Chapter Five: Building Organizational Capacity

Chapter Outline

Chapter Overview

Chapter 2 of this Toolkit (Taking Time to Plan) addresses some of the key areas in which you will need to assess your organization and community when preparing a new care transitions program. As you identify your organization's strengths and weaknesses, there may be areas in which you will look to build capacity or create efficiency across your existing programs. This chapter discusses some strategies for addressing organizational strengths and challenges on two levels:

- Building internal infrastructure related to administering a new care transition program (e.g., staffing models, justifying your costs, defining billable units, and incorporating consumer direction)
- Addressing program silos and building bridges across various programs offered by your organization (e.g., Medicaid Waiver, VD-HCBS)

Building Internal Infrastructure

Staffing Models and Workflow

As you define how participants will flow through the care transitions program, connections and communications needed between staff and program departments within your organization and with care transitions partners will be identified.

Some care transitions programs co-locate staff at hospitals within a care management or discharge planning unit, and there may be additional considerations with this staffing design:

- Are there scheduled times when the care transitions specialist will be onsite at the community organization and the hospital?
- Will the care transitions staff have access to the community organization IT system while onsite at the hospital?
- Will the care transitions specialist be included in hospital rounds or hospital discharge planning staff meetings?

An important consideration for co-located staff is the dual role they serve as the hospital's liaison to the AAA, ADRC, or Aging Network and as the Aging Network's liaison with the hospital. Co-location can

create opportunities for care transition staff to gain a deeper understanding of the communication style and culture of partner organizations and serve as a translator and facilitator across settings. First, Aging Network staff can help identify, enroll, and follow up with care transitions participants and begin the program. Secondly, they can provide linkages to participants to community based services and long-term care coordination. These staff should be visible and responsive to other hospital departments and staff as needed and appropriate according to any partnership agreements.

Co-located AAA/ADRC staff can:

- Identify appropriate candidates for care transitions programs and introduce them to the program.
- Identify existing AAA/ADRC consumers and notify case managers of a hospitalization.
- Collaborate with the discharge team to inform the discharge plan and develop or revise an existing communitybased care plan (including completing assessments for additional services).
- Screen for additional program eligibility or complete assessments.

Resources

- Sample Flowchart: Massachusetts Care Transitions Program
- Sample Job Description for Hospital Liaison (Riverside County Office on Aging)

Ensuring Person-Centeredness

A central theme to care transitions programs is patient- or participant-centered planning. The considerations, needs, and preferences of the individual drive service plan development, connections to other programs, and assessments for public benefits. Most care transitions strategies are designed to empower and support consumers to achieve their goals and objectives for their health and well being during and after a hospitalization. Your organization may already have experience implementing consumer directed programs, which can inform the development of participant directed care transitions strategies with partner organizations. Examining internal assessment tools and care plan protocols with partner organizations will also reveal potential opportunities to enhance person-centered services.

There are many resources available for developing person-centered thinking and facilitating self directed programs.

Resources

- Person-Centered Thinking Resource Guide
- Developing and Implementing Self Direction Programs and Policies: A Handbook
- National Resource Center for Participant Directed Services
- The Clearinghouse for Home and Community Based Services
- Consultant Training Program

Costs and Billing Procedures

When considering your costs and billing procedures, your goal should be to ensure that by charging the market rate or value you are left with a margin above covering your costs. While in the private sector this may be referred to as a profit, this margin or surplus could be used to augment other programs you offer. This may be a new concept for some organizations within the Aging Network and may need to be addressed within your board of directors. While your organization might be a not-for-profit, that doesn't necessarily mean you can't turn a profit. It is a matter of plowing profits, margins, or surplus back into the organization to provide additional services or serve more individuals.

Understanding the local market rate. Setting prices for your services is critically important and will require a good balancing act. The prices for your services should be placed at a competitive market rate and will require you to understand the wider market of programs and costs beyond your organization. You can begin a market analysis in several ways, including working with hospital partners, understanding total costs associated with hospitalization and readmissions, and knowing unit rates for your individual services. Additionally, there are consultants and services that can help you develop a complete market analysis.

Resource

- SCORE (a nonprofit association dedicated to educating entrepreneurs and helping small businesses start, grow, and succeed nationwide)

Determining your allocated costs. Once you determine the local market rate for your care transitions services, you will need to coordinate that rate with your organization's fully allocated costs. This should include both direct (cost of providing services, which can generally be fixed) and indirect expenses (percentage of administrative or overhead costs associated with providing the care transitions program). A preliminary list of costs could include:

- Staff salaries and wages
- Payroll taxes
- Benefits
- Professional and consultant fees
- Travel
- Postage
- Office supplies
- Telephone
- Legal
- Maintenance
- Insurance
- Occupancy/rent
- Printing and publications
- Communication
- Minor equipment
- Depreciation

Resource

- Council on Aging of Southwest Ohio Sample Budget Worksheet

Defining billable units. Billable units for your care transitions program can be defined in different ways:

- Will you bill for only those who complete your entire care transitions program intervention?
- What about the assessments and education and outreach you complete with those who ultimately opt not to participate? How will that affect your costs?
- Will you then bill based on a standard hourly rate? Depending on the source of anticipated funding for your care transitions program, you may or may not have a set definition for completing billable units.
- If you anticipate several funding sources for your care transitions program (Medicare, health plans, hospitals, etc.), the definition of billable units could vary. To achieve long-term sustainability, you will need to define your cost rate carefully and work with partners to determine your anticipated volume for the program.

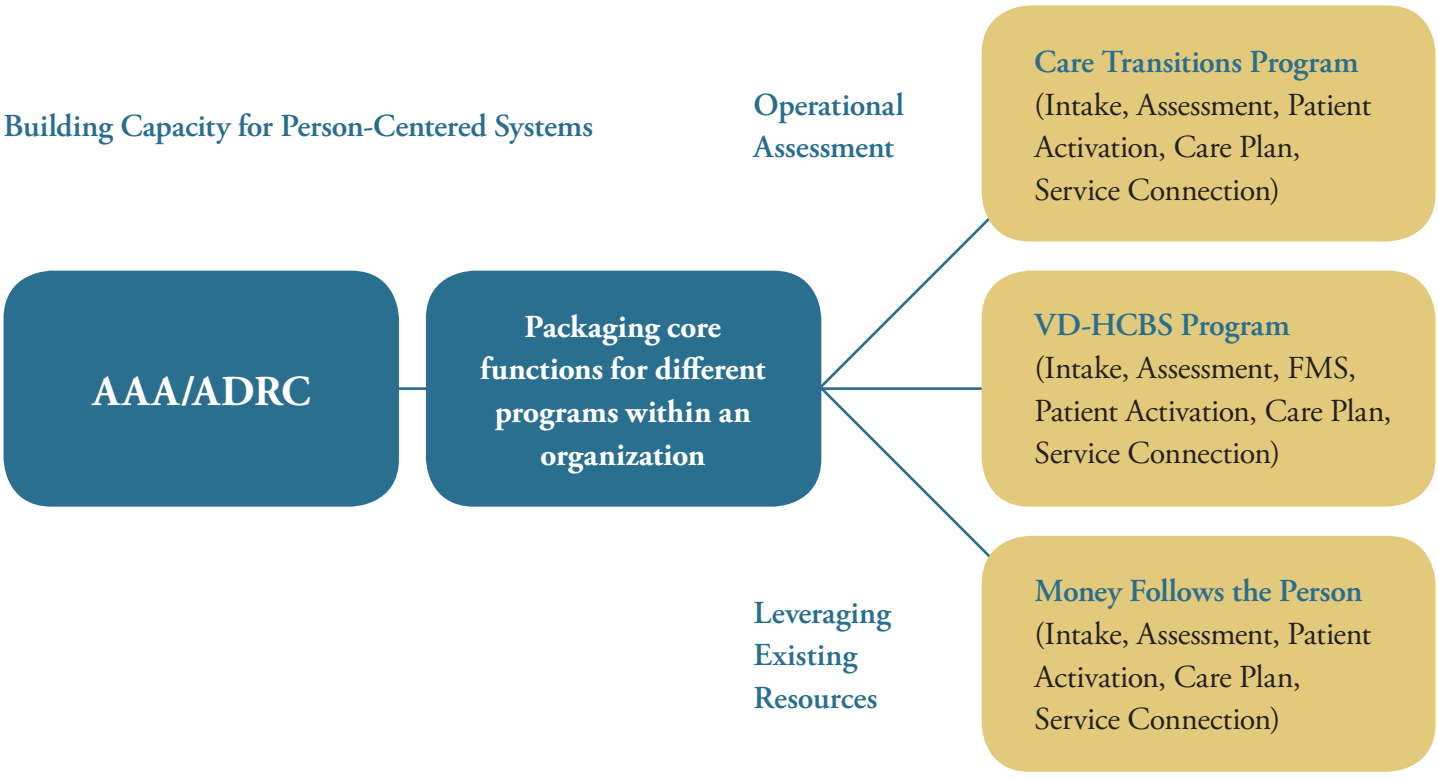
Bundling risk versus bundling services. In the context of managed care, the term bundling is sometimes used to refer to bundling units into a capitated reimbursement in a risk based environment. In this context, the service provider is paid a set (usually contracted) amount for each individual enrolled in a program, regardless of the cost or level of service utilized by the individual.

In another context, bundling can mean packaging all of the services and costs associated with providing a care transitions program. Determining the right combination of appropriate services and costs to include in a set of bundled services for a care transitions program may require time and some trial and error in order to understand your organization's long-term costs. Regardless of whether you are examining capitated payments or combinations of bundled service packages when developing your unit rates for care transitions participants, quoting a per-unit price that is below your actual operating costs will greatly impact your ability to sustain your program in the long run.

Resources

- AoA Care Transitions Webinar: Making the Business Case
  - Slides
  - Transcript
  - Recording

Integrating Core Functions Across Programs



Information and Assistance, Options and Benefits Counseling, and Care Transitions

Some individuals and families have little or no knowledge of the LTSS system, especially if they have been able to manage without any formal services in the past. They may need some very basic education about the types of service options that exist in the community. Providing options counseling during and after a hospitalization gives consumers a chance to learn about important community services and to consider available options, including personal care, nutrition services, transportation, adult day care, adult foster care, assisted living, respite care, and personal emergency response systems.

Individuals and families may also benefit from discussing service options, establishing a care plan, connecting with community providers, and applying for publicly financed service options. Options counselors can provide information about local resources to ensure that consumers and caregivers are making informed decisions and have support during the application process. Even if an individual decides that adult day care is an appropriate resource, for example, additional steps may be needed to locate the nearest adult day care centers, determine if they are accepting new clients, and explore transportation and payment arrangements.

One of the challenges of offering LTSS through care transitions programs is the length of time that it takes to establish eligibility for publicly funded programs like Medicaid. Rapid eligibility determinations provide a powerful tool for intervening during a time of crisis to prevent unnecessary institutionalization or readmission to the hospital. Short of presumptive eligibility, establishing a simple system (in partnership with your local or state Medicaid agency) to prioritize applications from hospital patients can help reduce wait times and make more service options available.

In addition, it is important to remember that some of your care transitions participants may also qualify for other public benefits such as the Medicare Part D Extra Help/Low Income Subsidy (LIS), one of the Medicare Savings Programs, energy assistance, or the Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps). Connecting these clients with your local State Health Insurance Assistance Program (SHIP), benefits enrollment center, or Medicare Improvement for Patients and Providers Act (MIPPA) grantee is an important strategy for your organization to consider.

Leveraging with Your Veterans Directed Home and Community Based Services Program

The VD-HCBS Program offered through the Aging Network provides veterans with a person-centered alternative to traditional home care services and programs. The Aging Network serves as a broker working directly with the U.S. Department of Veterans Affairs (VA) to deliver a bundle of services. This program empowers veterans and their caregivers by giving them the ability to have direct control over the goods and services they receive. Veterans manage their own flexible spending budgets; decide for themselves what mix of goods and services can best meet their needs; hire and supervise their own workers, including family and friends; and purchase items or services that help them live independently. Veterans:

- Develop consumer plans according to their preferences/needs.
- Decide for themselves, or with a family caregiver, what mix of goods and services will best meet their needs.
- Understand how to manage a flexible, individual budget.
- Are trained and educated on how to hire and supervise their own workers, including family or friends.
- Purchase items or services needed to live independently in the community.

- Have financial management and support services that facilitate service delivery.
- Utilize trusted resource providers, if desired, to supplement participant directed care.

The Aging Network's participation in VD-HCBS supports VA's commitment to increase its services and resources through a participant directed model and the delivery of bundled services customized for and by each veteran.

Connecting Your Care Transitions Program with Evidence Based Disease Prevention Programs

Individuals served by the Aging Network and your care transitions program are disproportionately affected by chronic diseases such as arthritis, heart disease, and diabetes. These issues are often compounded through multiple hospital admissions and managing multiple medications. In addition to implementing self management and activation activities described in existing care transitions models, some Aging Network sites have also developed referral mechanisms to AoA health, prevention, and wellness programs that provide consumers with the tools to maintain their health, reduce their risk of developing chronic diseases, and manage their health to live as independently as possible. The core programs are the Evidence-Based Disease and Disability Prevention Program and the Chronic Disease Self Management Program.

- **Evidence-Based Disease and Disability Prevention Programs:** In theses programs, seniors learn to maintain a healthy lifestyle through increased self-efficacy and self-management behaviors. 24 grantees across the country are supporting dissemination of evidence based programs in their communities. These programs may include:
  - » **Physical activity programs,** such as Enhance Fitness or Healthy Moves, which provide safe and effective low impact aerobic exercise, strength training, and stretching.
  - » **Fall management programs** such as Matter of Balance, which addresses fear of falling, and Stepping On and Tai Chi, which build muscle strength and improve balance to prevent falls.
  - » **Nutrition programs,** such as Healthy Eating, which teaches older adults the value of choosing and eating healthy foods and maintaining an active lifestyle.
  - » **Depression and/or substance abuse programs,** such as PEARLS and Healthy IDEAS, which teach older adults how to manage their mild to moderate depression.
- **Stanford University Chronic Disease Self-Management Programs:** Self-management programs provide older adults with education and tools they need to help them cope with chronic diseases such as diabetes, heart disease, lung disease, or arthritis. The programs help participants manage stress, discuss the benefits of physical activity and good nutrition, and help participants communicate more effectively with health care providers. Participants develop action plans related to these topics through structured planning and feedback exercises.

Resource

- AoA Health, Prevention, and Wellness Programs

Integrating Existing Services within Care Transitions Programs - A Case Study

Considering all of the ways consumers interact with your organization can provide a good roadmap for incorporating your care transition program with your services. This case study from Atlanta Regional Commission discusses four ways to integrate across your organization.

We began by integrating approaches of care transitions into our daily work on four levels: beginning from when older adults of the families first call for information or assistance, when providing case management, in the delivery of services, and in providing education so that clients and their families know what to expect when they go into a hospital.

Beginning in our information services that we provide as a resource connection, we incorporate care transitions protocols into the information counseling services we offer. We handle over 70,000 calls per year with older adults and their caregivers seeking information about long-term service options. Many of the individuals who call us are either in the hospital or have recently been hospitalized, or they are caregivers calling on behalf of such individuals. We've addressed care transitions protocols and staff training and provide educational materials via email or through mail. At the same time, we are tracking those calls to find out what is happening to individuals once they get home.

On the next level, we go beyond the information counseling and focus on case management services to more than 7,000 frail older adults and persons with disabilities. Our case management contracts and the Georgia Medicaid Waiver Program have led us to incorporate care transitions into our care management responsibilities. Care managers are making sure that individuals transitioning home and their caregivers understand their transition plans and instructions. They make sure that they know what medications to take and when to take them, what red flags to watch for, and to find out if they are following up with a medical appointment. In addition, care managers help their clients with their community care plans, ensuring that they seamlessly support the clients' transition plans.

Also, through developing protocol, we make sure that all the information is shared with the client, the caregiver, and the other providers in a timely manner, and that we are able to track any readmissions.

Next comes our service delivery system, which we support through the OAA since it is an AAA. This includes State and local funding for home delivered meals, in-home services, respite care services, transportation, and adult day care services that we provide. However, we have to acknowledge that our system is challenged by long wait lists and intensive intake process. Unfortunately, this results in unintended and sometimes cumbersome processes that can delay access to services. In order to respond to immediate needs of people transitioning from the hospital to home, we support and are replicating a pilot project through one of our county aging programs that includes a care transitions support package available within 24 to 48 hours after discharge. This package consists of a combination of services such as home delivered meals, in-home support services, transportation, and care management for 30 days. The average cost of the package is $500 per individual. Currently we are funding the package through public funding using some Federal, State, and local funding.

Our last effort is our approach in which we educate people before they are admitted to the hospital or emergency room. With the help of our care transitions workgroup and Piedmont Hospital, we have developed a special consumer education program called "How to Navigate the Health Care System." This educational program is implemented through our Retired Senior Volunteer Program. Last year we trained 40 volunteers and gave 77 presentations with pre- and post-testing so we know that we are successful in transmitting this critical

information. The goal is to get critical information to individuals before hospitalizations occur, to empower the patient who is going to face many serious decisions and who has to know what are the right questions to ask.

Atlanta Regional Commission AAA

Questions to Consider and Practical Advice from the Field

Q: How did you make sure that program elements are person-centered?

Our University of South Carolina partners, who brought years of expertise on person-centered planning to the table, provided us with a list of questions that we used during planning to determine whether our model was person-centered. USC also provides ongoing training for our partners, key staff, and all members of the project implementation team. *South Carolina Bureau of Senior Services, Hospital Discharge Planning Grant*

Q: What does staffing for the program look like? Training, caseloads, roles, etc.?

We use masters-level social workers or counselors. Additionally, all coaches have undergone the intensive training program offered by our evidence based model (CTI). The 2-day training was very intensive, but well worth it. We see the value in asking about expanding the training to other staff in our new Community Living Program site. *AAA Central Texas, ADRC Evidence-Based Care Transitions Program*

The role of the AAA or ADRC can be to provide the community with transition coaches. Coaches need not be medically trained. Their role is to meet with patients to establish goals, strategize barriers and solutions, and help discharged patients understand why reasonable adherence to treatment is in their own best interest. A coach can manage about 25 people. Patients are at different stages in the intervention at different times. We have 2 FTEs from 1 AAA and 4.5 FTEs from another. Only one coach is full time; the rest are multi-tasking. All have at least a bachelor's degree, many are in social work or related fields, or they are RNs. *Quality Insights (PA QIO) regarding work with Southwestern PA AAA and Westmoreland County AAA from the QIO 9th Scope of Work Care Transitions Theme*

Don't be afraid to take your time upfront selecting staff or hiring new staff who will be co-located at the hospital. It is so important to have the right person in this role. They are your bridge builder to the hospital and health care community. These staff members need to have multiple skill sets to be effective in both the roles of care transitions program specialist and hospital liaison including being politically savvy, having negotiating skills and experience building relationships, ability to be creative and think out of the box, ability to change or adapt systems quickly, as well as good clinical skills. They must be accessible and be willing to go beyond the defined duties as a program specialist. Before they actually begin implementing the program, they must build relationships across departments, and champion the program, and represent the Aging Network. *Riverside County Office on Aging, ADRC Evidence-Based Care Transitions Program*

Regarding overlapping roles between hospital discharge planners, coaches/case managers, and home health nurses/aides—it's a matter of talking it out. The role is slightly different in each location. You need to work out an understanding. Even then it can be flexible enough to allow the coach and the hospital case manager to assist each other based on workload. Role overlap has not been an issue in the model we use. Case managers identify the patients and facilitate the meeting with the patient in a timely manner. However, the bulk of the intervention provided by the coach takes place after the person leaves the hospital. *Quality Insights (PA QIO) regarding work with Southwestern PA AAA and Westmoreland County AAA from the QIO 9th Scope of Work Care Transitions Theme*

At our AAA we perform an initial screening, assessment, level of care determination, and ongoing care management for Medicaid and non-Medicaid programs. Nurses employed by the AAA are the long-term care assessors and are funded by the State's Medicaid waiver program. They have been working in hospitals with assessments since 2000, so they have relationships with the large hospitals in the Akron area. An assessor is based in each of these hospitals five days a week. Over the years, hospital discharge planners have learned to work with the assessors. Initially we focused on getting patients being discharged to home into services faster. In recent years, we have increased our focus on patients being discharged to nursing facilities to prevent short rehabilitative stays from becoming permanent. We are now on eight major campuses and have one outpatient clinic, both rural and urban. The waiver program is serving approximately 3,600 people. The nurses do about 600 assessments a month, asking people what their plans for care are and assisting them with long-term care planning. Our nurses perform follow up in the nursing facilities as well to try and keep the stay short and make sure they have services when they return home. The model is broad in that it covers transitions from multiple care settings—home and nursing facility. We are currently in a phase of re-educating hospital staff about which referrals to send to us, and informing hospital staff that we want to talk to people with Medicare paid stays. One hospital links us to their hospital computer system so we can track information on admissions; there were some barriers with this but we're working through it. *AAA 10B, Inc., Uniontown, Ohio*

A care transitions specialist has been hired by each of the ADRC sites implementing an evidence based care transition model, either Care Transition Intervention or BOOST. The specialists are employed by the ADRC project. However, they are fully integrated into the hospital staffing model. They participate in weekly rounds and/or discharge planning meetings as part of the multidisciplinary team. Responsibilities of the care transition specialist include hospital patient visits, follow-up home visits and phone calls per model protocols and individual needs of the consumer. Specific training was provided based on the identified model, in addition to person-centered planning and New Hampshire ADRC services. *New Hampshire Department on Aging Community Living Program*

Q: How are you streamlining access for your program's participants? How did you fit your program into your existing organization/partnerships?

Information technology is the backbone of the referral system that taps into our array of services. Discharge planners will be using the referral tools in the ADRC Online Resource Manual to coordinate services with AAA and CIL case managers for Medicaid HCBS waivers. Also, a problem that was identified through our discharge planner and community provider survey was the lack of information about home and community based services that are already in place when a consumer

is hospitalized. To address that issue, we developed several items to prompt patients/caregivers to tell discharge planners about services they are receiving at home (e.g., a poster for hospital rooms, brochures). And finally, the program will be closely coordinating with our nursing home diversion program/assessments (CARE and PASRR) that are required for anyone considering nursing home placement. *Kansas Department on Aging, Hospital Discharge Planning Grant*

During intake hospital discharge planners will be in contact with Medicaid HCBS case managers. Once eligibility has been determined, in conjunction with the discharge plan, coordination between both parties expedites enrollment into these services. *Idaho State University, Institute of Rural Health, Hospital Discharge Planning Grant*

Our ADRCs are fully State funded and they also have two State funded programs that provide in-home care. One of these, the Lighthouse Program, provides services to people above the Medicaid threshold, and so it is used for this project. People not on Medicaid will receive services from the ADRC on Day 1 of discharge from the pilot hospitals. If they are already on Medicaid, their current provider will be notified of the change and the ADRC will fill in until they can adjust and enroll in appropriate services. ADRC counselors also have the State Health Insurance Assistance (SHIP) program in-house that will assist program enrollees with their benefits. ADRC staff will be on call 24/7 for project participants with questions and needs. In addition, the sites will offer chronic disease self management programs to participants. Two State level trainers will train county staff so the county aging provider and ADRC staff can work together to offer the classes. Overall, the program will try and meet all of a person's needs for recovery. *West Virginia Bureau of Senior Services, Community Living Program*

Q: How are you cross-training partners and providers?

A person-centered training curriculum has been developed. Project partners and implementation staff received the most intense training on person-centered planning, coaching, motivational interviewing, SMART goal-setting, our enhanced discharge planning protocol, data collection and data sharing processes, and technical aspects of video conferencing for participants and their families. All hospital discharge planners at the pilot hospital attended a one-day training on the person-centered approach and community resources. This training will also be offered to local community service providers and AAA/ADRC staff statewide. *South Carolina Bureau of Senior Services, Hospital Discharge Planning Grant*

A survey of discharge planners' training needs and preferences was implemented in order to engage and retain them in statewide webinars. Rural providers are often overwhelmed with multiple roles, and so there is a need to identify training strategies and tools that assist in making care transitions an essential part of the larger care picture. *Idaho State University, Institute of Rural Health, Hospital Discharge Planning Grant* ¶

Additional Resources

- Navigating Across Care Settings: Choices for Successful Transitions (PowerPoint) or (PDF)
- Connecticut's ADRC Approach to Integrating the Care Transitions Intervention Model and Chronic Disease Self Management Program (PowerPoint) or (PDF)
- Care Transitions and AoA's Evidence Based Health Programs (PowerPoint) or (PDF)