Tompkins County Rural Community Based Care Transition Program

Tompkins County Office for the Aging, Cayuga Medical Center, Visiting Nurse Service of Ithaca and Tompkins County, Hospicare and Palliative Care Services

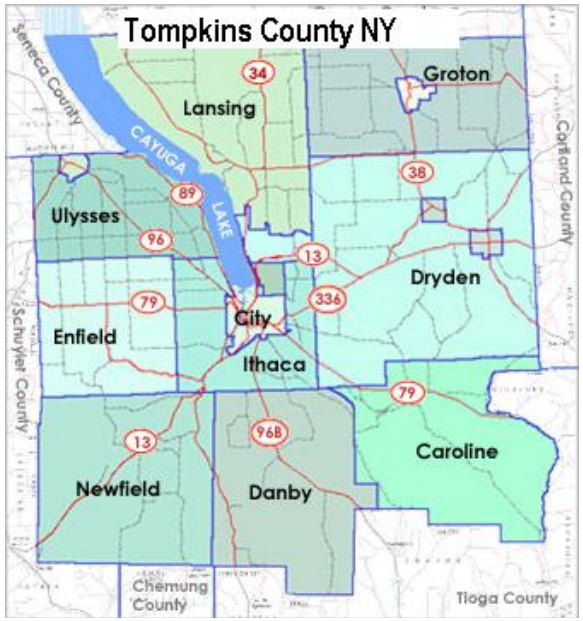
OUR COLLABORATION

Located in the Finger Lakes region of Central New York., our collaboration includes the Tompkins County Office for the Aging/ NY Connects/ADRC partnering with our area's sole hospital, Cayuga Medical Center. Visiting Nurse Service of Ithaca and Tompkins County and Hospicare and Palliative Care Services provide CTI certified transition coaches. Other key partners include Cayuga Ridge Extended Care (SNF), Beechtree Care Center (SNF), Health Planning Council of Tompkins County, Community Health Foundation of Western & Central NY, IPRO (QIO), and Tompkins County Department of Emergency Response.

OUR PREVIOUS EXPERIENCE

Through the Community Health Foundation of Western & Central NY, staff at Visiting Nurse Service and Hospicare and Palliative Care Services received training in the Care Transitions Intervention (CTI). Hospicare implemented two successful care transitions pilot programs utilizing CTI with oncology patients. NYConnects/Long Term Care Services partnered with Beechree Care Center (SNF) on a pilot program utilizing CTI with clients upon discharge. Most recently, as part of an AoA/NYSOFA funded pilot, the Tompkins County Office for the Aging has partnered with Cayuga Medical Center on a Community Supports Navigator Program, utilizing skilled and trained volunteers to assist with transitions and prevent problems leading to rehospitalizations.

OUR COMMUNITY



OUR TARGET POPULATION

After analyzing hospital readmission data, we targeted our intervention to include Medicare fee-for-service beneficiaries with the following primary or secondary diagnoses:

- Congestive heart failure
- Chronic obstructive pulmonary disease

We expect to reach approximately 428 people annually who are discharged from Cayuga Medical Center.

OUR IMPLEMENTATION STRATEGY

An extensive root cause analysis led us to the following problem statement: *Patients and family caregivers are not adequately prepared to manage their conditions during the transition between care settings in the absence of health care professionals, leading to symptom exacerbation, an increased likelihood of crisis, inappropriate health care utilization and readmission to the hospital.*

In order to address these issues, Dr. Coleman's Care Transition Intervention will be implemented with eligible patients. The community based CTI coach will arrange a home visit within 72 hours following discharge, followed by three follow up phone calls with the patient over a 30 day period. The CTI coach will also share information about NYConnects/ADRC as a source of additional information about community services.

In addition to CTI, the following programs and services will be emphasized:

- Use of Sharing Your Wishes and MOLST forms for advance health care planning
- Use of Next Step in Care resources to assist family caregivers to navigate care transitions
- Connection to evidence-based programming in the community, including the Stanford Chronic Disease Self-Management Program and Powerful Tools for Caregivers
- Teachback method will be utilized at the hospital to increase patients' understanding of their illness and care management