



Carondelet – Pima Council on Aging Transitional Care Navigation Program
 Carondelet Health Network - including Carondelet St. Joseph Hospital, Carondelet St. Mary's Hospital and Carondelet Heart and Vascular Institute, Pima Council on Aging and University of Arizona's Center on Aging



OUR COLLABORATION

Carondelet Health Network (CHN) is the largest faith-based integrate health care delivery network in Southern Arizona. Carondelet St. Joseph's Hospital, identified as a high readmission hospital, will lead the efforts along with Carondelet St. Mary's Hospital and Carondelet Heart and Vascular Institute. Pima Council on Aging (PCOA) is the county's Area Agency on Aging and will be the Community Based Organization for the Project. PCOA has extensive experience in serving the needs of the community, including health coaching and community case management services. The University of Arizona's Center on Aging will provide the professional education for the health professional team.

OUR PREVIOUS EXPERIENCE

CHN has 30 years of experience in delivering innovative and successful community programs. CHN was one of four CMS Community Nursing Organization Demonstration Projects for six years and currently has a nationally-recognized diabetes continuum of care. In 2010, CHN implemented its Transitional Heart Failure Program based on University of Pennsylvania's Naylor-model utilizing expert nurses. PCOA has been part of the AZ Department of Adult and Aging Services Care Transitions Programs and partnered with CHN in 2011 to be part of the CHN Transitional Heart Failure Program.

OUR COMMUNITY

Carondelet Health Network has three hospitals in Tucson, the second largest city in Arizona located in Pima County. CHN also operates a fourth hospital in Nogales, AZ, a border community located in Santa Cruz County. CHN also is a hospital provider for Cochise and Greenlee counties southeast of Tucson. CHN's service area has a high Hispanic population and is also home to the Tohono O'odham and Pascua Yaqui Nations. Overall, CHN serves more than 1.55 million people and reports more than 26,212 Medicare admissions annually from these counties.

OUR TARGET POPULATION

As a major community care provider for low income, underserved patients, CHN hospitals serve a high proportion of minority, low income patients, many of whom are Mexican-American, Spanish speaking patients. Forty-three percent of CHN patients are elderly and more than 41% are Hispanic. The percent of CHN patients at or below poverty (20%) far exceeds local, county, state and national data. Low functional health literacy related to aging, cultural disparities and poverty are major factors in inadequate care transitions, poor follow up with providers, low utilization of community resources and inadequate self-management of chronic disease. Therefore, the Medicare and Dual Eligible populations are the target population for the CHN-PCOA Transitional Care Navigation Program.

OUR IMPLEMENTATION STRATEGY

The Carondelet-Pima Council on Aging Transitional Care Navigation Program will focus on four evidence-based strategies related to the need for enhanced communication among inpatient and community providers and the need for improved patient self-management in the care transition phase. These strategies are: 1) a customized intervention based on Boston University's Re-engineered Discharge (RED) process at all three participating hospitals. This will include culturally-appropriate, bilingual patient education, comprehensive discharge planning, post-discharge home-based services and telephonic visits reinforced by web-based telehome monitoring devices; 2) an expansion of the Carondelet Transitional Heart Failure Program to include AMI and pneumonia using CHN Transitional Care Nurses and PCOA Social Workers and Navigators to transition patients across care settings for up to 60 days using risk stratification measures to assess the patient's health status; 3) Health information exchange (HIE) will be more meaningfully employed to improve coordination of care through a Transition of Care (ToC) web-based platform. This HIE intervention will support ToC chronic disease management processes and protocols that will enhance electronic communications between all care providers and the patient within a medical home environment; and; 4) Pima Council on Aging will provide social support and referrals for aging-related services and ensure that patients receive those supplemental needs otherwise unavailable through Medicare or Medicaid. The University of Arizona Center on Aging and Arizona Geriatric Education Center will deliver a high quality patient navigation training to the Carondelet-PCOA Care Transitions Team.