Care Transitions: What Do These Programs Look Like? And How Can The Aging Network Play a Role?

Administration on Aging

Agenda

- Welcome
  - Cindy Padilla, Principal Deputy Assistant Secretary, Administration on Aging (AoA)
- Overview of Care Transitions Models
  - Caroline Ryan, Aging Services Program Specialist, AoA
- Care Transitions and the Aging Network
  - Sandy Markwood, CEO, National Association of Area Agencies on Aging (n4a)
- Questions & Answers

Care Transition Models

Caroline Ryan
Office of Program Innovation and Demonstration
Administration on Aging

Common Care Transition Themes

- Interdisciplinary Communication/Collaboration
- Transitional Care Staff
- Patient Activation
- Enhanced Follow-up

Evidence-based Models

- Care Transitions Intervention℠
- Transitional Care Model
- Bridge Program
- BOOST (Better Outcomes for Older Adults through Safe Transitions)
- GRACE (Geriatric Resources for Assessment and Care of Elders)
- Guided Care®

Care Transitions Intervention℠ (CTI)

Eric A. Coleman, MD, MPH

Division of Health Care Policy and Research at the University of Colorado Denver, School of Medicine

http://www.caretransitions.org

Care Transitions Intervention℠: The Four Pillars™

- Medication Management
- Patient-centered Record
- Primary Care Physician/Specialist Follow-up
- Knowledge of Red Flags

Care Transitions Intervention℠ Framework

Staff: Transition Coach™

Training: 1 day training

Length of Intervention: Four Weeks

Care Transitions Intervention℠ Framework (continued)

- Pre-discharge
  - Hospital Visit
- Post-discharge
  - Home Visit
  - Three Phone Calls

The Transitional Care Model (TCM)

Mary D. Naylor, PhD, RN, FAAN

New Courtland Center for Transitions and Health, University of Pennsylvania School of Nursing

http://www.transitionalcare.info/

TCM Components

- Patient and Caregiver Understanding
- Facilitate Patient Self-management
- Medication Reconciliation and Management
- Transitional Care

TCM Framework

Staff: Transitional Care Nurse

Training: Web-based training modules

Length of Intervention: 1-3 months

TCM Framework (continued)

- Pre-discharge
  - Daily Hospital Visits
- Post-discharge
  - Home Visits
  - Physician Visit
  - Telephone Support

The Bridge Program

Illinois Transitional Care Consortium

http://hmprg.org/programs-projects/illinois-transitional-care-consortium/

Bridge Program Framework

Staff: Bridge Care Coordinator

Training: Bridge Training Module

Length of Intervention: 30 days

Bridge Program Framework (continued)

- Pre-discharge
  - Aging Resource Center
  - Hospital Visit
- Post-discharge
  - Phone Calls
  - Home Visit

Better Outcomes for Older Adults through Safe Transitions (Project BOOST)

Society of Hospital Medicine

http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm

Project BOOST Framework

- Comprehensive Intervention
- Comprehensive Implementation Guide
- Longitudinal Technical Assistance
- Project BOOST Collaboration
- Project BOOST Data Center

Project BOOST Intervention Tools

- Standardized Discharge Processes
  - The TARGET
- Patient/Caregiver Preparedness
  - Patient PASS: A Transition Record
  - Teach-back
- Medication Safety
- Follow-up Care

Geriatric Resources for Assessment and Care of Elders (GRACE)

Dr. Steven R. Counsell, MD

Indiana University Center for Aging Research,
Indianapolis, Indiana

http://medicine.iupui.edu/IUCAR/research/grace.asp

GRACE Framework

Staff: GRACE Support Team

- Nurse Practitioner and Social Worker

Training: 12 session training program

Length of Intervention: Long Term

GRACE Framework (continued)

- Home Visit
- Meeting with GRACE Interdisciplinary Team
- Meeting with Primary Care Physician
- Implement Individualized Care Plan
- Additional Home Visits and Phone Calls
- Support Transitions from Hospital to Home

Guided Care®

Dr. Chad Boult, MD, MPH, MBA

The Johns Hopkins University

http://www.guidedcare.org/

Guided Care® Framework

Staff: Guided Care Nurse

Training: 6 week, 40 hour web-based course

Length of Intervention: Long Term

Guided Care® Framework (continued)

- Home Visit
- Evidence-based Care Plan
- Promoting Patient Self-Management
- Monthly Monitoring of Patient Conditions
- Coordinating the Efforts of all Health Care Providers
- Smoothing Care Transitions
- Educating and Supporting Caregivers
- Facilitate Access to Community Resources

AoA's Evidence-based Care Transitions Grantees (16 states)

- California
- Colorado
- Connecticut
- Florida
- Illinois
- Indiana
- Maine
- Maryland
- Massachusetts
- New Hampshire
- New York
- Pennsylvania
- Rhode Island
- Tennessee
- Texas
- Washington

AoA Evidence Based Care Transition Grantee Activity Quick Snapshot of 2010 EBCT Grants (16 States)

Hiring Staff	**On Average 1-3 Months**
Begin Implementation	**100% within 7 months or less**
Estimated number of patients to be served	**In general, range from 200 to 800 per year**
Target Population	**14/16 Targeting Measures in Place**
CTI	**12/16 States**
BRIDGE	**Illinois**
TCM	**Pennsylvania**
Guided Care	**Maryland**
GRACE	**Indiana**
BOOST	**New Hampshire (*also doing CTI)**

Care Transitions and the Aging Network

Sandy Markwood

n4a

Why the Aging Network Is So Critical to Care Transitions

- Unique/Trusted Position in the Community for 40 Years
- Intellectual Property
- Knowledge of Older Adults and Caregivers
- Contracting Power Broker
- Service Provision Skills
- Quality Assurance and Outcomes

Why Care Transitions Is So Critical to the Aging Network

- Core Mission of Maximizing Independence for At Risk Population
- Need to Engage in Changing LTC Landscape
- New Revenue Stream
- Existing Clients are High Risk for Readmission

Care Transition Themes: How Do They Relate to The Older Americans Act (OAA) and Aging Network Services

Interdisciplinary Teams & Service Coordination

- Coordination of services (medical/ human services)
- Workforce development and training
- Planning
- Partnerships
- Coordination of benefits

Enhanced Follow-Up

- Case Management/ Care Coordination
- In-home services
- Home-delivered meals
- Transportation
- Monitoring/assistive devices/PERS
- Medication mgmt.
- Disease prevention & health promotion

Patient/Client Activation

- Patient/client assessments
- Self-directed care/coaching
- Health/nutrition education
- Insurance counseling
- Family caregiver support, counseling, training

OAA Services within Care Transition Themes:
Interdisciplinary Teams and Service Coordination

- Coordination services (seamlessly bridging medical & human services)
- Workforce development & training (standards)
- Develop Area and Strategic Plans including business development
- Create new partnerships, especially with health systems
- Coordinate access to benefits

OAA Services within Care Transition Themes:
Enhanced Follow-Up

- Case management/Care coordination
  - Develop, implement, monitor individual service plans
- In-home services
  - Home health
  - Personal Care
  - Homemaker
  - Visiting/telephone reassurance
  - Chore
- Nutrition/home-delivered meals
- Transportation
- Monitoring/assistive devices/PERS
- Medication management
- Disease prevention/health promotion
  - Health risk assessment
  - CDSMP
  - Evidence-based programs
  - Home injury screenings

OAA Services within Care Transition Themes:
Patient/Client Activation

- Comprehensive patient/ client assessments, including home/caregiver assessments
- Self-directed care/coaching
- Health/nutrition education
- Benefits/insurance counseling
- Family caregiver support, counseling, training

Care Transitions: Opportunities and Considerations for the Aging Network

- **Capacity:** To expand your agency's business model, develop and sustain new partnerships, establish fee for service billing systems
- **Human Resources:** To expand and enhance existing operations (quick turnaround/possible 24/7 services)
- **Partnership/Provider Relations:** To respond to broad scope of care transitions service needs
- **Culture Change:** To expand your agency's position- a new way of doing the business your agency/staff/providers have been doing

Resources: Models

- http://www.caretransitions.org (Care Transitions Intervention℠)
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- http://hmprg.org/programs-projects/illinois-transitional-care-consortium/ (The Bridge Program)

Resources: Models (continued)

- http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm (BOOST)
- http://medicine.iupui.edu/IUCAR/research/grace.asp (GRACE)
- http://www.guidedcare.org/ (Guided Care®)

Other Resources: Care Transitions

- http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313 (Community-based Care Transitions Program)
- http://www.adrc-tae.org/tiki-index.php?page=CareTransitions (AoA's Aging and Disability Resource Centers and care transitions)
- http://www.cfmc.org/caretransitions/Default.htm (Care Transitions Quality Improvement Organization Support Center)

Resources: Affordable Care Act

- http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx (AoA's Health Reform web page)
- http://www.healthcare.gov (Department of Health and Human Services' health care reform web site)
- http://www.thomas.gov/cgi-bin/bdquery/D?d111:1:./temp/~bdsYKv::|/home/LegislativeData.php?n=BSS;c=111| (Affordable Care Act text and related information)

Next Training

- Care Transitions: Making the Programmatic Case
  - Wednesday, February 9, 2:00-3:30 pm EST
  - Watch your email for registration information

Questions/Comments/Suggestions for Future Webinar Topics?

Send them to:

AffordableCareAct@aoa.hhs.gov