Merrimack Valley Care Transitions: A Collaborative Approach
In Partnership with
Anna Jaques ~ Holy Family ~ Lawrence General ~ Merrimack Valley ~ Saints Memorial

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey
360 Merrimack Street, Bldg. #5, Lawrence, MA 01843

OUR COLLABORATION

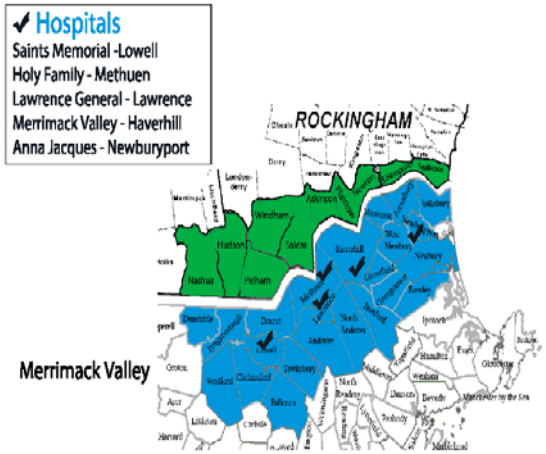
Our model includes collaboration with 5 acute care hospitals and improved collaboration with multiple SNFs, home health agencies, primary care practices and a Federally Qualified Health Center. Our hospital partners include Anna Jaques (High Readmission), Lawrence General, (Medically Underserved), Saints Memorial (Previous Care Transition Experience), Merrimack Valley, Holy Family (Small Community Based)

OUR PREVIOUS EXPERIENCE

ESMV and 5 Merrimack Valley hospitals have been working together through an Institute for Healthcare Improvement (IHI) learning collaborative called State Action to Avoid Re-hospitalization (STAAR) since 2009. The program aims to reduce preventable readmissions by implementing multi-disciplinary and multi-organizational collaboration. The hospitals are each in different stages of performing root cause analyses, strengthening community relationships, and implementing evidence-based interventions. ESMV is part of each STAAR team and support the hospitals with discharge planning .We also developed and implemented a self-funded care transitions pilot project. Dr. Eric Coleman provided Care Transitions Intervention℠ (CTI) training to eight ESMV Transitions Coaches™ who lead ESMV's care transitions teams. ESMV has trained 81 staff of nurses and care managers in the CTI model. 13 are bilingual in Spanish, 6 in Khmer, and we have bilingual capacity in Greek, Russian, Portuguese, and Italian.

OUR COMMUNITY

33 towns in the Merrimack Valley of Massachusetts and Southern New Hampshire



OUR TARGET POPULATION

Our target population is approximately 15,482 Medicare FFS, all cause- hospital discharges, of which 84% are eligible for CCTP. We expect to serve 7,853 unduplicated beneficiaries. Eligibility will depend on level of risk which is determined through an enhanced risk screening. Risk level determines types of intervention beneficiaries receive

OUR IMPLEMENTATION STRATEGY

We found the following Root Causes categories through our analysis:

1. Inadequate Care Coordination
2. Health systems Failures
3. Poor Patient/Caregiver Understanding
4. Behavioral Risks
5. Environmental Risks
6. Clinical Risks
7. Cultural Barriers

Our primary intervention is the use of the Coleman CTI Model with ESMV designed enhancements addressing various root causes indentified such as home safety. PCP follow-up assistance, enhanced communication via warm transfer from hospital to SNF (utilizing various models) and light touch Care Transitions will be used after SNF placements for high risk.

Other interventions based on the specific risks identified per eligible participant:
A. Immediate at-home services (a rapid response at discharge and services the first week if participant is not eligible for existing services); addresses 1,2,3,6
B. Interpretation - general and medical interpretation and advocacy by trained bi-lingual coaches and volunteer advocates; addresses 1,2,3,7
C. Mental Health - practical mental health interventions to encourage compliance and follow up with Mental Health systems; addresses 2,3,4,5,6
D. Patient Self Management - group and individual evidenced based interventions; 3,4,6,7
E. One Time Basic Necessities; 1,5,6
F. Nutritional Coaching and Assessment - home based; 3,4,5,6,7
G. Enhanced Home Health; 4,6
H. ESMV Community services (services not paid by CCTP but existing and fully utilized); 1-7