875

SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

FROM: Office on Aging

SUBMITTAL DATE: June 11, 2014

SUBJECT: Receive and file the Memorandum of Agreement (MOA) between Riverside County Office on Aging (OoA) and Riverside County Regional Medical Center (RCRMC) for Care Transitions Intervention (CTI) Program for FY2014/15. [Districts - ALL] [Total Cost: $50,000] [Source of Funds: Local: RCRMC]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Receive and file the MOA between OoA and RCRMC for CTI Program for FY2014/15;
2. Approve and direct the Auditor-Controller to make budget adjustments as outlined in the attached Schedule A for FY 2014/15; and
3. Direct the Clerk of the Board to retain one (1) copy and return (2) copies to the Office on Aging for further processing.

BACKGROUND:

Summary

In collaboration with Riverside County Regional Medical Center (RCRMC), Office on Aging will be providing Care Transitions Intervention (CTI) Transition Coach services for fiscal year 2014/15. CTI Coaching will assist RCRMC by preventing needless hospital readmissions among referred patients in the first 30 days post-discharge. CTI is an evidenced based program, consisting of a consultation with the

(Continued on Page 2)

Michele Haddock
Director

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost:	POLICY/CONSENT (per Exec. Office)
COST	$ 50,000	$ 0	$ 50,000	$ 0	Consent ☐ Policy ☒
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0	

SOURCE OF FUNDS: Local: RCRMC 100%

Budget Adjustment: Yes

For Fiscal Year: 2014/15

C.E.O. RECOMMENDATION: APPROVE

BY: Lani Sloson

County Executive Office Signature

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Jeffries, seconded by Supervisor Benoit and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes: Jeffries, Tavaglione, Stone, Benoit and Ashley
Nays: None
Absent: None
Date: July 1, 2014
xc: Office on Aging, Auditor

Kecia Harper-Ihem
Clerk of the Board
By: Deputy

Prev. Agn. Ref.: | **District: ALL** | **Agenda Number:** 3-32

FISCAL PROCEDURES APPROVED
PAUL ANGIULO, CPA AUDITOR-CONTROLLER
BY: Exec. Admin. Officer

Departmental Concurrence

FORM APPROVED COUNTY COUNSEL
BY: NEAL R. KIPNIS DATE

☐ Positions Added ☐ Change Order
☐ A-30 ☒ 4/5 Vote

BACKGROUND:
Summary Continued:
patient while in the hospital, a home visit following discharge, and follow up phone calls. Each contact addresses four key pillars proven to prevent readmissions.

The four pillars are medication self-management, use of a personal health record, primary care physician follow up, and knowledge of red flags indicating their condition is getting worse. CTI was formerly at RCRMC in FY 2009 through 2013 as a pilot project, at Desert Regional Medical Center (DRMC) in Palm Springs in FY 2012/13, and is currently in a one year pilot at JFK Medical Center in Indio, and Eisenhower Medical Center in Rancho Mirage.

Impact on Citizens and Businesses
The anticipated impact on citizens of Riverside County is positive. RCRMC patients will have access to the CTI Program upon discharging home, enabling them to learn medical self-management, to avoid costly readmissions for both patients and RCRMC. In addition, the strong partnership between OoA and RCRMC provides a continuity of care and smooth transition for RCRMC patients discharging from the hospital, enabling them to age in place in their homes in the community.

Locally, for the initial pilot program at RCRMC during the period of January through December 2010, patients who completed Care Transitions Intervention had a 30 day readmission rate of 15.73% compared to the overall Medicare 30 day readmission rate for RCRMC at 20.6%. From July 2011 - June 2012, the readmission rates for those who completed the CTI program at RCRMC were 9.88% versus those who did not complete the intervention, which had a readmission rate of 18.64%.

At the National level, key findings in the CTI program include significant reductions in 30-day readmissions, significant reduction in 90-day and 180-day readmits, and a net cost savings of $300,000 in avoided re-hospitalizations for 350 patients per each 12 month period.

SUPPLEMENTAL:
Additional Fiscal Information
This 1 year MOA between OoA and RCRMC is for $50,000 and is funded 100% by RCRMC for FY 2014/15. OoA match funding of $50,000 was included in the County budget process for FY2014/15.

ATTACHMENTS (if needed, in this order):

A. **BUDGET ADJUSTMENT** Schedule A attached.

Office on Aging
Schedule A
FY 2014/15

Increase Office on Aging Estimated Revenue:

21450-5300100000-774500	Health Services	$	50,000
	Total:	$	50,000

Increase Office on Aging Appropriation:

21450-5300100000-510040	Regular Salaries		31,183
21450-5300100000-518100	Budgeted Benefits		13,414
21450-5300100000-517000	Worker's Comp		929
21450-5300100000-527880	Training		457
21450-5300100000-529040	Private Mileage		2,000
21450-5300100000-527780	Special Program Expense		1,817
21450-5300100000-523720	Photocopying		200
	Total:	$	50,000

MEMORANDUM OF AGREEMENT (MOA)

BETWEEN
RIVERSIDE COUNTY REGIONAL MEDICAL CENTER (RCRMC)
AND
RIVERSIDE COUNTY OFFICE ON AGING (OoA)

I. PURPOSE OF MEMORANDUM

This Memorandum of Agreement establishes an interagency agreement between the Riverside County Office on Aging (OoA) and Riverside County Regional Medical Center (RCRMC) on the protocols between the two agencies to be used when referring patients to the OoA Social Worker for the Care Transitions Intervention (CTI) program. The protocols will apply to the Care Transitions Intervention project and relate to all referrals made for CTI. The program is to be implemented for a period of twelve (12) months effective July 1, 2014, and will end June 30, 2015. A minimum of 15 patients will be enrolled in the CTI monthly.

Both parties shall observe all Federal, State and County laws and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) of 1996, concerning the security and privacy of patient records and information.

No additional or alteration of the terms of the MOA, whether by written or verbal understanding of the parties, their offices, agents, or employees, shall be valid unless made in writing and formally approved and executed by both parties.

The Riverside County Regional Medical Center shall be responsible for reimbursing the OoA up to the maximum amount of $50,000 for services performed, products provided and expenses incurred as described in this agreement. Riverside County Regional Medical Center is not responsible for any fees or costs incurred above or beyond the contracted amount and shall have no obligation to purchase any services beyond this agreement.

II. BACKGROUND

On May 12 & 13, 2009 Dr. Monique Parish conducted training on Dr. Eric Coleman's Care Transitions Intervention. The training was conducted at the OoA and RCRMC Offices and staff participated in the training. On October 6 & 7, 2011, Traci Cornelius, MSW completed the training with Dr. Coleman in Denver, Colorado, to become a certified Master CTI Trainer with the understanding that Traci will train, oversee, and supervise the Transition Coach at RCRMC. CTI is a four-week intervention that supports patients to assert a more active role in their care. Patients receive specific tools and skills that are reinforced by a Transition Coach who follows

patients across care settings for the first four weeks after leaving the hospital, and focuses on four pillars:

1. **Medication Self-Management:** Focus: Reinforce the importance of knowing each medication—when, why, and how to take what is prescribed, and develop an effective management system.
2. **Personal Health Record** (PHR): Focus: Providing health management guide for patients; the PHR is introduced in the hospital visit and used throughout the program.
3. **Primary Care Provider/Specialist Follow-Up:** Focus: Enlist patient's involvement in scheduling appointment(s) with the primary care provider or specialist as soon as possible after discharge.
4. **Knowledge of Red Flags:** Focus: Patient is knowledgeable about indicators that suggest that his or her condition is worsening and how to respond.

III. AGREED UPON PROCEDURES

These components are addressed through a combination of visits and follow-up calls by the Transition Coach and the use of several care transition tools such as the Personal Health Record, attached hereto as Attachment A. The schedule of visits and follow-up calls represent the "stages" of the Care Transitions Intervention over the four-week intervention period and include the following:

- An initial hospital visit;
- one home visit scheduled 24-72 hours post-discharge;
- follow-up phone calls to the patient on days 2, 7, and 14 after discharge.

To flexibly address the patient needs, the calls may be either delayed or scheduled around specific events, such as appointments or home care encounters.

Target Population: Patients with one or more chronic health conditions such as Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, pneumonia, or others who have community discharges and who are at high risk for readmission are good candidates for CTI. Patients should be able either themselves or with a family member/advocate to engage in the coaching process. The patient must agree to voluntarily participate in the program and sign a release, attached hereto as Attachment B, acknowledging consent to participate.

Referral Process: Patients are to be referred to the Transition Coach based on information obtained on the daily admittance documents. The Transition Coach will participate in joint meetings with hospital staff in an effort to further identify potential patients for the program. The Transition Coach will also work with social workers and discharge planning staff to obtain referrals for the program.

The Transition Coach will be housed at RCRMC, and they will provide a workspace, telephone, computer, and access to electronic and/or paper hospital records.

Meeting Schedules: During the course of the project, the OoA Master CTI Trainer will meet with the designated hospital contact either in person or via phone on a quarterly basis at minimum. This contact will be to discuss progress and/or concerns in regards to the project.

Tracking/Data Collection: The Transition Coach will keep data collection records and provide them on a weekly basis to the Master CTI Trainer, who is designated as the supervisor for the Transition Coach.

Data collected will include the medical record number of patients enrolled in the CTI program, hospital discharge date, contact dates with Transition Coach, and 30 day readmission status. This log will also indicate whether or not the patient completed the intervention.

IV. CONCLUSION

Riverside County Regional Medical Center and Office on Aging are committed to working together to build an effective means of improving care transitions from hospital to home.

This MOA shall be in effect for a period of twelve (12) months effective July 1, 2014, and will end June 30, 2015 unless terminated earlier by either party upon thirty (30) days written notice.

The undersigned being duly authorized by the respective agencies, have agreed to these terms.

RIVERSIDE COUNTY REGIONAL MEDICAL CENTER

Annette Greenwood 5/15/14

Annette Greenwood, CEO Date

RIVERSIDE COUNTY OFFICE ON AGING

6-11-14

Michele Haddock, Director Date

FORM APPROVED COUNTY COUNSEL

BY: NEAL R. KIPNIS DATE

RIVERSIDE COUNTY OFFICE ON AGING

Care Transitions Intervention (CTI) Program

Application, Informed Consent, and Grievance Policy

The Care Transitions Intervention Program is a four week intervention, with the goal of empowering patients and their caregivers to increase their confidence in managing their health care, and avoiding repeat hospitalizations and unnecessary institutionalization.

The CTI will consist of a hospital visit by the Transition Coach, a home visit by the Coach, and three follow up phone calls. Each contact with the Coach will focus on the four pillars of CTI:

- Medication self-management
- Use of a patient-centered health record (PHR)
- Primary Care Provider and specialist follow-up
- Patient understanding of "red flags" indicating that condition may be worsening, and appropriate next steps

There is no charge for participation in the CTI Program.

Any personal and health related information collected from the patient and /or caregiver and the hospital will be kept confidential, and will not be used for any other purpose. Participants will not be individually identified in any public report about this program. Participants have the right to revoke this authorization at any time. Participants can initiate a grievance by contacting the CTI Supervisor in writing, at the address below.

Traci D Cornelius
Care Transitions Intervention Supervisor
Riverside County Office on Aging
6296 River Crest Drive, Suite K
Riverside, CA 92507

This authorization is effective immediately and expires in one year.
You will be given a copy of this authorization.
You may inspect or obtain a copy of the health information that you are being asked to disclose.

Print Name: _____

Signature of participant or caregiver: _____

Date signed: _____

PERSONAL HEALTH RECORD

Of

_____

REMEMBER:
Take this Record with you
to all of your doctor visits

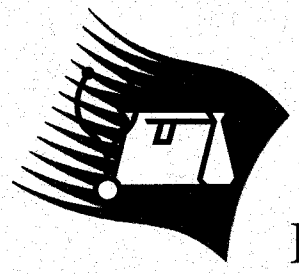
Your Transition Coach _____
(____) ____ - _____

Discharge Preparation Checklist

Before I leave the care facility, the following tasks should be completed:

- ☐ I have been involved in decisions about what will take place after I leave the facility.
- ☐ I understand where I am going after I leave the facility and what will happen to me once I arrive.
- ☐ I have the name and phone number of a person I should contact if a problem arises during my transfer.
- ☐ I understand what my medications are, how to obtain them, and how to take them.
- ☐ I understand the potential side effects of my medications and whom I should call if I experience them.
- ☐ I understand what symptoms I need to look out for and whom to call should I notice them.
- ☐ I understand how to keep my health problems from becoming worse.
- ☐ My doctor or nurse has answered my most important questions prior to leaving the facility.
- ☐ My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- ☐ If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

This tool was developed by Dr. Eric Coleman, UCHSC, HCPR, with funding from the John A. Hartford Foundation and the Robert Wood Johnson Foundation.



Provider Information

Primary Care Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

Other Providers:

_____

_____

_____

Personal Goal

_____

_____

_____

_____

_____

_____

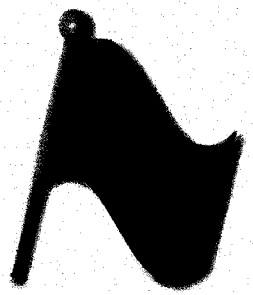
Recent Hospitalization dates: _____

Reason for Hospitalization:

_____

_____

_____



Red Flags (Symptoms that indicate I might need to see my doctor)

_____

_____

_____

_____

_____

_____

_____

Notes and Questions for my Primary Care Physician:

Medication Record

Write down only those medications you are taking, including over-the-counter and vitamins

Allergies: _____

Name	Dose	Reason	New?

Medication Record continued

Write down only those medications you are taking, including over-the-counter and vitamins

Name	Dose	Reason	New?

OFFICINA DE LA TERCERA EDAD DEL CONDADO DE RIVERSIDE

Programa de Intervención para Transiciones de Cuidado

Solicitud, Información de Consentimiento, y Poliza de Quejas

El Programa de Intervención para Transiciones de Cuidado es un programa de cuatro semanas, con el propósito de ayudar a los pacientes y las personas que los cuidan para que tengan confianza en el manejo del cuidado de su salud y evitar hospitalizaciones o institucionalidades innecesarias.

El Programa de Intervención para Transiciones de Cuidado consiste en una visita en el hospital de un Entrenador de Intervención para Transiciones de Cuidado, una visita al domicilio y tres llamadas de seguimiento. Cada contacto con el Entrenador de Intervención para Transiciones de Cuidado se enfocará en los cuatro siguientes pasos:

- Cuidado personal de Medicamentos
- Record de salud centrado en el paciente. (PHR)
- Seguimiento con su Doctor General o por un especialista (si es necesario).
- Buen entendimiento sobre las señales que indiquen que su condición puede estar empeorando y requieran atención médica.

Este programa es gratuito.

Toda información personal y de salud proporcionada por el paciente o la persona que lo cuida o por el hospital será confidencial. Los participantes no serán identificados individualmente en ningún reporte público de este programa. Los participantes tienen derecho a revocar esta autorización a cualquier momento. Los participantes pueden iniciar una queja contactando al Supervisor del Programa de Intervención de Transiciones de Cuidado por escrito, a la siguiente dirección:

Traci D Cornelius
Care Transitions Intervention Supervisor
Riverside County Office on Aging
6296 River Crest Drive, Suite K
Riverside, CA 92507

Esta autorización entra en efecto inmediatamente y expira en un año.
Usted recibirá una copia de esta autorización.
Usted puede inspeccionar y obtener una copia del informe de salud que se le ha pedido que nos proporcione.

Nombre: _____

Firma del paciente o persona que lo cuida: _____

Fecha: _____