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

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/ResourceRoom/Redesign/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)**

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

<table>
<thead>
<tr>
<th>Interdisciplinary Teams &amp; Service Coordination</th>
<th>Enhanced Follow-Up</th>
<th>Patient/Client Activation</th>
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</thead>
<tbody>
<tr>
<td>• Coordination of services (medical/human services)</td>
<td>• Case Management/Care Coordination</td>
<td>• Patient/client assessments</td>
</tr>
<tr>
<td>• Workforce development and training</td>
<td>• In-home services</td>
<td>• Self-directed care/coaching</td>
</tr>
<tr>
<td>• Planning</td>
<td>• Home-delivered meals</td>
<td>• Health/nutrition education</td>
</tr>
<tr>
<td>• Partnerships</td>
<td>• Transportation</td>
<td>• Insurance counseling</td>
</tr>
<tr>
<td>• Coordination of benefits</td>
<td>• Monitoring/assistive devices/PERS</td>
<td>• Family caregiver support, counseling, training</td>
</tr>
<tr>
<td></td>
<td>• Medication mgmt.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Disease prevention &amp; health promotion</td>
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</tbody>
</table>

**AoA Affordable Care Act Webinars**
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](http://www.caretransitions.org) (Care Transitions Intervention℠)
- [http://www.transitionalcare.info/](http://www.transitionalcare.info/) (The Transitional Care Model)
Resources: Models (continued)

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

Resources: Affordable Care Act

- [http://www.healthcare.gov](http://www.healthcare.gov) (Department of Health and Human Services’ health care reform web site)
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