PIERCE COUNTY RESPONSIVE CARE COORDINATION PROGRAM - RCCP

*Pierce County Department of Community Connections Aging and Disability Resources (ADR) – Area Agency on Aging
*Franciscan Health System (FHS) *MultiCare Health System (MHS)
*Pacific Lutheran University (PLU) School of Nursing *Comprehensive Gerontologic Education Partnership (CGEP)

OUR COLLABORATION

RCCP is a dynamic partnership led by our Area Agency on Aging; the 2 major healthcare systems in the county (both operate 3 acute care hospitals and a multitude of primary care clinics in the county); the PLU School of Nursing; and the Comprehensive Gerontologic Education Partnership. "Together We Care," a county coalition including many county providers, stakeholders and consumers, is concurrently working to achieve outstanding care coordination for chronically ill community members, providing broad and synergistic energy and support to RCCP and additional collaborative community solutions.

OUR PREVIOUS EXPERIENCE

All RCCP partners have successful experience in care transition work, with varied services that enabled development of a strong , shared program tailored to our community's needs. A community-based care transition program provided by MHS Good Samaritan Hospital for the last 3 years significantly reduced hospital readmissions for heart failure patients. Based on Eric Coleman's Care Transitions Intervention, the program was enhanced over time with care management principles to accommodate community and patient needs. Aging and Disability Resources proactively incorporates transitional care into client services after hospitalizations through Chronic Care Management and Case Management programs. Established in February 2010, the Franciscan Transitional Clinic improves access to care for hospital patients who need timely primary care post-discharge. PLU School of Nursing & CGEP have partnered with MHS since 2008 to provide community-based follow-up by nursing students to heart failure patients.

OUR COMMUNITY

Located in the South Puget Sound region of Washington State, Pierce County encompasses socioeconomically and culturally diverse urban, suburban, rural and island communities in a 1,678-square-mile area. Pierce County is the state's second most populated county with 813,600 residents, and includes 23 incorporated cities and towns. 12% of residents lived below the federal poverty level in 2010, and 30% of residents belong to non-Caucasian racial and ethnic groups.

Pierce County has the state's second largest Medicare population, a high proportion of Medicare/ Medicaid dual eligible patients, and the second highest county rates for both hospital 30-day readmissions and readmissions/1,000 Medicare beneficiaries.

Pierce County is a federally designated Medically Underserved Area and half the county is a Primary Care Health Professional Shortage Area. Pierce County ranks 25th out of 39 WA counties in Health Outcomes and 24th in Health Factors (Robert Wood Johnson Foundation County Health Rankings 2011), with much worse rankings than the 3 surrounding counties (King, Thurston & Kitsap).

OUR TARGET POPULATION

1,500 Medicare and Medicare / Medicaid dual eligible beneficiaries will be served annually. Participants must live in Pierce County and be hospitalized with one of the following anticipated discharge diagnoses:

- CHF (or active episode of CHF within 6 months)
- Acute Myocardial Infarction
- Atrial Fibrillation

Root cause analysis of partner hospitals' admissions, state and county CHARS data, and other research data revealed that these three diagnoses rank among the highest for admissions and readmissions, and have high potential for effective care transition interventions.

OUR IMPLEMENTATION STRATEGY

Based on a complexity matrix developed from our root cause analysis, RCCP patients will receive tiered services based on need. These services will include:

- Enhanced Hospital Transition Services
- Post Hospitalization Telephonic Support
- Personalized Community Support Referrals
- Home Visits as needed
- Patient Advocacy Services during clinic visits

These services will be provided by Care Partners from all partner organizations. Care Partners will participate in weekly multidisciplinary case conferences to optimize quality of care and team coordination. In addition, PLU nursing students will be mentored in this care delivery model, adding their support to RCCP participants. Volunteers from both health systems are being trained to provide ongoing telephonic support, and we are also developing longer-term support services provided by our strong regional network of faith community nurses.