Central Mass/MetroWest Transitions in Care Collaborative

Elder Services of Worcester Area, BayPath Elder Services, MetroWest HomeCare & Hospice, MetroWest Medical Center, Saint Vincent Hospital, UMass Memorial Medical Center, Clinton Hospital, HealthAlliance Hospital, Marlboro Hospital, Wing Memorial Hospital, Southboro Medical Group, Reliant Medical Group, Mary Ann Morse Nursing & Rehab, Radius HealthCare Centers, Montachusett Home Care Corp.

OUR COLLABORATION

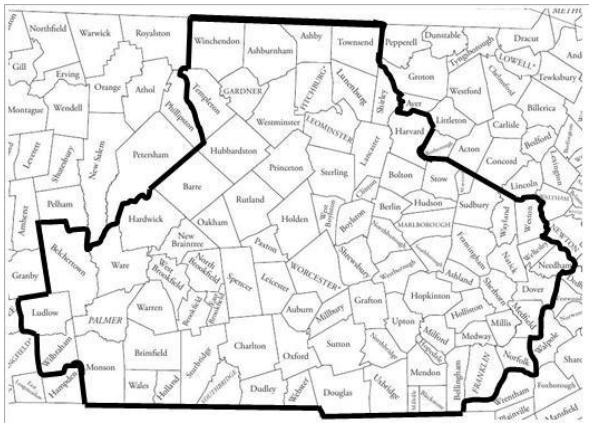
Our collaboration has created a partnership of 2 hospital systems, including 2 high readmission hospitals and 7 additional hospitals, community-based Aging Services Access Points and Area Agencies on Aging, home care, hospice, primary care physician practices, skilled nursing facilities and rehabilitation centers. Within the Central Mass/MetroWest regions many of the partners were historically competitive but have come together to redesign patient-centered care practices aimed at reducing avoidable readmissions.

OUR PREVIOUS EXPERIENCE

Beginning in 2009 the partners participated in the IHI STAAR Initiative across the 2 hospital systems. From this foundation each system created Transitions in Care (TIC) Teams and additional initiatives.
In 2010 MetroWest HomeCare & Hospice implemented Telephonic Care, Transition Care Coach and Palliative Care interventions in collaboration with MetroWest Medical and Saint Vincent Hospitals. The UMass Memorial system worked extensively on reducing readmissions for patients with HF. 28 staff from the Aging Services Access Points were trained as Coleman Coaches in 2010 and 2011 and the coaching model was implemented with community-based elders across the region.

OUR COMMUNITY

90 communities in Worcester County and portions of Hampden, Hampshire, Middlesex and Norfolk Counties in Central & MetroWest Massachusetts



OUR TARGET POPULATION

Each model has a slightly different target population.

- Patients with at-risk diagnoses used in the Coleman study.
- Patients being discharged without family or friends at home will be assessed for risk.
- Medicare fee-for-service patients with one of 3 high impact diagnoses.
- All Medicare fee-for-service patients admitted with the 11 Coleman diagnoses.
- Patients with any other diagnosis admitted 2 or more times in 12 months.
- Seriously ill patients referred to palliative care.

OUR IMPLEMENTATION STRATEGY

Elder Services of Worcester Area is the lead CBO for this large collaborative. The TIC Collaborative has been created to provide a broad spectrum of interventions and services to patients at high risk of readmission.

Coleman Coaching

- 1 hospital visit
- 1 home visit
- 3 phone calls within 30 days
- Personal Health Record

Coleman Coaching+Special Support Services

- Above services
- 6 hours of case management post-discharge
- 6 hours of in-home services post-discharge

Transition Care Coach RN

- 1 hospital visit
- 1 home visit OR 1 SNF visit prior to d/c from SNF
- 2 phone calls per week for 30 days
- 24/7 med planner, scale, other items needed to monitor and mitigate exacerbation of symptoms
- Personal Health Record

Telephonic Support

- 4 follow-up phone calls post-discharge
- Diagnosis specific script
- Gaps in care escalated to Care Transition Nurses for intervention

Palliative Care

- Palliative Care Team member meets with the patient and caregiver (as appropriate)
- Patient's wishes are discussed & options offered

Our Mission: To provide the right care for each patient at the right time in the right care setting