CJE SeniorLife's Community-Based Care Transitions Collaborative

Northwestern Memorial Hospital, Saint Joseph Hospital and Saint Francis Hospital

OUR COLLABORATION

Our partners include three major Chicago-area hospitals:

- Northwestern Memorial Hospital
- Saint Joseph Hospital
- Saint Francis Hospital

We will also be working closely with our local CCUs and the QIO. This Collaborative will bridge gaps in care for frail elderly patients who are at high risk of hospital readmission when transitioning from the hospital setting back home, or into sub-acute or long-term care.

OUR PREVIOUS EXPERIENCE

CJE has extensive experience in facilitating care transitions, including the following:

- Managed Community Care Program, which is an integrated home- and community-based services program for frail older adults at risk of transitioning to residential care.
- Advance Practice Nursing Model in our Short Term Rehabilitation Facility. This program has decreased hospital readmissions for patients requiring rehabilitation after a hospitalization.
- Medicare-Certified Home Health Care Agency, which uses a care management model implementing best practices on patient education similar to the Coleman intervention.

OUR COMMUNITY

Our community spans the North Side of Chicago and reaches through the northern suburbs, including Evanston, Highland Park, Deerfield, Northbrook, Skokie, Park Ridge, Lincolnwood, Morton Grove and Niles.

OUR TARGET POPULATION

Our target population includes:

- Medicare patients age 65 or older
- A principal diagnosis of AMI, CHF, Pneumonia, COPD or other medical conditions
- Secondary medical conditions
- Cognitive or functional impairment
- Takes more than seven prescription medications
- History of recent hospitalizations
- Lives alone, with an over-burdened caregiver or in a nursing home

OUR IMPLEMENTATION STRATEGY

The Collaborative is implementing the 30-day intensive Care Transitions intervention developed by Dr. Eric Coleman. The Coleman model picks up where hospital discharge planning leaves off – following the patient home.

CJE transitional care nurse coaches will be stationed in the hospital, working closely with the hospital discharge planning team. The transitional care coach will meet with the patient and the patient's caregiver prior to discharge. A home visit will be made within 24-72 hours following hospital discharge. At the home visit, the coach will:

- Work with the patient to develop an individualized, person-centered care plan and set 30-day health care goals.
- Assist the patient in scheduling and preparing for follow-up medical visits.
- Help the patient create a health care diary with a master medication list that will be taken to all physician appointments.
- Facilitate medication management.
- Develop the patient's knowledge, skills and confidence to self-manage medical conditions at home.
- Complete a home safety evaluation to identify fall and other risks.
- Ensure the necessary home-based supports are in place.
- Evaluate the need for a social worker intervention.

Telephonic follow-up will occur over 30 days.