Aging, Disability & Transportation RESOURCE CENTER
EL PASO & FAR WEST TEXAS

Amistad Care Transitions PATH
Patients Avenue To Home

Project Amistad℠

In partnership with: Providence Memorial Hospital • Sierra Providence Medical Center • Sierra Providence East Medical Center • Las Palmas and Del Sol Medical Centers

OUR COLLABORATION

Amistad Care Transitions PATH is a community-wide collaborative. The project champion is Project Amistad's Aging, Disability & Transportation Resource Center. The hospital partners include: Providence Memorial Hospital, Sierra Medical Center, Sierra Providence East Medical Center, Las Palmas and Del Sol Medical Centers. The goal of this collaborative is to improve quality of care for patients and improve communication between providers thereby reducing readmissions.

OUR PREVIOUS EXPERIENCE

Since 1992, Project Amistad has operated the Guardianship Program which now serves thirty-six counties in far West Texas.

Over 2000 wards have been transitioned from the hospital setting back to the community and received assistance with transportation, medications and referrals to various community resources.

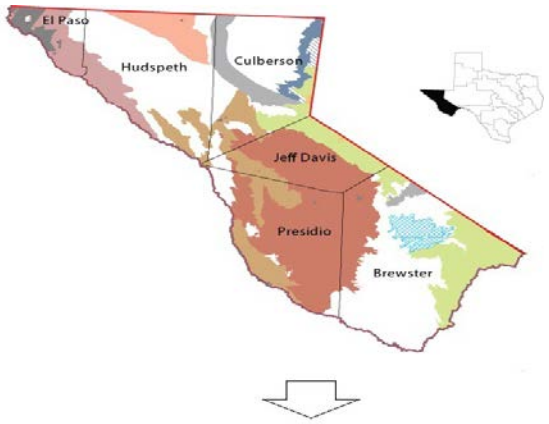
Three of the participating hospitals have implemented Project RED and are proactively following up on all CHF, AMI, and PNE patients.

Three Resource Coaches from the ADTRC are certified Care Transition Intervention (CTI) coaches under the Coleman model.

The ADTRC has assisted in the coordination of engaging downstream providers and providing educational presentations on various interventions and best practices.

OUR COMMUNITY

This project will serve six counties in and around El Paso, Texas to include: Brewster, Culberson, Jeff Davis, Hudspeth and Presidio.



Far West Texas Region

OUR TARGET POPULATION

During the course of the initiative, the collaborative expects to serve 9,725 FFS Medicare Beneficiaries. Eligibility will depend on various risk factors as identified by a High Risk Assessment Form. The focus will be patients discharged home with no certified services. As a community, FY 2010 CMS claims data indicated 65.1% of patients were discharged home without any certified services.

OUR IMPLEMENTATION STRATEGY

The following are findings, drivers and interventions based on our Root Cause Analyses:

Findings:

- Lack of physician follow-up post discharge
- 65.1% patients sent home with no certified services
- Lack of transportation to follow-up appointment
- Financial barrier in obtaining medications
- No medical home identified
- Patient not prepared for discharge
- Lack of family and community support
- Literacy issues

Drivers:

- Poor standard known process
- Transfer of information
- Low patient activation

Interventions:

- Eligible patients in the hospitals will be assigned a Coleman certified CTI coach post discharge from an Acute Care Hospital.
- A Social Services Support Package will be provided based on needs identified through the high risk assessment. The package includes: Four one-way trips to and from medical appointments and/or prescription pick-ups, a referral for delivered meals, and a free weight scale.
- Coordination of Regional Workgroup Meetings with downstream providers to promote and implement best practices.
- The ADTRC staff will assist the coaches in connecting patients to community resources.