SOUTHEAST WASHINGTON CARE TRANSITIONS INTERVENTIONS PROGRAM

A partnership between SE WA Aging and Long Term Care (ALTC) CBO
Hospitals: Kennewick General Hospital, Yakima Regional Hospital,
Toppenish Community Hospital and Yakima Valley Memorial Hospital

OUR COLLABORATION

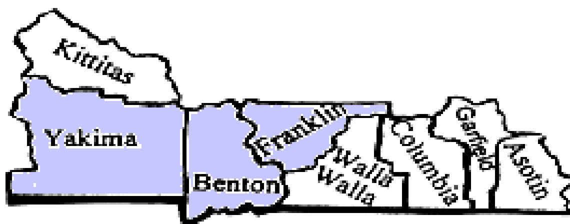
Kennewick General Hospital (high readmission hospital), Yakima Regional Hospital and its affiliate Toppenish Community Hospital, Yakima Valley Memorial Hospital are partnering with ALTC. Our partners have quality assurance programs that are working on a number of techniques to prevent avoidable hospitalizations, and have skilled staff who are engaging the community on methods of reducing avoidable ER visits and readmissions.

OUR PREVIOUS EXPERIENCE

SE WA ALTC has been working with the four participating hospitals on bridging hospital to home transitions using the Eric Coleman Care Transitions Intervention (CTI). The partners started working on Memorandums of Understanding (MOU) in January 2011, trained staff in the Eric Coleman model in September of 2011 and started the referral process in the latter part of September of 2011. SE WA ALTC is a community expert for elderly and disabled services in the home as the Aging and Disability Resource Center (ADRC), Family Caregiver Services and the Medicaid Case Management services and has a long history of working with the hospitals and medical community caring for mutual clients.

OUR COMMUNITY

This project will serve Yakima, Benton and Franklin counties in central and southeastern Washington. These communities have both metropolitan and large rural areas, are ethnically diverse and have many socio-economic challenges.



OUR TARGET POPULATION

Our target population includes Medicare beneficiaries with the following conditions:

- **Circulatory** (CHF, Stroke, Acute Myocardial Infarction, Atrial Fibrillation, PC with Drug Stent, Percutaneous Coronary Intervention)
- **Respiratory** (COPD, Asthma, Pneumonia, Pulmonary Failure)
- **Kidney and Urinary Tract** (UTI, Renal and Kidney failure)
- **Endocrine/Metabolic** (diabetes)
- **Digestive** (GI Obstructions, Pancreatitis)
- **Musculoskeletal**
- **Infection** (sepsis)
- **Skin** (cellulites)
- **Other** (dehydration)

OUR IMPLEMENTATION STRATEGY

The model to be used is Eric Coleman's Care Transitions Intervention (CTI). This is an evidence based model that works by helping beneficiaries to build skills for self-care. This model is built on four pillars of care: 1) Medication Self-Management, 2) Client-centered record 3) follow-up with beneficiary's medical provider(s) and 4) screening for, identifying and responding to "red flags," of potential medical concern. We chose this model because it is scalable, evidence based and allows us to use skilled social workers who have experience working with the hospitals and in the home and community. It also builds on self-management techniques that the beneficiary can use in many other settings and places them in the driver's seat. We will use the Personal Health Record (PHR), the Medication Discrepancy Tools (MDT) and the Care Transition Measure (CTM-3) from the Eric Coleman CTI tool kit. In addition we will incorporate the Patient Activation Measurement (PAM) during the home visit to evaluate and measure the beneficiaries' understanding of their medical condition(s) and their confidence in handling them. The Activated Behaviors Assessment Tool (ABA) will also be used to evaluate the beneficiaries understanding and confidence at the first home visit and during the last telephone call. The CTI coaching team is embedded in the Aging and Disability Resource Center that also houses the Family Caregiver Services and the Medicaid Title XIX Case Management and Chronic Care Management Program. This will allow for additional referrals and other support programs to help meet the needs of the beneficiaries and their families.