

For Immediate Release

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Lansing Area Healthcare Providers Unite to Improve Patient Care

National Initiative Centers on Improving Care Transitions and Reducing Hospital Re-admissions

(Lansing, MI February 26, 2009) — Healthcare providers from the Greater Lansing area have united to take part in the ***Patient Pathways/Care Transitions project***, a national healthcare initiative to improve patient care transitions across health settings and reduce hospital re-admissions. Led by MPRO, Michigan's Quality Improvement Organization, the two-year collaborative (through July 31, 2011) brings together local providers from the hospital, nursing home, home health and hospice settings with patients, families and community stakeholders to improve care transitions for Medicare beneficiaries. The region's two leading hospitals, Ingham Regional Medical Center and Sparrow Hospital are engaged in the project.

The ***Patient Pathways/Care Transitions project*** works to improve the coordination of care across health settings and reduce unnecessary re-admissions to hospitals. The process by which patients move from hospitals to other care settings is increasingly problematic as hospitals shorten lengths of stay and care becomes fragmented. Medicare patients report greater dissatisfaction related to discharges than to any other aspect of care that the Centers for Medicare & Medicaid (CMS) measures.¹ Within 30- days of discharge, 17.6% of Medicare beneficiaries are re-hospitalized, and the Medicare Payment Advisory Commission estimates that up to 76% of these readmissions may be preventable.² Furthermore, of beneficiaries who are readmitted within 30 days of discharge, 64% received no post-acute care between discharge and readmission.³

"CMS selected 14 states including Michigan to launch the initiative," said Donna Beebe, MPRO project manager. "***The Patient Pathways/Care Transitions project*** will develop and implement system-wide interventions to effectuate change and improve communications among providers and patients to advance care transitions and reduce hospital re-admissions within the region."

Program participants kicked-off the collaborative with an intense training on "the coaching" intervention on Thursday, February 26, 2009, at Burcham Hills Retirement Community in East Lansing. Training was conducted by Eric Coleman, MD, a nationally renowned expert and developer of the Care Transitions Intervention.SM Coaches learned how to empower patients to gain self-management skills to ensure their needs are met during the transition from hospital to home.

Provider participants to date include; Ingham Regional Medical Center, Sparrow Hospital, Sparrow Specialty Hospital, Burcham Hills Retirement Community, Dimondale Nursing Care Center, Eaton

¹ Care Quality Information from the Consumer Perspective Hospital Survey (HCAHPS) Pilot.

² MedPAC: June 2007 Report to the Congress: Promoting Greater Efficiency in Medicare.

³ MedPAC: June 2007 Report to the Congress: Promoting Greater Efficiency in Medicare.

County Medical Care Facility, Medical Care Facility & Rehabilitation Services of Ingham County, Holt Senior Care & Rehab Center, Great Lakes Home Health and Hospice, McLaren Visiting Nurse and Hospice, Sparrow Home Care Network, and the MSU School of Social Work. To learn more about the Patient Pathways/Care Transitions project go to: <http://www.mpro.org/pathways.htm>.

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