Western New York Rural Care Transitions Coalition

P² Collaborative of Western New York, Allegany County Office for Aging, Cattaraugus County Department of the Aging, Chautauqua County Office for the Aging, Community Concern of WNY, Inc., The Dale Association, Genesee County Office for the Aging, Orleans County Office for the Aging, Wyoming County Office for the Aging, Brooks Memorial Hospital, Jones Memorial Hospital, Niagara Falls Memorial Medical Center, Olean General Hospital, Orleans Community Health, TLC Health Network Lake Shore Health Care Center, United Memorial Medical Center, Westfield Memorial Hospital, WCA Hospital, Wyoming Community Hospital

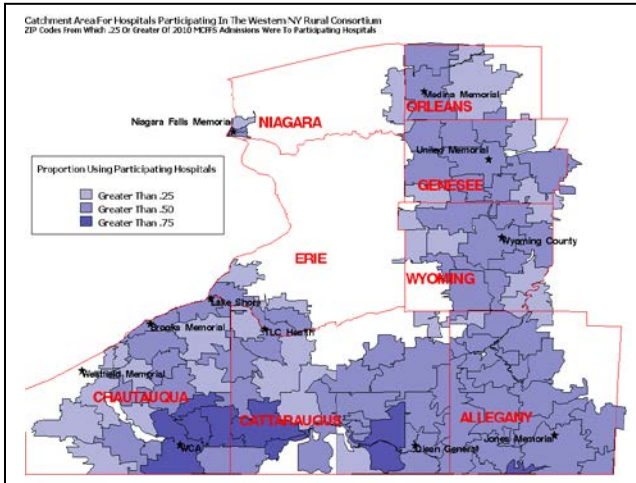
OUR COLLABORATION

The P² Collaborative of Western New York (the P² Collaborative), a non-profit regional health improvement collaborative, partnered with eight local community organizations and ten hospitals in seven of the eight counties of Western New York (WNY) for the WNY Rural Care Transitions Coalition. The community partners listed above will work collaboratively with other community agencies and organizations including the Community Health Foundation of Western & Central New York (the Foundation), IPRO (QIO), the Alzheimer's Association, local Hospice organizations and county health departments.

OUR PREVIOUS EXPERIENCE

Since 2005, the Foundation, WNY hospitals and local community organizations have worked together to improve care transitions in WNY. Many of the hospitals and local community organizations have experience with Care Transitions Intervention™ (CTI) and realized significant reductions in readmissions. For example, one pilot demonstrated that patients who participated in CTI had 50% fewer hospital readmissions within 30 days of discharge. Many of the hospitals and organizations participating in this Coalition will utilize transition coaches who were previously trained in CTI during one of the previous pilots. The Coalition will build upon and expand this prior care transitions work.

OUR COMMUNITY



OUR TARGET POPULATION

Participating hospitals and local community organizations identified the target population for this program after conducting a thorough root-cause analysis that included review of hospital readmissions data, chart reviews and patient and partner interviews. All counties will target Medicare FFS patients who are readmitted to the hospital within 30 days of discharge. In addition, nine of the ten participating hospitals will flag specific high readmission conditions like Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Pneumonia and Diabetes. Each county chose a target population that addressed the specific needs and concerns of the local community.

OUR IMPLEMENTATION STRATEGY

The P² Collaborative will serve as the regional community-based organization, aligning the partners across the region in this consortium. Each participating hospital will work very closely with one local community-based organization to implement Dr. Coleman's Care Transition Intervention™ (CTI). The local community organizations will deploy health coaches certified in CTI to help eligible Medicare FFS patients transition from participating hospitals to home. The program will include:

- Oversight and leadership from the P² Collaborative, who will staff a Steering Committee and Operations Committee.
- Education and referrals from hospital staff, who will reinforce the importance of this intervention and flag eligible patients for referral to CTI.
- Staffing and oversight of CTI-certified health coaches by local community organizations, who will deploy coaches to the hospital and arrange a home visit within 72 hours following discharge. In addition to the home visit, coaches will make two to three phone calls to patient over a 30-day period.
- Targeted referrals from local community organizations to existing community services and programs such as Meals on Wheels, transportation services and Stanford Patient Education's Chronic Disease Self-Management program.
- Access to training and collaborative learning groups through the Foundation and IPRO.