- 175

Stair ride through special funding	4
PERS through special funding	2
Air conditioner through special funding	1
Weight scales	5
Home support	2
Personal care	1
Meals	9

» Family Caregiver Support Program consumers – 2

» Life at Home consumers- 1
(Life at Home is a PACE product)

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Case Study from Pennsylvania

Mr. C. was referred to the Care Transition program because he had been hospitalized twice within the past three weeks for breathing difficulties and he is experiencing a decline in his ability to function. His medical conditions include COPD, CHF, HTN, leukemia, anxiety, history of skin cancer, and GERD. Maryanne, the APN, enrolled him in the program.

When the assessor was discussing the specifics of how he will manage at home, he was made aware that he will have homecare including a visiting nurse and physical therapy. Mr. C. is walking independently, but unsteady at times. There are also stairs in the home and we discussed the possibility of a stair ride.

Upon Mr. C's discharge, the APN, Maryanne, continues to see him weekly. His care manager, Laura, also follows him. Without this level of support and monitoring Mr. C. would have been readmitted to the hospital. His stair ride as been installed and he is very happily managing well at this time – at home.

Mr. C. had an exacerbation of COPD and CHF two weeks ago. When he called his doctor he was instructed to go to the ER. Instead, Maryanne, the APN, went to Mr. C's home and changed his medicine and was in direct contact with his pulmonologist and cardiologist. Since his medications were adjusted, blood work was checked, and his plan of care readjusted. Mr. C. is doing well – at home.

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Patient Satisfaction Surveys – *Public Health Management Corporation*

- Surveys conducted over the phone by staff at PHMC.
- Survey based on a patient satisfaction survey used by Dr. Mary Naylor.
- Topics include discharge instructions, medications, managing patient care at home, and follow-up services at home.
- To date, 113 patients or their caregivers participated in a patient satisfaction survey. Five patients or their caregivers declined to complete the survey or were unable to do so (e.g., deceased, hearing difficulties).

Major findings from the patient satisfaction surveys

- Overall patients and their caregivers reported being pleased with the Care Transitions Program.
- 97.5% received the name and phone number of the home care nurse.
- 97.4% said that their care instructions were explained to them.
- 96.9% reported that medical equipment and supplies were available to meet their needs.
- 94.6% said that the services arranged for them at their home met their needs.
- 92.3% were included in discussions about managing their care.
- 90.2% agreed that their questions and concerns about follow-up services in their home were answered.
- 42.1% reported that no one talked to them about their daily routines at home.

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Lessons Learned

- Set and Maintain standards re: screening criteria, appropriateness of patient.
- Create a system for Patients to be followed by a single Care Manager across the continuum-Bedside to home.
- Manage the influx of new cases to a care managers caseload
- Designate a care manager for CCTP
- Stagger home visit between the care manager and APN
- Create special funding for those AAA's with waiting lists
- Hold weekly conference calls with the APN and identified care managers
- Educate the Homecare nurses regarding availability of APN for patients with high acuity.
- Maintain the integrity of the relationships among stakeholders.
- Training is a vital component of the project

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Questions?

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