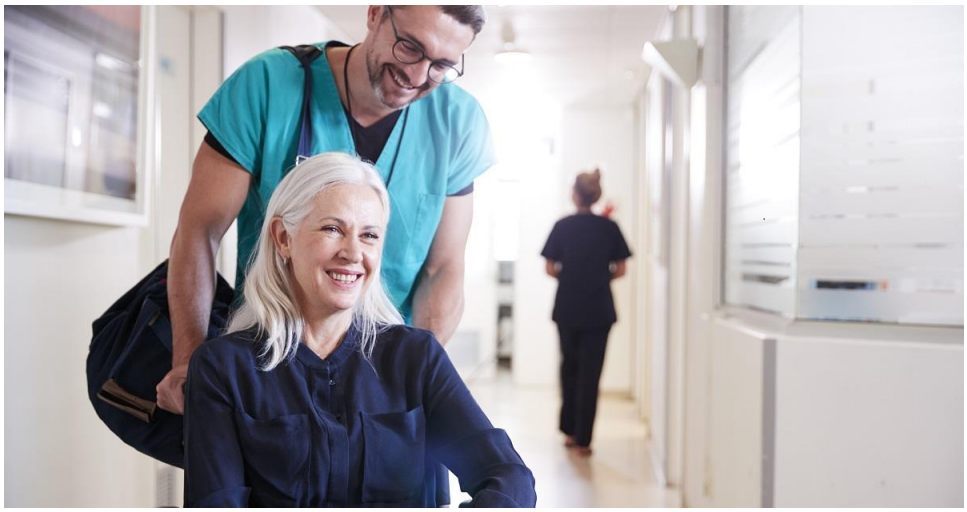
CASE STUDY: A 30-DAY POST-DISCHARGE CARE TRANSITION MODEL

Care Transitions Intervention Model to Manage Social Determinants of Health

By The Remington Report Editorial Team



The Care Transitions Intervention (CTI) program at Sharp Grossmont Hospital (SGH) provides 30-day post-discharge care transition coaching and community resources for underinsured or uninsured vulnerable patients (including homeless and refugee populations).

The CTI program involves a multidisciplinary team of healthcare professionals and is provided at no cost to patients by CTI "coaches" that include a registered nurse and medical social worker. Patients are identified as high-risk through SGH's comprehensive risk assessment tool that assesses for clinical as well as social risks.

Goals of the Model

The goals of the program are to improve quality of care, reduce readmission rates, and ensure patients have the resources to maintain their health and safety. In this program, collaborations with community organizations also connect patients to critical services such as access to fresh food, transportation, and social support. Through an innovative partnership with 2-1-1 San Diego, SGH can connect CTI patients with 2-1-1 health navigators to address both short- and long-term care needs and social determinants of health.

Results: Readmission Rates and Outcomes

From May 2014 to November 2016, 1,106 patients went through the program, with an overall average readmission rate of 13%. For patients who qualify for but do not accept CTI services, the average readmission rate is 22%.

The average readmission rate for calendar year (CY) 2016 (through November 2016) is only 9% among program participants. This notable decrease follows the implementation of 2-1-1 San Diego evaluation tool and connection services. In CY 2016, 62 CTI patients were referred to 2-1-1 San Diego's health navigation program. Of the patients that were referred to 2-1-1 and completed the program during CY 2016 (n=31):

- 24% decreased vulnerability regarding activities of daily living
- 38% decreased vulnerability regarding ambulance use
- 36% decreased vulnerability regarding health management
- 20% decreased vulnerability regarding housing
- 46% decreased vulnerability regarding income/employment
- 36% decreased vulnerability regarding nutrition
- 31% decreased vulnerability regarding primary care
- 44% decreased vulnerability regarding social support
- 16% decreased vulnerability regarding transportation

In addition, 95% of CTI patients referred to 2-1-1 San Diego felt confident in their ability and current plan to help them manage their health. This is a critical measure of patient self-efficacy that exemplifies the true goal of the CTI program – to maintain the health and well-being of community members after they have left SGH.

Lessons Learned

By tracking successful access to social supports (e.g., housing, medical homes, food distribution/CalFresh, and other community resources), in addition to readmission rates through 2-1-1 San Diego and Sharp's electronic medical records, respectively, the program's impact can be successfully evaluated by other hospitals interested in implementing this model.

It is this capability to track and measure program milestones that have communicated the positive impact of the CTI program for both patients and SGH, and these results have gained widespread recognition across Sharp HealthCare and in the community. Further, the partnership with 2-1-1 San Diego and the ability to evaluate the impact of specifically addressing social determinants of health as part

of whole-person care has presented this program as a successful practice in community health improvement.

Through root cause analysis of each readmission, the CTI team determined that lack of social supports (as opposed to disease process) is what truly brings patients back to the hospital. Thus, the health coaches have been central to identifying and connecting patients to the support services and community resources – particularly access to healthy food and 2-1-1 San Diego – that patients need to manage their care and maintain their health and safety. In addition, the development of a tool to understand patient needs, and the connection to critical community resources that address social determinants of health further contribute to the success of CTI.

The ancillary support for CTI has been critical to its success as well as its strong potential for expansion and the capacity to replicate the program in other hospitals. The intervention alone is not enough.

CTI has clinical specialists, pharmacy, community partnerships, and social connections in place, as well as hospital leadership support. Together, these elements result in a powerful collaborative impact. With strong leadership, a collaborative patient care team, and community partnerships to address social determinants of health, this program provides a successful model for hospitals to consider as they seek to measurably improve the health of their community.

Future Goals

Sharp Grossmont Hospital's CTI program is examining its current partnerships (both internal and external) for opportunities to improve access to community resources and help meet needs around social determinants of health, particularly access to healthy food and housing. These are complex challenges to community health, so leveraging current and growing new partnerships are essential to this component of the program, as well as to overall program maintenance and potential expansion.

Additional Insights on Social Determinants of Health

- 2023 Providers are Responsible for Social Determinants of Health Quality Measures