Southwest Ohio Community Care Transitions Collaborative

Council on Aging of Southwestern Ohio in collaboration with: Greater Cincinnati Health Council, Hamilton County Mental Health and Recovery Services Board, HealthBridge, Health Care Access Now, Health Collaborative, Clinton Memorial Hospital, Jewish Hospital, Mercy Hospital Fairfield, The Christ Hospital, UC Health/University Hospital.

OUR COLLABORATION

COA has partnered with the Greater Cincinnati Health Council, Hamilton County Mental Health and Recovery Services Board, HealthBridge, Health Care Access Now, Health Collaborative. In addition, five regional hospitals in urban and rural settings joined the Collaborative: Clinton Memorial Hospital (21st), Jewish Hospital (8th), Mercy Hospital Fairfield, The Christ Hospital, and UC Health/University Hospital (University Hospital) (1st). (Rank on CMS list of hospitals with high readmission rates.)

OUR PREVIOUS EXPERIENCE

COA has been providing CTI at University Hospital for almost one year where COA has delivered impressive results and has recently expanded to The Christ Hospital. COA is considering expansion to a third hospital. In addition, COA has the technology, operational monitoring, and financial management background to ensure results.

The remaining partners in the collaboration have extensive experience using health information technology to provide patient alerts, employing quality management tools to standardize processes, managing quality, establishing community-wide best practices, and providing care coordination that connects patients to resources and health care providers.

OUR COMMUNITY

The Collaborative will serve patients admitted to one of the five participating hospitals. We anticipate the majority of the patients living in the Cincinnati – Middletown – Wilmington Combined Statistical Area which includes these counties:

Indiana: Dearborn, Franklin, and Ohio

Kentucky: Boone, Bracken, Campbell, Gallatin, Grant, Kenton, and Pendleton

Ohio: Butler, Brown, Clinton, Clermont, Hamilton, and Warren

OUR TARGET POPULATION

The targeted population was defined following analysis of COA's pilot program, local hospital admission data, and numerous national studies. The target population includes:

- Patients who are admitted to a partner hospital; and,
- 65 and older; and,
- Medicare fee for service; and
- Have an admitting diagnosis with a historically high readmission rate (Heart Failure, Heart Attack, and Pneumonia); and/or
- Have multiple (two or more) chronic conditions

OUR IMPLEMENTATION STRATEGY

Council on Aging of Southwestern Ohio (COA) will lead the Southwest Ohio Community Care Transitions Collaborative to expand COA's existing Care Transitions Intervention ^{SM} (CTI) program. The Collaborative will build a comprehensive system that joins hospitals, physicians, health information technology, and community-based programs to address region-specific factors that contribute to hospital readmissions. The strengths of the partners allow the Collaborative to integrate CTI with resources that improve access to primary care physician services, outpatient care, mental and behavioral health services, and home and community-based services (HCBS). Key strategies include:

- **COA** will provide the CTI intervention and connect patients to HCBS.
- **HealthBridge** will provide electronic alerts when patients in the target population are admitted to a partnering hospital.
- **Health Care Access Now** will assist patients who need help accessing primary or specialist care.
- **Hamilton County Mental Health and Recovery Services Board** will assist patients with mental health issues to help them access to medical homes.
- **Health Collaborative and the Greater Cincinnati Health Council** will work with physician offices and hospitals to employ quality improvement processes to enhance system efficiency and effectiveness.