Aging and Disability Resource Centers
Implementing the Affordable Care Act:
Making it Easier for Individuals to Navigate Their Health and Long-Term Care through Person-Centered Systems of Information, Counseling and Access
Evidence Based Care Transition Program

State Agency: State of California Health and Human Services Agency

Name of ADRCs and Healthcare Partners:
Riverside ADRC and Riverside County Regional Medical Center
Orange ADRC and Area Hospitals Serving OneCare Members
San Francisco ADRC and St. Mary's Medical Center
San Diego ADRC and Sharp Memorial Hospital

Project Period: September 30, 2010 to September 30, 2012

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Evidence Based Care Transition Model: Care Transitions Intervention℠

Project Summary:
Four California Aging and Disability Resource Connection (ADRCs) programs are implementing the Care Transitions Intervention℠ (CTI): Riverside, Orange, San Francisco, and San Diego. Early data from the sites underscore the need to reach out and present the CTI to underrepresented communities. In response to these findings, California seeks to expand the current ADRC CTI program, with the goal of improving the care transitions experience and hospital readmissions among diverse and underserved communities at all four ADRCs.

Goal/Objectives:
Objectives for the expanded project are: 1) to identify diverse and underserved communities at each ADRC; 2) to develop and implement strategies to reach these patient populations; 3) to maintain a robust ADRC CTI Learning Community to share best practices; 4) to master train ADRC Transition Coaches in CTI; 5) to develop four ADRC business cases; and 6) to secure additional financial support for the transition coach positions.

Anticipated Outcomes/Results:
1) Increased CTI participation from identified diverse and underserved communities by 30% at Riverside and Orange ADRCs (baseline to be determined; total annual CTI patient target number per site is 100); 2) increased patient confidence and capacity in the CTI's four pillars; 3) improved hospital readmission rates for patients with chronic conditions; 4) improved critical pathways between hospitals and ADRCs; and 5) project sustainability through secured financial support from partner hospitals and other organizations that benefit from reduced hospital readmissions and reduced medication errors. Products from this project are: outreach strategies to diverse and underserved patients, four ADRC CTI business cases, and a final report.