

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



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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



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Common Care Transition Themes

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



Evidence-based Models

- Care Transitions InterventionSM
- 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 InterventionSM (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>



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Care Transitions InterventionSM: The Four PillarsTM

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



Care Transitions InterventionSM Framework

Staff: Transition CoachTM

Training: 1 day training

Length of Intervention: Four Weeks



Care Transitions InterventionSM 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/ResourceRoom/Redesign/RR_CareTransitions/CT_Home.cfm



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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](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/>



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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



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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

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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



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