Southern Maine Agency on Aging/ ADRC
MMC Physicial-Hospital Organization
MaineHealth
Southern Maine Medical Center, Maine Medical Center, Mid-Coast Hospital, Miles Memorial Hospital, PenBayMedical Center

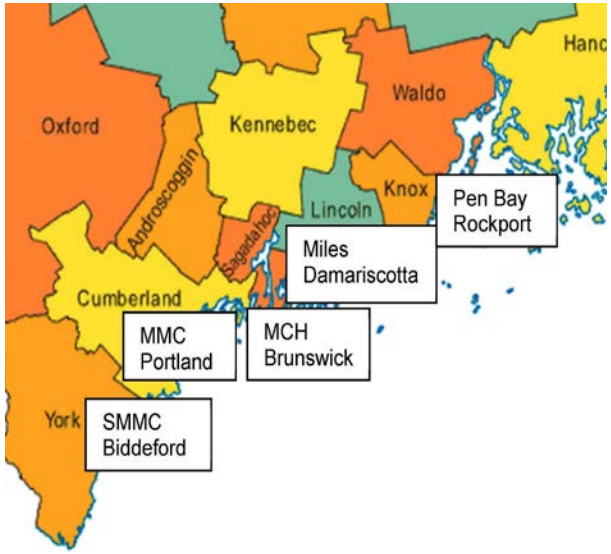
OUR COLLABORATION

Participating hospitals include Southern Maine Medical Center, Maine Medical Center, Mid-Coast Hospital, Miles Hospital, and PenBay Medical Center (HRH). Other key partners are MaineHealth and the Spectrum Generations AAA/ADRC. MaineHealth brings the root cause data analysis and systems leadership capacity to our collaboration. Spectrum Generations provides community resource coordination for three counties outside the SMAA service area. The MMCPHO provides the critical connection with the five hospitals and medical practices.

OUR PREVIOUS EXPERIENCE

In 2006, the MMC PHO care management staff received training by Dr. Eric Coleman in the Care Transition Intervention™ (CTI) model as the first step toward implementing a care transitions pilot project in 2007, in collaboration with MaineHealth's Partnership for Healthy Aging. After the successful pilot, MMC PHO initiated its Care Transitions Program in 2008 at Maine Medical Center. Over the past three years, the CTI has expanded to four additional MaineHealth hospitals. In 2010, the Southern Maine Agency on Aging (SMAA)/ADRC partnered with the MMC PHO to enhance the model by providing social work support and community resource development to CTI patients as part of an AoA-funded demonstration project.

OUR COMMUNITY



OUR TARGET POPULATION

The target population includes 5,700 Medicare beneficiaries living in five southern Maine counties with multiple chronic conditions identified as being at risk based upon the following root cause findings:

- 100% of readmitted had Polypharmacy or need for Med Reconciliation
- Only 50% of patients had a scheduled follow up visit; of those that did, 43% did not keep the appointment.
- 30% did not understand their medications
- 30% left the hospital unprepared to meet their health management responsibilities (CTM 3 measures)

OUR IMPLEMENTATION STRATEGY

Our partner hospitals are implementing a MaineHealth system-wide Transitions of Care Bundle (comprised of Project Red & BOOST components, including risk stratification, discharge checklist, medication reconciliation, patient/family education through teach back methodology, timely communication, and timely follow-up visit post-discharge) . As part of a multi-approach strategy, the five hospitals recognize the importance of the Care Transitions Intervention™ (CTI) and will refer patients who can benefit from the CTI.

In addition to the expansion of the CTI to two new hospitals (PenBay and Mid-Coast) the SMAA/ADRC and partners will build upon the current efforts to increase the rate of adoption and implementation of the 8 P risk assessment at admission to assure that patients are appropriately identified and referred to the CTI. The root cause analysis identified the opportunity increase the number of patients offered the CTI if they are identified better as at risk for readmission.

SMAA/ADRC and MMC PHO are in year two of an AoA-supported ADRC/Care Transitions Intervention ™ collaboration. We have added to the Care Transition team an ADRC Senior Resource Specialist, a social worker who works closely with the Care Transition Coach to identify and connect patients with resources in their communities. We plan to expand this service model to additional MaineHealth hospitals and communities.