Care Transitions Initiative/ Healthy at Home

CTI/HAH

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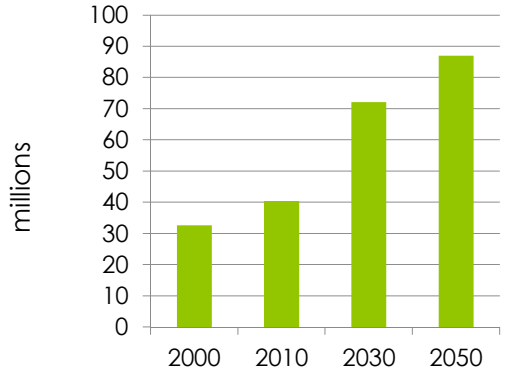
Client Story

Aging Statistics 65 + years



CTI - What and Why

- Home-based patient navigation program
- To prevent readmission to hospital for 30 days for people with a diagnosis of:
  - Pneumonia
  - Congestive Heart Failure
  - Heart attack
  - COPD
  - Diabetes
- 93% Success Rate

Pillars of CTI

- Medication management
- Use of a dynamic patient-centered record
- Primary care and specialist follow-up
- Knowledge of red flags

Table 1: The Four Pillars of Care Transitions Intervention	
1. Medication self-management	The patient is knowledgeable about medications and has a medication management system.
2. Use of a dynamic patient-centered record	The patient understands and utilizes the Personal Health Record (PHR) to facilitate communication and ensure continuity of care plan across providers and settings. The patient or informal caregiver manages the PHR.
3. Primary care and specialist follow-up	The patient schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.
4. Knowledge of red flags	The patient is knowledgeable about indications that their condition is worsening and how to respond.

Source: http://www.caretransitions.org/physicians.asp

But wait!!

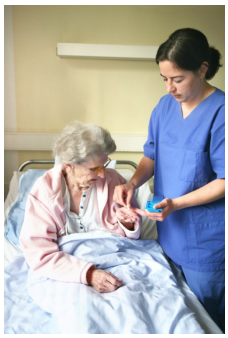
There's more….

we now have a fifth

NUTRITION!

How it Works

- Finding clients
- RD Referrals
- Setting appointments in the home
- The visit!



The Visit- What we do!

- Nutrition assessment
  - Medical conditions
  - Medications
  - Lifestyle
- Help set BEHAVIORAL goals
- Small steps

What we are NOT!

What the Future Holds

- By 2045 more seniors years than children
- Healthcare costs
- Healthcare savings
- Where do you want to be?