

Southern Ohio Care Transitions Project

Buckeye Hills – Area Agency on Aging , Region 8, Central Ohio Area Agency on Aging, Region 6, Area Agency on Aging, Region 7, Adena Regional Medical Center – Ross County , Fairfield Medical Center – Fairfield County, Holzer Medical Center – Jackson County, Memorial Health System – Washington County , Southern Ohio Medical Center – Scioto County, Ohio’s KePRO , Southeast Ohio Aging and Disability Resource Network

OUR COLLABORATION

Buckeye Hills –Area Agency on Aging 8 is partnering with two subcontractors (AAA6 and AAA7), five hospitals, and 28 providers along the continuum of care including critical access hospitals, primary care providers, FQHCs KePro and the Southeast Ohio Aging and Disability Resource Network comprised of senior centers, home health care providers, hospice providers, nursing homes, rehabilitation facilities, county boards of developmental disabilities, county boards of mental health, county veteran’s service commissions, independent living centers and county 211s.

OUR COMMUNITY



OUR IMPLEMENTATION STRATEGY

During interviews and discussion groups conducted in the spring and summer of 2011, Transition Coaches and Case Managers currently providing home-based services in the community highlighted a lack of health literacy and self-advocacy as causes for readmission. Medication discrepancies, limited awareness of the importance of symptoms, and a paternalistic approach to primary care were identified both as causes for readmission and opportunities for Transitions Coaches to intervene.

The Southern Ohio Care Transitions Project will use the evidence-based Care Transitions Intervention. CTI is built on four pillars:

1. Medication self-management
2. A dynamic patient-centered record
3. Physician follow-up
4. Identification of “red flags”

Patients who meet the target criteria will be referred to the CTI Coach within 24 hours of admission. The CTI Coach will meet with the patient in the hospital to introduce the CTI. Upon agreement to participate in the program, after discharge, the CTI Coach will follow up in the patient’s home to review the discharge plan; promote attendance at follow-up appointments; identify and rectify medication discrepancies; use teach- back techniques to describe a medication adherence plan, and assist with completion of the Personal Health Record. The CTI Coach will follow up with the patient by phone during weeks three and four post-discharge.

OUR PREVIOUS EXPERIENCE

AAAs 8, 6, and 7 began preparing to implement the Care Transitions Intervention in 2009. AAA8 staff attended the CTI training hosted by Eric Coleman, MD, MPH and his staff in Colorado. After training, the AAAs collaborated with Fairfield Medical Center, Adena Medical Center, Holzer Medical Center, and Southern Ohio Medical Center to develop protocols and integrate the CTI into existing discharge planning services and other hospital-based projects. In the spring of 2011, AAA6, AAA7, and AAA8 began piloting the CTI at four hospitals as a complement to STAAR initiatives and AAA programs. Also in 2011, AAA8 partnered with the Memorial Health System to pilot the Care Transitions Intervention.

OUR TARGET POPULATION

Seventeen counties in the twenty-six county service area are rural and underserved; nineteen of the twenty-six counties include HRSA designated Medically Underserved Areas and Medically Underserved Populations.

Using the results of a multi-faceted root cause analysis conducted in collaboration with five partnering hospitals, the project will target:

- Medicare Fee-for-Service beneficiaries who are 65 years of age and older;
- Who reside in the twenty-six county service area and are admitted to and discharged from one of the partnering hospitals;
- Have diagnosis of AMI, CAD, COPD, HF or Pneumonia.