INNOVATION
IN HEALTH CARE
AWARD

UNIVERSITY OF CALIFORNIA, LOS ANGELES: COMMUNITY BASED CARE TRANSITIONS PROGRAM

Recognizing the potential to achieve better health outcomes and improve the lives of older adults through integrating health care and social services, the University of California, Los Angeles Health System (UCLA Health) and Partners in Care Foundation (Partners), a community-based organization, established the Community Care Transitions Program (CCTP). Launched in 2010 through the Centers for Medicare & Medicaid Services (CMS), CCTP is a demonstration to evaluate the effectiveness of hospitals and community organizations partnering to improve care transitions and reduce readmissions. Today the partnership serves Medicare Fee for Service, Medicare Advantage, and select Accountable Care Organization (ACO) members. Caring for approximately 4,000 individuals each year, services include care transitions coaching, community-based care coordination, and medication reconciliation.

RESULTS

- Reduction in readmissions for the intervention group (19%).
- Improvement rate for physician follow-up visits within seven days of discharge (14%).
- Improved medication safety through HomeMeds risk screening and MyMeds pharmacists intervention.
- Older adults have greater access to resources in order to reduce risks that might negatively impact health.

INSPIRATION

At the time of a hospital discharge, individuals are in greater need for services and support to navigate the transition and to manage their own care within the home. Times of transition enhance the risk of adverse outcomes, such as unnecessary readmissions and emergency department visits. UCLA and Partners saw an opportunity to collaborate at the hospital discharge. They believed that by integrating health care and social services they could achieve reduced readmissions and emergency department visits and improve outcomes, lower health care costs, and improve satisfaction.

UCLA HEALTH SYSTEM:

"UCLA Health's long-standing and successful collaboration with Partners in Care Foundation has been mission-critical for both organizations and has helped thousands of older adults return home from the hospital safely."

ORGANIZATIONS INVOLVED

The primary partners include UCLA Health and Partners. However, the partnership collaborates with many other community organizations, including Health Net, Durable Medical Aid Society, and WISE & Healthy Aging.

PARTNERSHIP STRUCTURE

The partnership is primarily a referral relationship and is formalized with a contract between UCLA Health and Partners for the delivery of services to individuals beyond the CCTP demonstration. The partners entered into a two-year agreement with CMS for the CCTP demonstration, which was then extended annually through the life of the demonstration.

MODEL DESIGN

Building on the success of the transition model developed for the CCTP demonstration, UCLA refined the model and secured it as a benefit for their Medicare Advantage and select ACO populations. The model begins with identifying eligible individuals. To do this, they use the LACE criteria (which looks at Length of stay, Acuity, Comorbidities, and admission

through the Emergency department). Those with a qualifying score receive a referral to Partner's coaches, who then perform psychosocial, environmental and functional assessments, and develop a community care plan while they are in the hospital or other institutional care setting, such as a skilled nursing facility. Medication reconciliation – utilizing the evidence-based MyMeds intervention as well as UCLA's team pharmacists – is also a critical part of this process.

Once the older adult is discharged from the hospital, Partners maintains a connection with them through home visits and calls to ensure their care plan stays on course. If needed, referrals to additional community organizations are made for services, such as meal delivery or transportation.

CAREGIVER:

"I am so appreciative of this service. I cannot put into words what it meant to not only get the assistance and guidance; the personal touch and kindness made the process so much easier!"

FUNDING MECHANISM

The primary funding source for the model is provided by UCLA Health, in which they provide Partners with a per-case payment for their transition services.

During the CCTP demonstration period, the partners received funding from CMS for eligible Medicare beneficiaries receiving the transition services.

LESSONS LEARNED

- Partners must be adaptable—open to change and new ideas. For instance, many adjustments have been required by both partners to continually improve their operations, including new workflows and information exchanges.
- Partners should use data to highlight the successes and opportunities within the model to capture the interest of additional partners and funders. For instance, partners expanded the data measures being recorded to better display the results achieved. The willingness of UCLA Health to share their data with Partners has been instrumental for partnership success.

FUTURE

The partners continue to focus on improvement in efficiency and quality for the care transition model to better serve individuals and ensure sustainability. They are working to improve and streamline the data collection and coaching process.

Additionally, the partners seek to expand their partnership to new organizations and funders, such as foundations and health plans.