Project Independence Plus: Addressing the Gap in Transition Care Services
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Project Summary

Project Independence Plus: Addressing the Gap in Transition Care Services aims to serve those who are left behind by the Affordable Care Act's (ACA) 30-day Hospital Readmission Reduction Program (HRRP). Project Independence Plus (PI Plus) builds on the proven success of Project Independence, a hospital to home transition care program that is over a decade ahead of ACA's HRRP. PI Plus is an expansion of Project Independence's efforts that will focus on the following populations that are left behind by ACA's hospital 30-day readmission reduction initiatives: (1) older adults who are returning home after a skilled-nursing rehabilitation who are not served by ACA's hospital readmission reduction program; (2) hospitalized adults age 50-59 with complex medical conditions who are at risk of developing chronic illnesses; and (3) individuals who score low in activation who live alone or lack social support when they return home from hospitals or skilled-nursing facilities. At least 40% of the clients that will be served by PI Plus will be Medicaid and dual eligible Medi-Medi populations. The program will assemble a coalition of health, mental health, and social service agencies that will collaboratively and collectively address the needs of these populations. PI Plus would be most attractive to health care and social service organizations that disproportionately serve the safety net populations.

Project Independence was developed by Marin County's Department of Health and Human Services in 2001. The program provides person-centered, community-based transition care services offered free of charge and includes care planning, home visiting, and health coaching. Transportation to appointments, medication management support, and referrals to services and resources are also provided. The Project Independence team includes public health nurses, community volunteers, and nursing students that are highly in transition care intervention models. Since its inception, Project Independence has served over 1,000 Marin residents. Compared to more than 20% nationally and 18% in California, only 6% of Project Independence clients were readmitted to hospitals within 30 days of discharge.

As a result of a strategic planning process in the fall of 2013, Project Independence was reengineered in order to adapt to the changing healthcare landscape and reassess program capabilities. Three levels of intervention were developed out of this process: (1) PI Lite: coaching model using Dr. Eric Coleman's Care Transition Intervention; (2) PI Traditional: administered by a team of highly-trained volunteers and nursing students under supervision of a Public Health Nurse; and (3) PI Plus: a care management approach for clients with low activation and those who have multiple and complex needs. PI Lite and PI Traditional were piloted in January 2014 and have been fully implemented. PI Plus was deferred, as addressing the needs of these more vulnerable populations is beyond Project Independence's capacity and would require the development of a strategy that brings other stakeholders to the table. The Practice Change Leaders program provides an incredible opportunity to develop PI Plus.