Southeast Michigan Community-Based Care Transitions Coalition

Area Agency on Aging 1-B in partnership with
Henry Ford Hospital Macomb, McLaren Oakland Hospital, and
William Beaumont Hospital - Troy

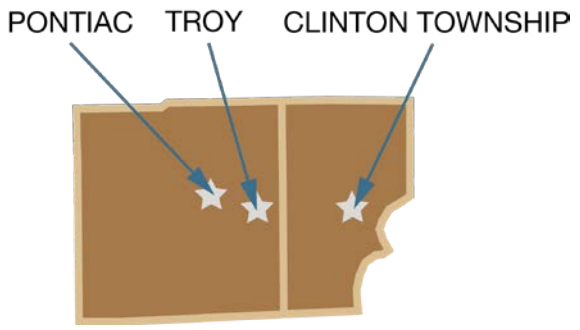
OUR COLLABORATION

- Three high readmission hospitals
- Ten skilled nursing facilities
- Three hospice organizations
- Three skilled home health care agencies
- One personal emergency response/tele-health provider
- One visiting physician provider
- MPRO, the Michigan QIO
- One behavioral health organization
- One Six Sigma quality improvement company

OUR PREVIOUS EXPERIENCE

- A 2010 Care Transitions Study in collaboration with major regional health systems
- AAA 1-B Care Transitions Intervention pilot programs with two hospitals
- Coleman trained CTI Transitions Coaches
- Six years of experience implementing Nursing Facility Transition program
- Hospital patient nursing home diversion program
- Development of telephonic care management skills and protocols
- Participation in Michigan State Action on Avoidable Readmissions coalition

OUR COMMUNITY



Serving Macomb and Oakland Counties

OUR TARGET POPULATION

High risk Medicare fee-for-service beneficiaries discharged from hospital to home or a skilled nursing facility with the following primary conditions or history:

- COPD
- CHF
- Pneumonia
- AMI
- Previous readmission within 30 day period
- Other high risk patients identified through hospital screening

OUR IMPLEMENTATION STRATEGY

The intervention utilizes the Care Transitions Intervention model developed by Dr. Eric Coleman, with additional supports and strategies which wrap around the CTI, and that are targeted to specific populations. The five core strategies are:

1. CTI Transitions Coaching
2. CTI Transitions Coaching with the provision of additional supportive services for individuals with unmet needs
3. CTI Transitions Coaching by a behavioral health specialist with linkages to behavioral services
4. Transitions Coaching with directive interventions and services for patients who are unsuccessful at self activation
5. Transitions Coaching for patients discharged to skilled nursing facilities.

Our root cause analysis and transitions coaching experience found that many patients have unique circumstances or characteristics that appear to contribute to avoidable readmissions, such as behavioral problems, inability to access needed community-based supports and services due to cost and lengthy wait lists, and cognitive impairments or dysfunctional environments which diminished capacity for self activation, so strategies were developed for these populations. High readmission rates were found for targeted patients discharged to skilled nursing facilities, so a strategy was developed that bridges communication for 96 hours after discharge.