Destination: Healthy at Home

St John Providence Health System and Adult Well-Being Services

OUR COLLABORATION

St John Providence Health system (SJPHS) and its partner CBO, Adult Well-Being Services (AWBS) will provide care transition services using the Coleman model to Medicare patients admitted to three hospitals all of which are included in the CMS list for readmissions in the 4th quartile for at least two DRG's.

SJPHS is the leading provider of health care comprised of five hospitals and more than 125 medical facilities. It is a non-profit organization and a subsidiary of Ascension Health, the nation's largest Catholic and non-profit health system and the third largest health system in the US.

AWBS is a non-profit community-based organization founded in 1953 and serves Wayne, Oakland and Macomb counties and twenty-one other counties. It is accredited by the Commission on Accreditation and Rehab Facilities (CARF) since 1991 and provides health promotion and disease prevention; mental health and substance abuse prevention and treatment; community outreach, information and referral; family caregiver support, training and education; comprehensive developmental disability services; and independent senior housing. Also AWBS has worked with multiple hospitals in the target area and has a particular experience in connecting people with support groups and other community services. It also has multiple programs and services funded by the Administration on Aging.

OUR PREVIOUS EXPERIENCE

SJPHS is a leader in serving the diverse needs of the Detroit community. Improving patient care and reducing hospital readmissions are both mission-driven initiatives that are part of its strategic plan. Over the last few years SJPHS has been actively involved in efforts to reduce readmissions, such as the IHI STAAR Initiative, a tele-monitoring program, and Adult Chronic Disease Center of Excellence. These support patient-centered care transitions services served by *Destination: Healthy at Home*. SJPHS has also embarked upon a joint venture with physicians "St. John Providence Partners in Care" to meet the demands of health care reform and improve care processes. AWBS has almost 60 years of experience providing community based care including active engagement with the local ADRC (aging and disability resource center). They have also worked with other area hospitals to successfully reduce the cost of ED readmissions by 80% over a two year project period.

OUR COMMUNITY

The patients served reside in southeast Michigan in a tri-county area that includes Wayne, Oakland, and Macomb counties where the SJPHS hospitals are located. This is a diverse area composed of urban, suburban and some rural communities. In many areas access to community based support services is limited. We expect that approximately one third to one half of the target population will reside in a federally designated Medically Underserved Area (MUA), a Health Professional Shortage Area (HPSA), or be considered part of a Medically Underserved Population (MUP).

OUR TARGET POPULATION

Based on the root cause analysis developed by the St. John Hospital Adult Chronic Disease Center of Excellence, the target population will consist of Medicare beneficiaries admitted as patients to St. John Hospital and Medical Center, Providence Hospital and Medical Center, or St. John Macomb-Oakland Hospital, Macomb Center. All of these hospitals are included in the CMS list for readmissions in the 4th quartile for at least two DRG's. The target criteria for these patients will be an admission diagnosis related to congestive heart failure, pneumonia, acute myocardial infarction, chronic obstructive pulmonary disease, coronary artery bypass grafting, percutaneous transluminal coronary angioplasty, and other vascular disorders. The program offers transition services to nearly 2,000 patients and will screen about 7,000 patients year one, with an estimated one third to one half residing in a Medically Underserved Area, Health Professional Shortage Area or part of a Medically Underserved Population.

The root cause analysis revealed seven primary causes of hospital readmission: medication issues, self management issues, lack of transportation, ineffective patient education, primary care provider's issues related to poor hand offs and lack of follow up visits, lack of connection with community-based support services, and end of life/disease progression issues. All these causes will be addressed by *Destination: Healthy at Home* by offering the following three approaches: 1) develop a timely, patient-centered discharge process that is culturally and linguistically competent; 2) improve patient utilization of community-based support services, and 3) address the special needs of persons experiencing disease progression and/or end-of-life issues. The core of this program will be the implementation of two care transitions models approved by CMS -- Project BOOST and The Care Transitions Intervention, as well as providing specialized consultative services.

OUR IMPLEMENTATION STRATEGY

We will offer three approaches with *Destination: Healthy at Home* to address all seven issues identified in the root cause analysis: 1) develop a timely, patient-centered discharge process that is culturally and linguistically competent; 2) improve patient utilization of community-based support services, and 3) address the special needs of persons experiencing disease progression and/or end-of-life issues.

Of the 33,000 annual all-cause Medicare admissions to these three hospitals, 44% are estimated to meet the target population with a diagnosis of COPD, CHF, AMI, Pneumonia, PTCA, CABG, or other vascular conditions. A health navigator (HN) will conduct inpatient interviews with identified patients with these diagnoses using the BOOST assessment tool. This tool demonstrates validity and reliability to identify our target population. Those identified as high risk for readmission will receive services by the HN, a registered nurse, and others on the care management team to address their specific risk factors such as medication management, and health literacy. Those discharged home with unresolved issues will be contacted before discharge by a transitions coach (TC) to address patient-specific health issues. This includes transportation to the primary care provider for follow up visits within 5 days of hospital discharge; connection to other organizations and services (e.g., support groups, Meals on Wheels); assistance with medication management and assistance with other identified needs such as chore service or care-giving support. Transitions coaches are trained community health workers who represent the cultural diversity of the patient population served and who reside in the service area. The staffing model is based upon the effective staff-to-patient ratios employed by the BOOST and CTI programs.