

**Critical Access Hospital Annual Conference  
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**What is the Care Transitions Project?**

A Greater Lansing area health care community project to reduce unnecessary hospital readmissions and improve communication across health settings to improve health care quality and safety.

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**What is a Care Transition?**

Care Transition refers to the movement of patients between health care practitioners and settings as their coordination and care needs change during the course of a chronic or acute illness.



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### How Did This Project Develop?

- The Centers for Medicare & Medicaid Services selected 14 states including Michigan to conduct this national pilot project.
- MPRO, Michigan's Quality Improvement Organization, leads the program in Michigan and selected the Greater Lansing area to conduct this important work.

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### What are Rehospitalizations?

- Rehospitalizations are instances in which an individual who has been a hospital inpatient is released and readmitted within 30 days of their initial release.
- Rehospitalizations are costly events to both the patient and health care providers, both financially and in resources and time.

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### Facts and Figures

- Analyzed Medicare claims data from 2003-2004 reveals that almost one fifth (19.6%) of the 12 million Medicare beneficiaries who had been discharged from a hospital nationally were rehospitalized within 30 days.
- 34% were rehospitalized within 90 days with estimated costs to Medicare in 2004 of more than 17 billion dollars.

Rehospitalizations Among Patients in the Medicare Fee-for-Service Program, New England Journal of Medicine, April 2, 2009

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**Who are Participating Care Providers?**

Representatives within the following health settings from across the Greater Lansing area are involved:

- Acute Care and Critical Access Hospitals
- Home Health
- Hospice
- Nursing Home
- Physician Offices

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**What is the Project Focus?**

- Care Transitions works to improve the coordination of care across health settings.
- Participating providers will work as a community to develop system-wide interventions and improved communications tactics to promote seamless transitions across all health settings.

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**What will the Community of Partners Do?**

- Improve processes to address interventions within their own facilities.
- Develop interventions system-wide to improve communication.
- Educate patients and providers to coordinate care more effectively.

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### What Can Patients Do?

- Understand discharge instructions, don't be afraid to ask questions.
- Understand your medications. Again, ask questions if confused.
- If symptoms worsen see your doctor.
- Follow-up with your provider as directed.



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### What are the CAH's doing?

#### Clinton Memorial Hospital

- Reviewing 30 day readmissions
- Discharge Phone Calls
- Empowering/Coaching Patients to make follow-up appointments and enhance compliance
- Attending Work Group Meetings
- Discharge Education Folders
- Working with skilled nursing care and home health care
- Patient Rounding

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### What are the CAH's doing?

#### Eaton Rapids Medical Center

- Participating in bi-monthly meetings, moderated by MPRO, and focusing on Transitions of Care for Heart Failure patients across settings.
- Reviewing readmission records for avoidable circumstances.
- Implementation of call back to discharged patients 24-72 hours post discharge.
- Met with local SNF's to determine needs and identification of problems.

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*By participating in this project, the critical access hospitals in Michigan once again demonstrate their commitment to improved efficiency and safety of healthcare.*



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