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Intensive Case Management:

A COMMUNITY APPROACH TO AVOIDING HOSPITAL READMISSIONS

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Presentation Outline

- Overview of CSA & Senior Case Management
- Evolution of the Program
- Program Implementation
- Program Structure
- Referral Process
- Data & outcomes
- Lessons learned

Background: CSA & Senior Case Management

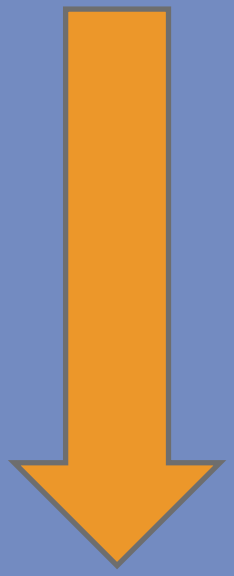
Overview

- CSA: 1957
- SCM: Goals
  - Eligibility
  - Service Delivery

Program Profile

- Age
- Ethnicity
- Income
- Strengths based

Program Evolution



- Direct Practice: Client Trends
- Research: National Trends
- Programs
- Community Interest

Intensive Case Management

- 2008: El Camino Hospital/Health Trust/Valley Foundation
- 2009: El Camino Hospital & Kaiser
- 2010-2011: El Camino Hospital
- 2011-2012: El Camino Hospital
- Scope of services

Client Eligibility

- 60 years +
- Recent Hospitalization
- Not a LTC
- No income requirement/ all services free
- Service Area

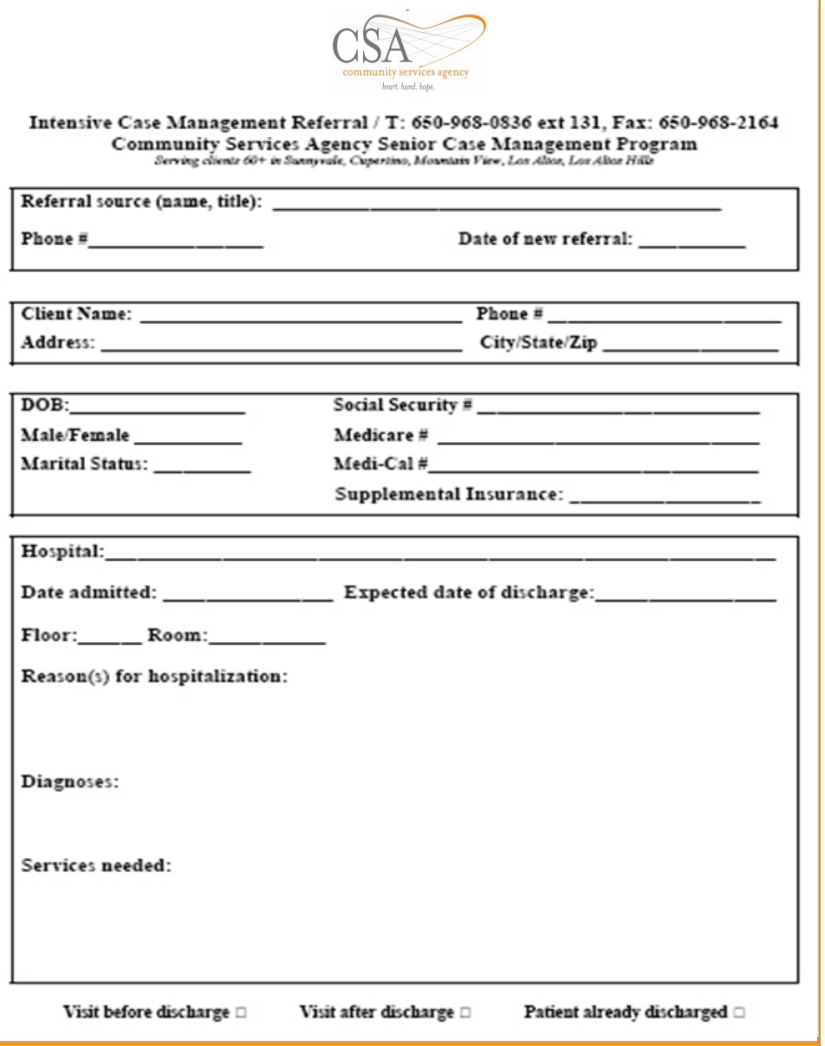
Program Structure

- Social Work Case Manager
- Nurse Case Manager
- Referral Process
- Initial Visit
- Assessments/interventions/monitoring

Referral Process

Community Referral Sources:

- El Camino Hospital Care Coordinators
- Home Health Agencies
- Mental Health programs
- Adult Day Health Care centers
- Senior Centers
- Primary Care Physicians
- CSA employees



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Intensive Case Management Referral / T: 650-968-0836 ext 131, Fax: 650-968-2164
Community Services Agency Senior Case Management Program
Serving clients 60+ in Sunnyvale, Cupertino, Mountain View, Los Altos, Los Altos Hills

Referral source (name, title): _____

Phone #_____ **Date of new referral:** _____

Client Name: _____ **Phone #** _____

Address: _____ **City/State/Zip** _____

DOB:_____ **Social Security #** _____

Male/Female _____ **Medicare #** _____

Marital Status: _____ **Medi-Cal #**_____

Supplemental Insurance: _____

Hospital:_____

Date admitted: _____ **Expected date of discharge:**_____

Floor:_____ **Room:**_____

Reason(s) for hospitalization:

Diagnoses:

Services needed:

Visit before discharge □ **Visit after discharge** □ **Patient already discharged** □

Common Reasons for Initial Hospitalizations

- 22% Fall
- 11% Stroke/ Transient ischemic attack
- 10% Orthopedic Surgery
- 8% Urinary tract infection
- 7% Pneumonia
- 7% Congestive heart failure
- 6% Heart attack/ Chest pain
- 4% Shortness of breath

* Data based on number of clients opened since program inception ; Clients may have been admitted for multiple conditions.

Other Reasons for Initial Hospitalizations

- 3% COPD
- 3% Cellulitis
- 3% 5150
- 3% Altered level of consciousness
- 3% Stoma surgery
- 2% Cirrhosis
- 1% Hematuria
- 2% Hyperglycemia
- 1% Panic attack
- 1% Dehydration
- 2% Anemia

* Data based on number of clients opened since program inception ; Clients may have been admitted for multiple conditions.

Chronic Conditions

- 54% Hypertension
- 33% Diabetes Mellitus
- 21% Heart Disease
- 19% Congestive Heart Failure
- 17% COPD
- 15% Depression
- 13% Stroke/ TIA
- 12% Dementia/ Alzheimer's Disease
- 11% Renal Failure
- 7% Diverticular Disease
- 6% Parkinson's Disease
- 6% Asthma

* Data based on number of clients opened since program inception ; Clients may have multiple chronic conditions.

Goals and Outcomes

Metrics	target	08/09	09/10	10/11	2008-2011
Unduplicated clients served	50	88	61	98	247
Hospital readmission rate 30 days post discharge	3%	3%	1%	2%	2%
Hospital readmission rate 1 year post discharge	8%	3%	8%	4%	5%
Clients or caregivers who increased medication knowledge & compliance	80%	N/A	88%	80%	84%
Clients or caregivers who increased chronic condition knowledge that promoted lifestyle changes	80%	N/A	76%	80%	78%
Clients who were able to remain independent outside institutional setting	90%	99%	97%	97%	97.6%

Lessons Learned

- Referral sheet
- Success stories
- Follow-up letters
- Client instructions
- Transition records
- Medication reconciliation record
- Partnerships