

Recognizing the potential to improve health outcomes, quality of care, and health care spending, Alta Bates Summit Medical Center (ABSMC) and LifeLong Medical Care, along with support from the Community Health Center Network (CHCN), established the Community Based Care Transitions Program (CBCT). This program provides care transition services for low-income older adults as they discharge from the hospital to the community, ensuring that the full scale of needs, whether medical or non-medical, are addressed. The program features a “warm hand-off” between the hospital and community health center prior to hospital discharge, at which point a Care Transitions RN (CTRN) manages care through the transition, making referrals to needed services. The partnership strives to achieve seamless transitions between care settings.

RESULTS

- Decrease in both emergency department utilization and hospital readmissions (17%).
- Increase in primary care provider follow-up within 30 days of discharge (32%).
- In 2016, 1,350 older adults received the care transitions services.

ABSMC:

“We’re constantly looking at ways to provide better care to individuals while controlling health care costs. This [program] does both and it’s a win-win for the East Bay community.”

INSPIRATION

The hospital discharge process is a vulnerable time for older adults, as the historically fragmented system consists of numerous gaps and risk factors that can have a negative impact on their health and well-being. This is particularly true for low-income older adults who often lack the resources and support necessary for their recovery. This can lead to an increased risk of complications and poor health outcomes resulting in readmissions.

LifeLong, a leader among community health centers in serving low income elderly patients, had no system in place to track or support their patients when they entered the hospital. This resulted in missed opportunities to assist with post-discharge care needs. Payment and delivery reform initiatives, such as the Hospital Readmission Reduction Program that holds hospitals accountable for readmission rates, provided financial incentive for ABSMC to address this issue. This resulted in the collaboration between these entities and the joint development of the CBCT Program.

ORGANIZATIONS INVOLVED

The partnership includes ABSMC (a Sutter Health affiliate hospital), LifeLong Medical Care (a FQHC), and CHCN (a nonprofit MediCal MCO that provides FQHCs with administrative support and services).

PARTNERSHIP STRUCTURE

As a hospital/community health center partnership, Lifelong and ABMC are jointly leading the development of a system of care that better serves the health needs of vulnerable populations including low-income older adults. Leadership from partner agencies oversee CBCT program planning, implementation, and sustainability/growth initiatives. Representatives of the hospital, CHCN and health center partners meet monthly to discuss operational issues, system improvements and evaluation processes for data collection and reporting. Review of evaluation metrics guides program development.

MODEL DESIGN

Through the establishment of data sharing agreements and IT innovations and relationships between health center and hospital staff, LifeLong now identifies patients, on a daily basis, who visit the ED or are hospitalized. LifeLong CTRNs track these hospital admissions and initiate transition services, including a review of diagnoses and care needs, discharge instruction consultation, medication management, community support needs, and follow-up calls.

LIFELONG MEDICAL CARE:

"The CBCT Program has evolved as a win-win-win partnership that benefits older adults, the hospital system, and the primary care home."

This model is unique in that it directly links individuals back to the FQHC post-hospitalization to properly address immediate and long-term medical and social needs, ranging from medical follow-up and medication consultation to transportation services and case management. If services are not offered by LifeLong, direct referrals are made to community-based organizations to address the full range of needs, and reduce the risk of complications and readmissions.

FUNDING MECHANISM

Funding for the program is provided primarily by Sutter Health, with added support from LifeLong. Hospital funding is essential for this partnership as RN services are not billable for FQHCs. Each partner provides in-kind support for the program, including the staff, IT support and other resources.

LESSONS LEARNED

- Unmet healthcare needs of vulnerable populations and barriers related to real-time data sharing and program implementation inspired the organizations to streamline processes and systems.
- Optimal use of HIPPA compliant communication, IT tools and data sharing enables providers to quickly and effectively respond to medical and social service needs of patients transitioning out the hospital.
- Timely communication between the patient, hospital and primary care provider enables effective linkage back to the FQHC primary care home and to community resources.

COMMUNITY MEMBER:

"When the LifeLong nurse first reached out to me I was so relieved and felt that, finally, someone was looking out for me."

FUTURE

The partners are seeking to improve efficiency within their operations, such as connecting electronic medical records. They are pursuing additional funding streams for sustainability through partnerships with managed care organizations. They also seek funding for standardizing and developing resources to aid the expansion of the program to other centers. While the

partnership was initially a pilot, three additional FQHCs in the CHCN network have joined the program to provide CBCT services for their patients.. Finally, the hospital and health center partners have expanded access to timely follow-up care and promote reduction in avoidable hospital and emergency services through a jointly funded urgent care clinic.