Chapter Six: Implementation and Day-to-Day Operations

Chapter Outline

Chapter Overview

Although specific implementation details vary according to the care transitions program and other local factors, models typically have some type of referral mechanism to identify consumers who would benefit from the program, protocols for sharing information, as well as strategies to support consumers as they transition from hospital to home. This chapter addresses some common practices that walk participants through their transition intervention, starting at the hospital and moving through post-discharge follow-up and connection to long-term services and supports.

Cross-Training Partners

Understanding your new partners' level of familiarity with your organization or the Aging Network in general will be key to maintaining an ongoing and growing relationship with hospitals and other health care providers. Care transitions programs operated through local Aging Network organizations have spent significant time and resources on keeping their hospital partners engaged and abreast of their program operations. Strategies range from performing a training assessment of local discharge planners, hosting focus groups, performing in-services, and providing continuing education units (CEUs).

Content for training curriculum can vary greatly depending on the local need and interest. Many AAAs and ADRCs say that it is helpful to go through any care transitions model/intervention training together with their hospital or other medical provider counterparts. These trainings provide a shared opportunity to observe and work through differences in terminology and perceptions in a supportive learning environment.

Another consideration for cross-training should include a basic framework for the Aging Network and updates regarding your organization. Staff turnover at hospitals and other partners will make it necessary to frequently revisit these topics so that you can build on the momentum of the care transitions program despite changes in staffing. Presentations and materials could include:

- Introduction to the OAA
- Basic structure for AoA, State Units on Aging, and AAAs
- Specifics as to how this is structured within your state, including:
  - » State authorities
  - » Its progression over time
  - » ADRCs and other State level initiatives (Medicaid Waiver)

- Basic tenets for service delivery:
  - » Your mission and vision for the community and people you serve
  - » Your organizational structure and in relation to other community services and providers
  - » Your case management or service delivery model
  - » Consumer planning and direction or focus on independence, choice, and control of individuals

Resources

- Cross Training—The Aging Services System
- Maine Care with Transitions Brochure
- Course for Hospital Discharge Planners—Missouri Hospital Discharge Planning Grant

Identifying Appropriate Candidates for Your Program

Choosing a target population may depend on the care transitions program, staffing, or other factors. The following strategies have been used by other care transitions programs within the Aging Network to identify consumers who would benefit from a care transitions program:

Through clinical judgment of hospital staff. Some sites use the judgment of the hospital discharge staff to determine who is an appropriate candidate for the care transitions program. Referrals made through this strategy capitalize on the expertise of hospital discharge staff, build relationships, and serve as a mechanism to increase commitment to the program. With this strategy, it will be helpful to give a clear picture of the target population and provide hospital staff with feedback on the appropriateness of referrals. If you are planning to provide some level of assistance to everyone referred to you, this may be a good strategy. If you are operating a program with a more specific target population, other referral methods may be more appropriate, such as written protocols.

Developing written protocols. Some sites have established written protocols and eligibility criteria to generate referrals from hospital discharge planners or to decide which patients to approach. Protocols can help establish consistency in the process of identifying clients. They can include factors such as age, diagnosis, and length of stay. Referral strategies that minimize additional burden on the hospital staff and are responsive to the organizational culture often support successful program implementation.

Resources

- Oregon Real Choice Hospital Discharge Model Policies and Procedures
- Oregon Real Choice Hospital Discharge Model High-Risk Screening Tool
- South Carolina Real Choice Hospital Discharge Model Process Enhancements Book

Through onsite placement of your organization's care staff. Many Aging Network partners have found that positioning community based staff onsite at the hospital can create a greater opportunity to become a part of the discharge planning culture, provide formal or informal education to discharge planners and other members of the health care team, and track the number of individuals who could benefit from intervention. Some partnerships have designated office space for network staff within the discharge planning department or within other areas of the hospital to increase opportunities for identifying consumers who would benefit from the care transitions program.

With onsite placement at the hospital, network sites have employed the following strategies to identify individuals who would benefit from the care transitions program:

- Using internal hospital data systems to identify consumers by appropriate diagnoses, age groups, etc.

- Attending morning rounds
- Soliciting referrals from physicians, hospitalists, floor nurses, physical therapists, occupational therapists, discharge planners, and other hospital staff

The range of options available for the program may be dictated in part by the hospital's willingness to grant care transitions staff access to computer systems and patient care units in the hospital. Finally, it is important to note that the ability to identify potential consumers within the target population may depend on the structure of the discharge planning unit in the hospital. Some hospitals maintain a centralized discharge unit, while others have separate discharge planners for different floors or units in the hospitals.

Resources

- Missouri Hospital Discharge Planning Grant Map for Options Counselors
- Brochure for Central Texas ADRC's CLP/Care Transitions Program

Providing Care Transitions Support to Consumers and Caregivers

Most care transitions models identify specific protocols and implementation strategies to support consumers and caregivers as they transition across the continuum of care. Program components may include patient activation, medication management, and ensuring follow up with primary or specialty physicians post-discharge.

Yet during and after a hospitalization, consumers and caregivers often do not know how to access available community services or what options are available to them. Some studies have found that 40 percent to 50 percent of readmissions are linked to social problems and lack of community resources.[17] The Aging Network is uniquely qualified to address these transition challenges. Care transitions programs implemented by the Aging Network have developed strategies to maintain fidelity to existing care transitions models while augmenting transition services to include greater access to LTSS and post- discharge community support. These strategies include:

- Completing assessments for OAA services onsite at the hospital to expedite start of services
- Providing a package of temporary LTSS services immediately following discharge to offer short-term support while long-term supports and services are being secured
- Connecting consumers and caregivers to health programs to promote patient activation after the care transitions program is complete, including:
  - » Chronic disease self management programs
  - » Diabetes self management programs
  - » Medication management
  - » Fall prevention programs
  - » Caregiver health program (for more information, see Chapter 5—Building Organizational Capacity)
- Using technology to facilitate transitions (see Tech4Impact grantees factsheet and abstracts).
- Developing agreements across AAA/ADRC sites to fast track services for individuals discharged to a location outside of a particular AAA/ADRC's service area.

17 Proctor et al. (2000). Adequacy of Home Care and Hospital Readmission for Elderly Congestive Heart Failure Patients. Health and Social Work, 25(2): 87-96(10)

Dealing with Emergent Issues

In the course of providing support for care transitions participants, it can be difficult to know when it is necessary to consult a doctor, nurse practitioner, physician's assistant, or nurse, or when someone should return to the hospital. There are resources available that provide general guidelines for determining when issues are emergencies (e.g., medical crises manifested by symptoms such as shortness of breath or pain, fainting or loss of consciousness, changes in mental status, and evidence of abuse); when issues are urgent (e.g., serious medication discrepancies, major medication side effects, changes in chronic symptoms such as shortness of breath or pain); and when issues are important (e.g., questions about medications, requesting medication refills, minor illnesses such as symptoms of the flu). Understanding the importance or urgency of the issues will help staff and participants determine if an urgent call to a doctor or other health care provider, or a trip to the hospital is necessary.

Because some AAA or ADRC staff do not have a background in medical services, it can be difficult to make recommendations or determinations about medical emergencies or health concerns. Your program should establish protocols for handling these situations that will take local policies, staff qualification, and care transition model into consideration. You can develop these protocols with your partners—your hospitals, local physicians, and other health care providers.

Resources

- When I Go to the Hospital and See My Doctor
- INTERACTII Early Warning Tool Developed for Nursing Home Residents
- Management Zones and Emergency Contact
  Sample tool for heart failure patients

Individual and Partner Follow-Up

After discharge. Most care transitions programs identify important timeframes for following up with consumers and caregivers post-discharge. The first few days post-discharge are often the most vulnerable time for consumers. Many models provide a structured home visit or phone call within 48 to 72 hours of discharge. Follow-up, either in person or over the telephone, provides an opportunity to check on health status, identify unmet needs, provide education, empower patients to self manage their care, and remind them of important next steps.

For example, studies have shown that approximately 50 percent of Medicare beneficiaries do not attend a follow-up outpatient physician visit within 30 days of discharge.[18] Most care transitions models have developed strategies to encourage and support scheduling follow-up visits. Although a visit may be scheduled, lack of

18 Stephen F. Jenks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H. Rehospitalizations Among Patients in the Medicare Fee for Service Program. N Engl J Med 2009; 360: 1418-1428

transportation to and from the appointment may serve as a critical barrier prohibiting the individual from keeping the appointment. AAA/ADRC's are well equipped to address these community based needs as plans change during or after the hospitalization and connect consumers with resources to improve the consumer's ability to obtain follow-up care.

Developing a structured feedback process for informing hospitals and other partners or referral sources is also a good idea. This can take the form of a letter thanking the partner for the referral and providing information about the care transitions participant's status, including:

- Enrollment in certain programs such as Medicaid Waiver, and other evidence based disease prevention or management programs
- Identifying case managers, physicians, home health agencies, or others who may be working with the participant
- Results of a medication reconciliation or follow-up physician appointment, etc.

Work with partners and hospital staff to determine exactly what information is helpful and what format is preferred.

Resources

- Riverside County Office on Aging Hospital Liaison Chart Letter
- Riverside County Office on Aging Consumer Pre-Survey
- Riverside County Office on Aging Consumer Post-Survey

After the intervention. Post-discharge follow- up activities within care transitions programs typically end between 30 and 90 days post-discharge. For consumers who need additional support and services beyond the transitions program time period, Aging Network sites have developed strategies to ensure seamless internal transitions from the care transitions program to other longer term support mechanisms that already exist within the organization.

Additionally, it is important to build and budget for systematic follow-up after the intervention or once additional supportive services have been arranged. In general, many care transitions models do not include this functionality. It is a unique component that the Aging Network can offer beyond the transition period for individuals who need additional support. How will you know if someone goes back to the hospital? For care transitions participants who are connected to options counselors or to community based care management, how will this information be shared with hospital partners? Some sites have developed protocols within their partner hospitals to alert Aging Network partners when a care transitions participant is readmitted to any local hospital connected to a larger health system. Other sites pay for a health information exchange (HIE) service. The role of the HIE is to electronically move clinical information among disparate health care

information systems while maintaining the meaning of the information being exchanged.

Day-to-Day Operations—A Case Study

Moving from planning your care transitions program to implementation takes time. This case study from the New Hampshire ADRC Evidence-Based Care Transitions Program illustrates the process for setting up your day-to-day operations.

We developed a planning process to approach receiving referrals for those seeking information about nursing homes and community based long-term supports in a timelier manner. We created a committee with home care agency staff, visiting nurse staff, and hospital discharge planning staff to talk about what an approach by which the resource center's long-term support counselors would receive referrals from hospital discharge planners might look like. To avoid hospitals referring everyone, we identified key criteria for hospital referrals to resource staff. After identifying pilot counties, we met with hospital staff in those counties to talk to them about what criteria we had drafted for discussion and to refine the approach we'd like to use, initiating these conversations through their CEOs. At first, the staff was not even aware of the existence of our services. After meeting with the hospital staff, we put together a one-page referral form, which is available on our website. Hospitals have patients sign a release form and will give patients a flyer on our resource center so that they may refer back to their discharge packets and understand who is contacting them.

The Aging and Disability Resource Center model operates in all 10 New Hampshire counties. During the planning and implementation phase of the project each locally based ADRC began accepting referrals from individuals seeking assistance, caregivers, hospitals, nursing facilities, sub-acute rehabilitation settings, home care, and visiting nursing agencies.

In 2009, a statewide workgroup was established to research and implement a person-centered hospital discharge pilot in three ADRCs. The goal was to improve the acute care discharge process through the integration of ADRC staff. Day-to-day operations in each site vary based on unique characteristics of the model being implemented and the needs of the community.

Commonalities between the pilots include:

- Each of the three county based ADRCs is working with one hospital in its region on a specific evidence based care transitions model (either the Care Transitions Intervention or BOOST).
- A care transitions specialist is employed by the ADRC and fully integrated into the acute care hospital.
- The target population was established through a combination of the evidence based model protocol, evaluation of readmission rates, and criteria for high-risk social factors.
- The hospitals refer patients to the care transitions specialist who participates 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.

New Hampshire Department on Aging
ADRC Evidence-Based Care Transition Program

Questions to Consider and Practical Advice from the Field

Q: What processes/protocols were established to share information?

An online resource manual was created with a public access database for patients, caregivers, and discharge planners to search provider listings. Limited access tools were developed on the back end of the website for case managers and discharge planners to share patient information and make referrals. *Kansas Department on Aging, Hospital Discharge Planning Grant*

The online data system used statewide by ADRC information, referral, and assistance specialists was modified to allow hospital discharge planners and ADRC-based coaches to share information. Information shared includes risk assessment data, discharge plans, individual needs/preferences, and referral information. This data system is tied to SC Access, our statewide resource database. Information sharing is limited to methods specified in the protocol. *South Carolina Bureau of Senior Services, Hospital Discharge Planning Grant*

A Hospital Discharge Virtual Program Center is used as the main portal to exchange information (developed through funding with an existing IT contractor). It has a specific "partner" link to Idaho's ADRC and person-centered grant through the Council on Developmental Disabilities. Accessibility is coordinated through AGIS Inc. and 508 compliance. *Idaho State University, Institute of Rural Health, Hospital Discharge Planning Grant*

Q: How did you target populations?

We work closely with our emergency departments (ED) to target those who get treated but not admitted to inpatient. ED staff are familiar with "frequent flyers" who come in frequently for emergent care issues. The ED pages our LTC specialists for a referral into the care transitions/community living program and they distribute brochures about the program available in the ED. *Area Agency on Aging of Central Texas, ADRC Evidence-Based Care Transitions Program*

At the beginning, the criteria used to assess eligibility (assessment) was much more stringent. But we found that if a patient isn't mentally capable of becoming empowered, they try to involve a family member as a proxy. The goal is to get the support information out there. Often, we look at their discharge history to identify who would benefit from the intervention. *Quality Insights (PA QIO) regarding work with Southwestern PA AAA and Westmoreland County AAA from the QIO 9th Scope of Work Care Transitions Theme*

Q: How is your organization addressing concerns with hospital partners related to HIPAA?

We gather consent electronically for all project participants. An advisory group involves all partners to resolve any issues of concern in a quick and coordinated fashion. Having a business agreement with hospitals about speaking to patients is also helpful. Other data that are gathered is aggregated by the hospital and is not personally identifiable. *West Virginia Bureau of Senior Services, Community Living Program*

Within our partner sites, coaches are generally not looking at patients' charts. AAAs are considered a continuum of care provider. The process varies. Some coaches are made employees of the hospital to access

information while others remain external. *Quality Insights (PA QIO) regarding work with Southwestern PA AAA and Westmoreland County AAA from the QIO 9th Scope of Work Care Transitions Theme*

Q: What general advice or tips do you have for running your programs?

Regarding referral protocols, hospital case managers choose the patients and make referrals to the coach at the AAA. The coaches then initiate visits to the patients to begin working with them and distributing tools. We try to make the referral more than 48 hours before discharge, if possible. Earlier is better. When patients are being discharged, they have a lot on their mind. Meeting a coach at that point is not the best time. Many patients opt out of coaching's in-home visit, but they're open to phone coaching. We try to meet people where they are. Separately, AAA partners are helping identify senior centers where presentations can be made. This allows the project to provide education before hospitalization. They can introduce many of the tools, such as the personal health record. *Quality Insights (PA QIO) regarding work with Southwestern PA AAA and Westmoreland County AAA from the QIO 9th Scope of Work Care Transitions Theme*

We are implementing our program in mid-size community hospitals throughout the State, two pilots and two controls. The hospitals are primarily county based so the volume of patients is appropriate and easy to track. We are targeting people with some chronic conditions that are at higher risk of readmission—COPD, diabetes, and congestive heart failure. The AAA/ADRC counselor makes either a hospital or in-home visit to patients that receive the intervention. The counselor will also meet with the hospital discharge planner and make an action plan that will take effect at time of discharge that guarantees seniors will have transportation home and to the doctor, prescriptions filled, in-home care at the level the patient needs, and in-home meals. *West Virginia Bureau of Senior Services, Community Living Program*

Additional Resources

- Armstrong, Amy and Kraft, Kylene. A Report of Questionnaires Administered to North Dakota Hospital Discharge Planners. September 2006. Available at: http://www.hcbs.org/files/109/5411/ReportofHDP.pdf
- Chapin, Rosemary et al. Real Choice Project: Referral System Assessment, Final Report. The University of Kansas School of Social Welfare, Office of Aging and Long Term Care. 2007. Available at: http://www.oaltc.ku.edu/research/reports.shtml
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