Area Agency On Aging

Akron/Canton Area Agency on Aging
Regional Community-Based Care Transitions Program

Affinity Hospital, Aultman Hospital, and Mercy Medical Center in **Stark County**; Akron General Medical Center, Summa Akron City Hospital, Summa Saint Thomas Hospital, Summa Barberton Hospital, and Summa Western Reserve Hospital in **Summit County**; Robinson Memorial Hospital in **Portage County**; and Summa Wadsworth Rittman Hospital in **Medina County**.

Akron Regional Hospital Association

OUR COLLABORATION

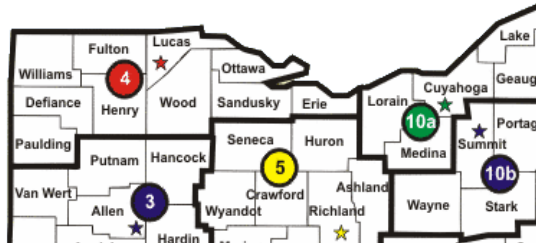
This Care Transitions Consortium of 10 hospitals is comprised of independent hospital systems, and ***crosses the competitive boundaries of those hospital systems in a mutually beneficial manner.*** We believe that such cooperation among competitors, though unusual, explicitly acknowledges the overarching public policy goal that uses community partnerships as a key strategy to achieve a reduction in Medicare costs by reducing redundancy, improving quality, and improving efficiency through a reduction of unnecessary readmissions.

OUR PREVIOUS EXPERIENCE

The A/C AAA has substantial experience in providing Care Transitions assistance to hospital partners. Specifically, it builds upon the innovative and ***longstanding A/C AAA program (begun in 1998) of placing A/C AAA Medicaid Waiver Long-Term Care Nurse Consultants in 8 local hospitals in order to facilitate patient transitions to home and community-based settings.*** In addition, we will utilize A/C AAA's transition coaching experience gained in two care transitions projects at acute care hospitals, our current transitions coaching program under a contractual arrangement with a Medicare Advantage Plan, as well our long history of formal collaborative efforts directly integrating acute medical care systems with A/C AAA care management programs.

OUR COMMUNITY

This project will be undertaken through a unique collaborative effort among 10 acute care hospital partners and the Akron/Canton Area Agency on Aging (A/C AAA). They are located within ***Stark, Summit, Portage, and Medina Counties in Northeast Ohio*** (see lower right on map).



OUR TARGET POPULATION

An ***expert panel*** comprised of representatives from each hospital was convened by ARHA to examine the ***causal issues surrounding the readmissions data.*** The panel assessed the readmissions issue and decided to target patients with primary diagnoses of AMI, HF, and PNEU. Further, data indicated ***Lack of patient compliance*** with the discharge plan (e.g., medication management); and ***lack of timely follow up*** with medical professionals as key causes. The expert panel's review and their conclusions lent themselves to the Coleman Model (CTI) coaching intervention, since these root causes stem from discharge planning that is well-designed, but limited in scope.

OUR IMPLEMENTATION STRATEGY

All 10 respective hospitals participating herein have agreed to utilize the ***evidence-based CTI™ model*** to provide care transition coaching to appropriate patients discharged from the hospital. This model is based on Care Transition Initiative of Dr. Eric Coleman of the University of Colorado. We will also incorporate best practices learned through our other care transition experiences.

Being designated as an ***Aging Disability Resource Center (ADRC)*** by the Ohio Department of Aging, as well as having experience in care transitions coaching, ***A/C AAA is in a unique position to achieve multiple goals***:

- Reduce hospital readmissions;
- Help patients access long term care;
- Achieve nursing home diversions; and
- Combine A/C AAA expertise on community-based care with the Transitions Coaching program, thus empowering patients to better manage their own chronic conditions remain in the community.

In addition, by expanding A/C AAA services to consumers who are not currently eligible for care through government programs, both dual-eligible and non-Medicaid older adults are provided home and community-based options as well as offered Chronic Disease Self-Management Programs.