Advanced Care Transitions (ACT)

A Collaboration of the Marin County Health & Human Services, Division of Aging & Adult Services; Marin General Hospital and Novato Community Hospital

OUR COLLABORATION

The Advanced Care Transition (ACT) initiative represents a full partnership between the Marin County Health and Human Services, Division of Aging and Adult Services and these two acute care hospitals: Marin General Hospital, the county's largest hospital, and Novato General Hospital, a smaller suburban hospital in the northern part of Marin.

OUR PREVIOUS EXPERIENCE

In 2002, the Division of Aging and Adult Services initiated a community care transitions project, Project Independence, a cost effective model that is clinically led by nursing staff and supported by a large, closely-coordinated and well-trained volunteer cohort. Our project has been successful in serving a vulnerable and medically compromised patient population with strong outcomes. More than 93% of the program's patient population are restored to full independence or are provided with on-going support enabling them to remain in their homes. A recent research review of 257 patients served from 2007-2010 found that just 4% of transitioned patients were re-hospitalized within 30 days of discharge. In 2011, Project Independence was awarded an "Aging Innovation Award" by the National Association of Area Agencies on Aging.

OUR COMMUNITY

OUR TARGET POPULATION

Partnering with each of the hospitals, ACT will target patients who (1) are diagnosed of Acute Myocardial Infarction, Heart Failure, Pneumonia, Diabetes or have multiple diagnoses that require close medical supervision; (2) score 2 or greater on the Transitional Care Risk Assessment (Naylor); and (3) are appropriate for this program as validated by the use of the Patient Activation Measure. Patients who are not cognitively able to participate in their own self-care or who are being discharged to Skilled Nursing Facilities will not be eligible for ACT.

OUR IMPLEMENTATION STRATEGY

Advance Care Transitions (ACT) will implement a two-tiered approach to transitional care in the community. We have selected Care Transition Interventions (CTI) and an enhanced Transitional Care Model (TCM). A coordinated team approach will effectively carry out the program.

- At each hospital, a "Hospital Transition Team" which includes the hospital Nurse Case Managers/Discharge Planners, a Pharmacy Technician and a co-located ACT Community Coach/Nurse will work collaboratively to screen, educate and orient patients.
- Within the community, the ACT Community Coach/Nurse will lead a "Community Transition Team" which includes student nurses, pharmacy technicians and volunteers who will be assigned according to the needs of each patient.
- For those patients accepting ACT services, each will have a "Personal Health Team" that includes family, caregivers, clinical and transitional staff and volunteers, and, as needed, cultural, religious or recovery advocates Using this collaborative team approach the project will focus on and meet specific project objectives.