San Diego Care Transitions Partnership
Transforming Care Across the Continuum

Live Well, San Diego!

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

HHSA  PALOMAR HEALTH  Scripps  SHARP
UC San Diego HEALTH SYSTEM
Regional Dynamics

THE LEVEL OF COOPERATION

THE LEVEL OF COMPETITION

LOW

White Space (No Network)

“Rumble in the Jungle”

HIGH

“Love-Fest”

“Co-opetition” (San Diego County)
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 by using services to manage patients’ transitions effectively.
• CCTP supports the three-part aim of: better health for the population, better care for the patient, and lower cost for all Americans.
Community-based Care Transitions Program (CCTP) Goals

• Improve transitions of patients 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% in two years
  – Document measureable savings to the Medicare program
Community-based Care Transitions Program (CCTP)

- 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

- Participants are awarded two-year agreements that may be extended annually through the duration of the program based on performance

- CBO is paid an all-inclusive rate per eligible discharge based on the cost of care transition services provided at the patient level and systemic changes at the hospital level

- CBO is only paid once per eligible patient in a 180-day period of time
San Diego
Care Transitions Partnership (SDCTP)

- Partnership between the HHSA/AIS and Palomar Health, Scripps Health, Sharp HealthCare and UC San Diego Health System
  - 11 hospitals with 13 campuses
- Planning began in 2011 with HHSA/AIS, Hospital Teams and Consultants
- Planning Process:
  - Each health system completed a Root-Cause Analysis (RCA)
  - Each health system identified CCTP interventions based on RCA
  - Each health system and AIS determined the cost for direct transition services and established the SDCTP blended rate which is paid by CMS for every eligible patient
  - CCTP began in January and roll out will continue over the next few months
SDCTP Program

Primary Causes of Readmissions and Planned Interventions

1. Inadequate or inconsistent communication and continuity of care coordination and hand-off to downstream providers within hospital systems
   – Re-engineer discharge and post-discharge practices to screen FFS beneficiaries for high risk of hospital utilization and channel those patients into appropriate supportive patient-centered discharge plans that include follow-up calls after discharge.

2. Lack of patient or caregiver activation
   – Implement the Care Transition Intervention (CTI) to provide patients with tools and support that promote knowledge and self-management and address continuity of care across multiple settings and practitioners.

3. Insufficient connections to social supports and services
   – Provide short term intense care coordination to the highest risk patients to ensure that their social support needs and barriers to care are addressed through coordinated connection to Home- and Community-Based Services (HCBS) and emergency support services.

4. Need for medication education and reconciliation
   – Implement a comprehensive Pharmacy Intervention aimed at reducing medication discrepancies, adverse drug events (ADEs) and increasing adherence to medication regimen among patients who are high risk due to number, type and complexity of medications required.

5. Need for greater disease management for patients
   – Implement the Bridges Program for patients with advanced chronic illness.
Care Transitions Intervention (CTI) Pilots

- August 2010-December 2011 - Partnership between AIS ADRC and Sharp Memorial Hospital
- November 2011-March 2013 Beacon Community Collaborative - Partnership between AIS ADRC and
  - UCSD Hillcrest,
  - Sharp Memorial, and
  - Scripps Mercy San Diego
AIS’ Role in CCTP

- Administration
  - Facilitation of SDCTP
  - Liaison with CMS
  - Invoicing for CCTP Services
  - Data collection, monitoring and reporting

- Care Transitions Intervention (CTI) for Palomar Health and University of California San Diego Health System

- CTI Care Enhancement Program for all Health Systems
Care Transitions Intervention (CTI) Model

- Evidence based program
- Patient and caregiver centered
- 4 week program
- Patients are supported by a coach
- Patients with complex care needs receive specific tools - can choose electronic or paper
- Patients learn self-management skills
Care Transitions Intervention (CTI)

COACH

Key Attributes of a CTI Coach

- Model & Facilitate New Behaviors & Skills
- Promote Patient Self-Activation
- Competent in Medication Review & Reconciliation
- Bridge between Staff and the Patient and/or Family
Care Transitions Intervention (CTI)

Focus on 4 Pillars:

- Medication Management
- Patient Centered Record
- Physician Follow-Up
- Knowledge of Red Flags
Key Elements of CTI

- Referral Process
- Hospital Visit
- Social Support Risk Assessment
- Phone call to patient after discharge from hospital
- Home visit within 2 days after discharge
- Phone calls to patient 7 days and 14 days after the home visit
The goal of CTI Care Enhancement is to provide patients/caregivers critical social support services, either by referral or direct provision of support services, to reduce the risk of an avoidable readmission.
CTI Care Enhancement
Link to CTI

☑ CTI Transition Coach assesses the patient’s need for critical social supports

☑ As needed, the Coach refers the patient to an AIS Social Worker for intense short term coordination and purchase of required social supports
CTI Care Enhancement
Key Elements

- Coordination with the patient’s care team
- Hospital visit - Immediate Needs Assessment
- Home visit 24-72 hours after discharge
  - Long Term Needs Assessment
  - Care plan
  - Coordination of after care
  - Purchase of services for first 7 days
  - Link patient/caregiver to support services
- Home visits and follow-up phone calls to coordinate services as determined by patient need, for up to 30 days
The intervention options

1. CTI
   - 1 home visit
     ✓ Set personal goal
     ✓ Complete PHR
   - 3 to 4 telephone follow-ups

2. Post-Acute Navigation Services (PAN)
   - 4 post-DC telephone calls
   - Follows CTI path w/o home visit

3. CTI w/ Care Enhancement
   - All items in #1
   - AIS Care Enhancement Svcs

4. Bridges
   - 2 home visits
   - 4 telephone follow-ups
   - Advanced Care Planning
   - Medical prognostication
# Eligibility Criteria** for Sharp’s CTI Program

**Criteria is being revised and adapted to new findings on a regular basis so check with your facility’s CTI Coach for questions.**

<table>
<thead>
<tr>
<th><strong>Inclusion</strong></th>
<th><strong>Exclusion</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- High risk for readmission</td>
<td>- Dialysis (facility- or home-based)</td>
</tr>
<tr>
<td>- Medicare FFS primary / MediCal secondary ok</td>
<td>- Hx substance abuse within one year</td>
</tr>
<tr>
<td>- Independent (able to actively participate in their own care)</td>
<td>- Hx limited compliance</td>
</tr>
<tr>
<td>- Can have caregiver</td>
<td>- Hospice-eligible end-stage disease</td>
</tr>
<tr>
<td>- Chronic disease diagnosis</td>
<td>- Lives in or is DCd to Nursing Facility or Board &amp; Care</td>
</tr>
<tr>
<td>- Willing to accept home visit from CTI coach</td>
<td>- Active Cancer</td>
</tr>
<tr>
<td></td>
<td>- Active Mental Health dx – poorly controlled</td>
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<tr>
<td></td>
<td>-- Bipolar</td>
</tr>
<tr>
<td></td>
<td>-- Schizoeffective disorder</td>
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</table>
# Eligibility for Post-Navigation Services Program

## Inclusion
- Pt elig for CTI but refuses home visit, agrees to telephone follow-up …OR…
- Pt lives > 30 miles from facility at which he/she was hospitalized
- Moderate risk of readmission
- Medicare FFS primary / MediCal secondary ok
- Independent (able to actively participate in their own care)
- Chronic disease diagnosis

## Exclusion
- Same as Full CTI exclusion list
What are PAN Services?

- Use CTI model and methodologies
- Patient completes PHR in hospital prior to discharge
- Patient Activation Assessment completed at each encounter
- No home visit
- Four (4) telephone “coaching” sessions
- Same data collection and metrics
Sharp’s Bridges Program

Target Population:
- Patients with advanced chronic illness with a diagnosis of CHF, COPD or dementia and/or other End of Life dx.
- Not “ready” or eligible for hospice

The Model:
- Proactive model of disease management focused on EOL
- Comprehensive proactive in-home patient and family education about their disease process.
- Evidence-based prognostication
- Professional proactive support of the caregiver
- **FOCUS on Advanced care planning**
- Uses CTI coaching model, PHR and all other documentation
Goals of Bridges

- Strong focus on decisions regarding goals of treatment
- Encourage proactive participation of patient and family in health care decision making
- Establish a realistic and effective plan of care
- Facilitate Advanced Health Care planning
- Improve quality of living
- In collaboration with the physician, discuss disease process and expected course with patient and family
- Manage disease symptoms
- Prevent unnecessary emergency room visits and hospitalizations
Care Management Redesign to Community Care Transitions

Susan Erickson RN, MPH
Senior Director Patient Navigation
Scripps Health Care System
San Diego, CA
Scripps Health Care System

Not for Profit
Integrated Health System
13,000 Employees
2600 Physicians
Care Management Kaizen April 2011

One Contact
- **While in the hospital**, I want one designated person to answer my questions or figure out how to get the answers. **Post discharge**, I want one number to call, one designated person to answer my questions...

Advocacy
- I want someone to go to bat for me. I want to know you heard my needs and tried to address them.

Team Coordination + Hand-off
- I want every healthcare team member that works with me to know me, my history, my disease process and my plan, and I want it coordinated and communicated across the continuum.

Information/Communication
- I want simple, clear information verbally and in writing daily and at discharge

Assumptions and Guiding Principles in Building Model:
- Put the patient first
- Support the patient across the care continuum
- Team based
- Consistent care providers
- Manage handoffs
- 7 days per week
- Efficient and cost-effective
- Migrate from an inpatient (sickness) model to an outpatient health and wellness model

“Through the Eyes of the Patient”
Two (3 Month) Pilots
Scripps Encinitas

- **Focus:** CHF & Joint Replacement Hospitalist Teams
- Interdisciplinary team
- Team Bedside rounds
- Care boards in rooms
- Milliman™ Guidelines
- Inpatient Navigator
- ED Navigator
- Outpatient Navigators

**Results**
- ↓ LOS
- ↓ Readmissions
- ↓ Admissions from ED
- ↑ Patient satisfaction
- ↑ MD & staff satisfaction

**Observations:**
- Overlap of roles
- Duplication of services

**Encinitas** – Complete CM conversion to Navigation
**La Jolla, Green, SD, CV** – Phased implementation on target unit/teams

**PILOT**

2011

2012

ROLLER OUT
Navigators: ED → Inpatient → Outpatient → ......

Interdisciplinary Team: MD + MTM Pharmacist + Navigator + RN

Bedside Rounds ~ 7-12 minutes/patient

- Bedside RN presents patient and review of core measures
- Goal boards in room – patient input into plan / lay language
- Milliman Guidelines™ to identify goal LOS, barriers to D/C

UR Nurse - distinct role focused on payer aspects of acute stay

MTM Pharmacist provides support to patients at risk for readmission due to medication issues... *not clinical pharmacist*

ON follows patient for 30 days post acute care discharge

Evaluation of outcomes including RCA readmissions
### LA JOLLA: Key Performance Indicators

**Monthly Dashboard**

**CARE MANAGEMENT METRICS**

**ALL ADULT ACUTE CARE DISCHARGES EXCLUDING OB & TRAUMA FROM 7-WEST**

<table>
<thead>
<tr>
<th>Source: HPM, MIDAS, LAWSON</th>
<th>PRE-GROUP</th>
<th>POST-GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KEY PERFORMANCE INDICATORS</strong></td>
<td>JUNE 2011 TO MAY 2012</td>
<td>AVERAGE FROM &quot;GO LIVE&quot;</td>
</tr>
<tr>
<td>Average Discharges per month</td>
<td></td>
<td></td>
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<tr>
<td>Average Days per month</td>
<td></td>
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<tr>
<td>ALOS</td>
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<tr>
<td>Average Case Mix Index (CMI)</td>
<td></td>
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<tr>
<td>ALOS - CMI Adj</td>
<td></td>
<td></td>
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<tr>
<td>ALOS - CMI Adj Var %</td>
<td></td>
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<tr>
<td>Readmits within 30 days *</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmits* as a % of Total IP Discharges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Inpatients admitted from ER</td>
<td></td>
<td></td>
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<tr>
<td>Total Cost per discharge</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>CMI Adj Total Cost per discharge</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>Total Direct Variable Labor per discharge</td>
<td>$</td>
<td></td>
</tr>
<tr>
<td>CMI Adj Total DVL per discharge</td>
<td>$</td>
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**Cost:**
- LOS
- Cost / Discharge
- ED Admissions
- Denials

**Quality:**
- Readmissions

*Readmissions within 30 days of discharge to any Scripps facility as an inpatient; excluding death

NOT AVAILABLE

08/06/12
Patient Satisfaction:

- Rate Hospital 0-10
- Communication with Nurses
- Communication with Doctors
- Communication about Medications
- Discharge Information
- Care plan review with you daily
- Provide input into care plan daily
- Good understanding manage health
- Understood purpose of taking meds
Readmission Root Cause Analysis Process

- Readmission List Generated
- CM / Navigator Interviews Patient in Real Time & Reviews Chart
- Findings Entered into Common Midas Database
- Quarterly Meeting at System Level to Review Trends and Identify Opportunities, Strategies
- Monthly Hospital Specific Data Review & Presentation to Site UR Committee
- Decreased Readmissions!
What Changed / Is Changing:

- Transition from traditional case management model to navigation model
  - Unbundle UR from disposition planning
  - Navigator co-manages cohort of patients with Hospitalist
  - Focus on transition...readmission risk

- Increase role/engagement of bedside RN in patient management, transition of care planning...increase critical thinking

- Migration of clinical pharmacists to transition of care focus

- Change in MD pre-rounding, rounding...GME practices

- Front load the day in rounds to ensure team / patient know the plan....decrease extraneous calls on back end

- Involvement of the patient in the plan of care

- Redefine the acute care episode to be hospitalization + 30 days post discharge
Teams and Holistic Roles...

This has brought the fun back to medicine...

This is why I went into nursing.

I trust that the Navigator will always know what's going on with the patient.

I didn't think they would like it but now all the residents want to be assigned to a Navigator team.

This is so good for our patients!

I trust that the Navigator will always know what's going on with the patient.

I'm having a nursing high!

This is my dream Pharmacist job!
OUR EFFORTS AND FUTURE PLAN FOR TOC

Eileen Haley, RN, MSN, CNS, CCM
Manager, Care Coordination
## History of Transitions of Care Efforts UC San Diego Health System

<table>
<thead>
<tr>
<th>Year</th>
<th>Project</th>
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</thead>
<tbody>
<tr>
<td>2003</td>
<td>Formation of the Discharge Process Committee. Effort led by Hospital Medicine</td>
</tr>
<tr>
<td>2006</td>
<td>A standardized template for patient discharge instructions was implemented in the electronic medical record</td>
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<tr>
<td>2006</td>
<td>Hospital Medicine became involved in Project BOOST</td>
</tr>
<tr>
<td>2008</td>
<td>Preliminary project completed with observations of RN teaching at the time of discharge</td>
</tr>
<tr>
<td>May 2010</td>
<td>EPIC discharge module, electronic medication reconciliation implemented</td>
</tr>
<tr>
<td>Sept 2010</td>
<td>RN Teach back coach project, EPIC implementation (February 2011)</td>
</tr>
<tr>
<td>Nov 2011</td>
<td>RN DC advocate project, Care Transitions Intervention Collaboration with Aging and Independent Services</td>
</tr>
<tr>
<td>2012</td>
<td>RN Transitions coach project, Reorganization of Discharge Process Committee into project-focused workgroups</td>
</tr>
</tbody>
</table>
Lessons Learned and 2012 Steps

• Reorganization of Transitions of Care Committee
  • Chair identified to lead each task force
  • Chairs meet monthly to present updates and request resources
  • Transitions of Care Committee meets quarterly with all members, other vested parties, public invitation to staff
• Task force groups:
  • Medication Management - Pharmacy
  • Improve Medication Reconciliation – EMR MD Competency
  • Improve DC Summary Communication to outside Providers
  • RN Transition Coaches + CTI
  • Medical Home/PCP Assignments
  • Follow up phone calls
Transitions of Care & Care Coordination Department

High Level Overview of Unit Based Case Managers & Social Workers

- Care Coordination staff works with Physicians and multidisciplinary staff to identify patient with discharge needs
- Unit based

Nurse Case Managers

- Average workload 30 patients
- Identify patients who have medical needs post discharge and coordinate medical equipment and/or transfers

Social Workers

- Average workload 50 patients
- Consult on patients with psychosocial needs, hospice referrals
- Help patient identify community clinic/primary care physician for post discharge follow up, if patient has no primary care physician
Transitions Coach

✓ Blended role: nurse educator, case manager, community health nurse
✓ Bridge patients from inpatient to outpatient
✓ Available to patients for up to 30 days post discharge
✓ Manages high risk patient populations
✓ Average daily caseload of 8 patients
Transitions Coach Daily Workflow

- Receives list of patients who are high risk (PADB in future, now EPIC chart pull)
- Uses Project BOOST 8 P’s as a tool: In-depth patient/family interview, assessment
- Develops patient-centered discharge plan
- Uses teach back for patient/family education
- Communicates discharge plans and patient education needs with physician and multidisciplinary team
- Arranges post-discharge follow up appointment with primary care physician
- Communicates important updates with patient’s primary care provider
- Reviews discharge instructions with patients
- Requests additional interventions, as appropriate:
  - Pharmacy
  - CTI Coach
Key Components of BOOST Toolkit

- **Standardized Risk Assessment:** Tool for Identification of High Risk Patients (8Ps)
- **Patient-centered Preparation for Discharge**
  - Checklists - GAP, Universal Patient Checklist
  - Use of Teachback Technique
  - Medication Reconciliation
  - Patient-friendly discharge forms
    - Principal Care Provider identification
    - Who to contact with questions/concerns
    - Warning signs/symptoms and how to respond
    - Outpatient appointments
    - Pending tests
- **Standardized PCP communication**
- **72 hour follow-up call for high risk patients**
8P Risk Assessment

• Prior hospitalization
• Problem medications
• Psychological
• Principal diagnosis
• Polypharmacy
• Poor health literacy
• Patient support
• Palliative Care

Each associated with risk specific interventions
NEW CONCEPT: Health information, advice, instructions, or change in management

Adherence / Error reduction

The Teach Back Method

Assess patient comprehension / Ask patient to demonstrate

Explain new concept / Demonstrate new skill

Patient recalls and comprehends / Demonstrates skill mastery

Clarify and tailor explanation

Re-assess recall and comprehension / Ask patient to demonstrate

Transitions Coach: Patient Follow Up Post Discharge

- Completes follow up phone call within 72 hours on a subset of patients
- Reviews Discharge Summary with patients: Reason for admission, medications, follow up appointments, and red flags that would require follow up
- Provides number to call should patient have questions/concerns
- Refers any questions or concerns to patient’s primary care provider, as appropriate
Transitions of Care: Medication Management Program

- Medication Reconciliation
  - Admission
  - Discharge

- Discharge counseling with MedAction Plan

http://medactionplan.com
Pilot results:
Point of Pharmacist Intervention

<table>
<thead>
<tr>
<th>Point of Intervention</th>
<th>Admission</th>
<th>Discharge</th>
<th>Post Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Med Rec</td>
<td>38%</td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td>Discharge Med Rec</td>
<td>32%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow Up Phone Call</td>
<td>17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow Up Visit</td>
<td>7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge Counseling</td>
<td>5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
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N=131
Keep the patient at the center

• Vision – Provide best quality service to all patients, regardless of payer
• Go outside of boundaries to accommodate our patients
• DSRIP / CCTP etc. give us payment mechanism and opportunities to collaborate
Palomar Health
Community-Based Care Transitions Program

Elissa Hamilton RN, NE-BC, MBA
Director Home Care Services
Palomar Health by the Numbers

- 4500 Employees
- 840 Physicians
- 760 Volunteers
- 850 Clinical Career Extenders
- $2.4 Billion Gross Revenue
- 244,100 Weighted Patient Days
- 101,200 Emergency Visits
- 55,000 Home Health Visits
- 850 Square Mile Health District
- 2200 Square Mile Trauma District
Palomar Health System Overview

- Palomar Medical Center (Acute Care)
- Retail Health (Clinics)
- Pomerado Hospital (Acute Care)
- Palomar Health Downtown Campus (Specialty)
- Villa Pomerado (Skilled Nursing Facility/ Subacute Care)
- Arch Health Partners (Physician Practice Group)
- Palomar Continuing Care Center (Skilled Nursing)
- Ambulatory Care Centers- Wound Care
- Home Health
- Pomerado Outpatient Pavilion
- Hospitals with Pilot Units
CCTP Excitement of Potential

- Transitional Care Models are recognized Across the Continuum Nationally
- We had Conceptual Support at Palomar Health because we had common goals
- This project should be a piece of cake
The Pain of the Start-up Process

Many Questions to Answer at the Beginning:

- What are we doing right now?
- What is our Route Cause Analysis?
- Why are our patients being re-admitted?
High Risk Criteria based on RCA at Palomar Health

- Eight or more medications
- Multiple Chronic Conditions
- AMI or PNEU or CHF
- Two or more readmissions in the past 12 months
- Two or more ED visits in the past 6 months
Okay You want to start a Transitions Care Project!

This is what we have needed to address:

- What patient identification system will work for us for the High Risk patients?
- What is the skill level of our High Risk Coach or Pharmacist?
- What steps will we take when these patients are admitted and identified?
More Questions

- Who are the key stakeholders and when should we involve them?
- What data elements should we collect?
- How are we going to collect them?
- What is our IT support?
- What collection device should we use?
  - Bedside computer
  - Laptop
  - Tablet
And More Questions ... 

- Where should the Coaches make their Follow-up Phone Calls? (Quiet)

- What are the key elements that should be asked and recorded?
Advice to Providers Considering this:

This is very hard work! It takes:

- Consistent, stable leadership and committed time
- Constant managerial oversight for staff accountability
- Encouragement and real-time praise for those early adopters
- Relentless focus on the goals
- Engage those who are engaged first before trying to engage the masses