



# Care Transitions in Action: From Hospital to Home in Two Communities

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ADMINISTRATION ON AGING, WASHINGTON DC 20201  
PHONE 202.619.0724 | FAX 202.357.3523 | EMAIL [AffordableCareAct@aoa.hhs.gov](mailto:AffordableCareAct@aoa.hhs.gov) | WEB [www.aoa.gov](http://www.aoa.gov)



# Agenda

- Introductions/housekeeping
- Chicago: The Bridge Model
  - Robyn Golden, Rush Older Adult Programs
  - Robert Mapes, AgeOptions
  - Walter Rosenberg, Rush Older Adult Programs
  - Ilana Shure, Aging Care Connections
  - Louise Starmann, Aging Care Connections
- Akron: Care Transitions Programs
  - Dr. Kyle Allen, Summa Health System
  - Carolyn Holder, Summa Health System
  - Joseph Ruby, Area Agency on Aging 10B Inc.
- Resources
- Next training
- Questions & answers



# The Bridge Model

Hospital-Community Partnerships in a Social Work Transitional Care Model

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PHONE 202.619.0724 | FAX 202.357.3523 | EMAIL [AffordableCareAct@aoa.hhs.gov](mailto:AffordableCareAct@aoa.hhs.gov) | WEB [www.aoa.gov](http://www.aoa.gov)



# Overview

- Overview of the aging network in Illinois
- Illinois Transitional Care Consortium
- ADRC Care Transition Grant
- Bridge Model
- Connecting to hospitals
- Making the business case for care transitions
- Policy developments

# The Aging Network in Illinois

- Illinois Department on Aging (IDOA) -- first cabinet level Department in the nation
- Thirteen Illinois area agencies on aging (AAA) – not for profit except for the City of Chicago. System reaches over 500,000 persons yearly and partners with 300 community based service agencies offering meals and a wide variety of services and information
- Care Coordination Units (CCU) established by IDOA and the AAAs to provide universal pre-screening of home bound patients, in-home assessments (under Medicaid Waiver Program), care planning and often elder abuse and neglect interventions



The ITCC was formed to more effectively address needs of older adults transitioning from the hospital to the community by linking hospital based services with the aging network through intensive care coordination.

# ITCC members

- Community-based organizations
  - Aging Care Connections
  - Shawnee Alliance for Seniors
  - Solutions for Care
- Hospitals
  - Rush University Medical Center
  - MacNeal Hospital
  - Adventist LaGrange Memorial Hospital
  - Herrin Hospital
  - Carbondale Memorial Hospital
- Research, Evaluation & Policy
  - University of Illinois at Chicago, School of Public Health
  - Health & Medicine Policy Research Group

# Advisory Board

- **Jean Bohnhoff** - Executive Director, Effingham County Committee on Aging
- **Thomas Cornwell** - Medical Director, HomeCare Physicians
- **Bob Clapp** - Senior Vice President, Hospital Affairs, Rush University Medical Center
- **Jim Durkan** – President & CEO, Community Memorial Foundation
- **Karen Freda** - Executive Director, Illinois Council of Case Coordination Units
- **Michael Gelder** - Senior Health Policy Advisory to Illinois Governor Pat Quinn
- **Michael Koronkowski** – Pharmacist and Geriatrics Professor, University of Illinois at Chicago
- **Jonathan Lavin** – President & CEO, AgeOptions, Suburban Cook County Area Agency on Aging
- **Patricia Merryweather** - Vice President, Illinois Hospital Association
- **Marta Pereyra** - Coalition of Limited English-Speaking Elderly
- **Cheryl Schraeder** - Director of Policy & Practice Initiatives, Institute for Healthcare Innovation, University of Illinois at Chicago College of Nursing
- **Patricia Volland** - Senior Vice President, Strategy & Business Development, The New York Academy of Medicine
- **Rebecca Zuber** - President, Rebecca Zuber, Inc.

# ADRC Care Transitions Grant

- Expand the Bridge Program to serve persons with disabilities under age 60, in addition to older adults 60 years and older
- Implement the expanded Bridge Program at 3 ITCC sites
  - Mac Neal Hospital (CCU partner: Solutions for Care)
  - Adventist LaGrange Memorial Hospital (CCU partner: Aging Care Connections)
  - Rush University Medical Center (CCU partner: Central West Case Management)

# ADRC Role in Promoting Improved Care Transitions

- Suburban Cook County ADRC
  - AgeOptions
  - Progress Center for Independent Living
- Training and Programs
  - Specialized training in working with people with disabilities
  - Plan, coordinate and fund support services
  - Evidence-based health promotion (CDSMP)
- Coordination
  - Informed funded agencies about the Bridge model and upcoming grants
  - Coordinated outreach to hospitals

# The Bridge Model



# The Bridge Model

- Overview of Components
  - Social-worker Based: Bridge Care Coordinator
  - Interdisciplinary Teams
  - Hospital → Home
  - Patient Focused, Community-Specific
  - Partnership between Community-Based Organization and Hospital
    - The Aging Resource Center
- Urban, Suburban, and Rural applicability

# Patient admitted into a hospital



## After hospital admission the Bridge Model Care Coordinators receive patients in one of two ways:

- Risk-screen incorporated into hospital electronic medical record (EMR) producing daily report of upcoming discharges that fit criteria
- Direct referral made by discharge planner or family member walking into an Aging Resource Center (ARC) located on-site at hospital

## After receiving a referral, a pre-discharge assessment takes place:

- Bridge Care Coordinators meet with full or partial interdisciplinary team in charge of patient's hospital care and participate in pre-discharge rounds, discussing possible post-discharge needs that may arise
- Where possible, interim in-home services ordered to decrease time for start of needed services

# Patient returns home



Patient is re-assessed 48 hours after returning home and Bridge Care Coordinators intervene to address identified issues

- **Bridge Care Coordinators coordinate all of the following:**
  - Ability to follow-up with discharge plan of care
  - Clarify any confusion over medication regimen
  - Follow-up with primary care physician in the community
  - Help to make and attend follow-up medical appointment(s)
  - Promptly set-up appropriate in-home services
  - Communicate with Home Health and/or other community service providers to ensure timeliness and address mistakes (wrong addresses/times, etc.)
  - Assist referred patients with psychosocial needs, including depression, adjustment to change, caregiver burden/stress, etc. with short term counseling or appropriate referral

# Building off Aging Network

- Conducting Choices for Care Assessments and Comprehensive Care Coordination Assessments (Standardized case management assessments utilized throughout Illinois)
- Setting up Medicaid Waiver Interim Services and/or other community-based services as need
  - Referrals made to both private and public agencies
- Providing and referring families for Caregiver Support Services and Respite
- Conducting Benefits Check-Ups
- Providing Information & Assistance to Patients and their families on site (i.e. Medicaid, Food Stamps, Circuit Breaker, Tax Freezes, Medicare Part D, Home Modification, FSS)

# Bridge Care Coordinators



# The Post-Discharge Environment

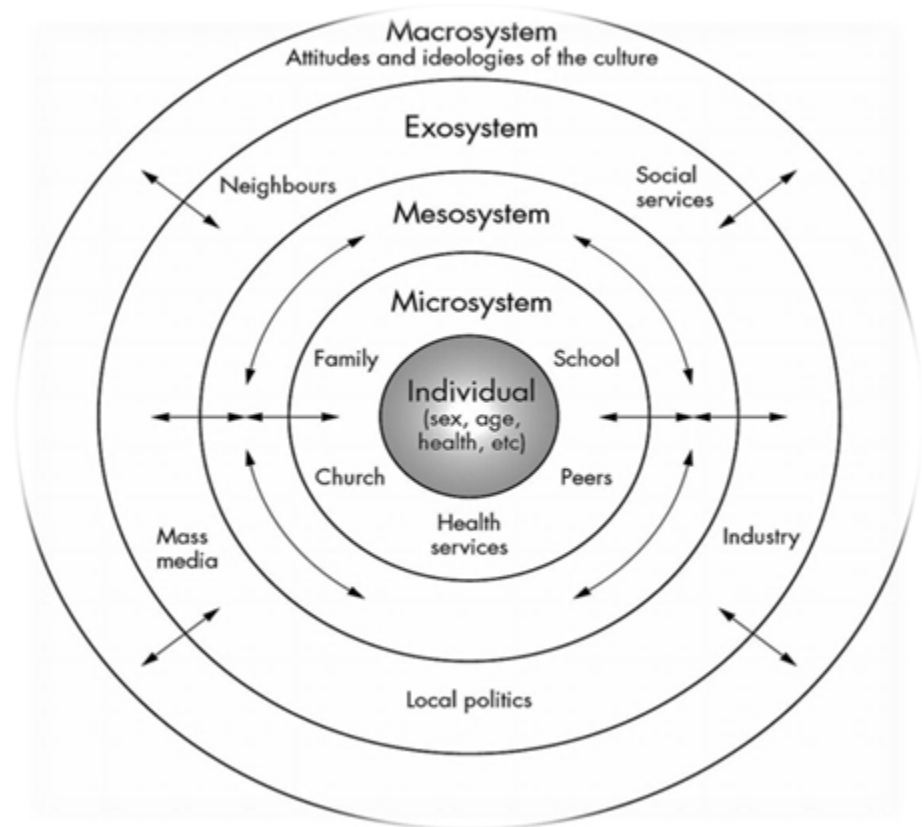


# Psychosocial Issues

- Social isolation
- Depression
- Difficulty coping with change
- Financial stressors
- Language barriers
- Health literacy barriers
- Older generations taught to be “good patients”

# Bridge Care Coordinators

- Why Social Workers?
  - Systems Theory
  - Biopsychosocial framework
  - Psychosocial determinants of health



# Evidence Base

- Rush Enhanced Discharge Planning Program randomized controlled trial
- N=720
  - Referrals generated through electronic medical record at discharge
  - June 2009 to March 2010



# Outcomes

- 30, 60, 90, 120, 180 days readmission
- Increase access to formal services
- Decrease time between discharge and start of services
- Follow-up physician appointments
- Increased understanding of purpose of prescribed medication
- Greater understanding of responsibilities for managing own health
- Decreased mortality

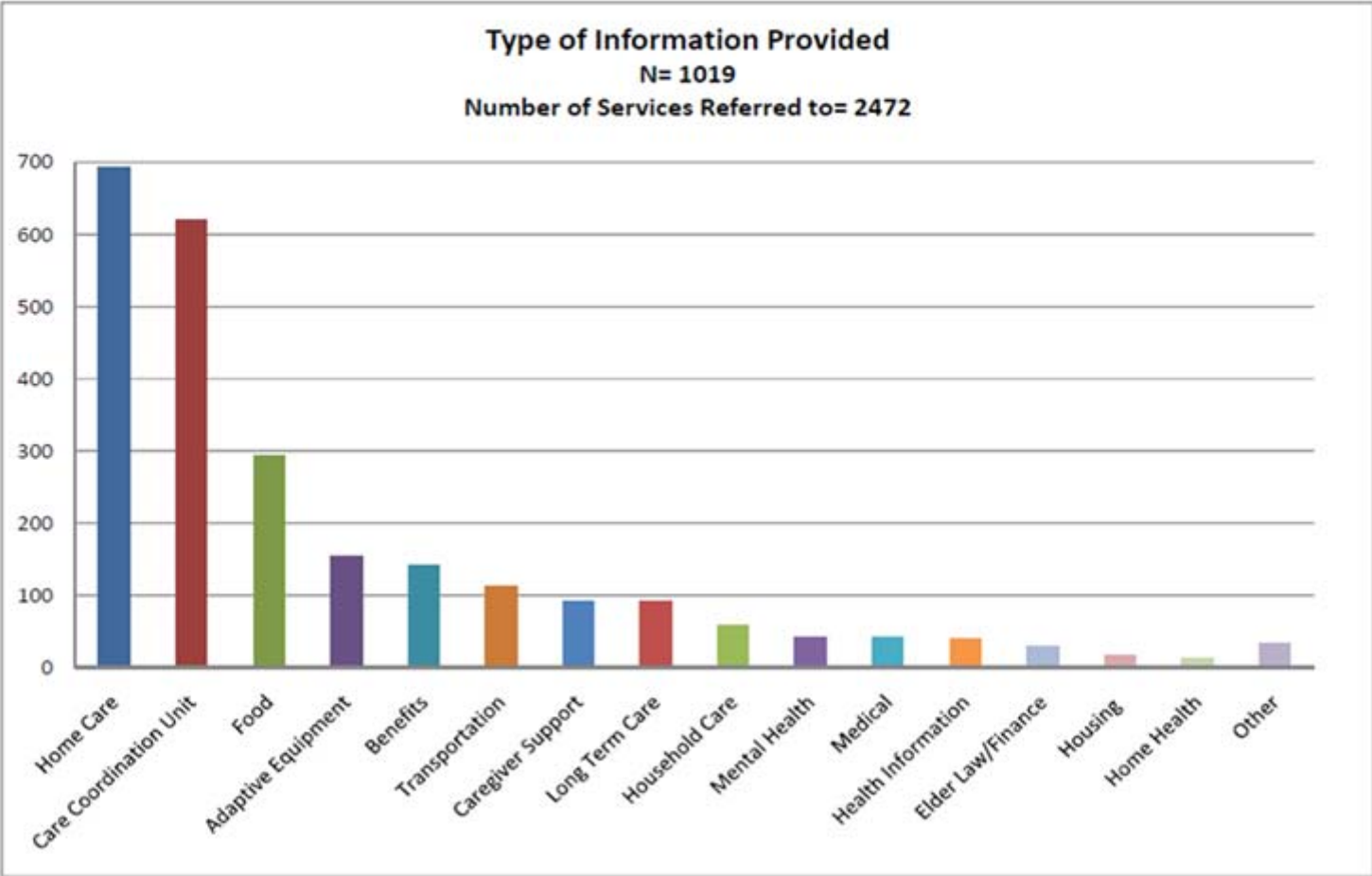
# Aging Resource Center (ARC)



# The Role of the ARC

- Symbol of hospital-community collaboration
- Greater ability to interface with the community
  - Creates continuity for the patient across healthcare silos
- Promotes the notion of “systems” approach to discharge planning
- Maximizes the opportunity for a servable moment

## Aging Care Connections Aging Resource Center Program



## Aging Care Connections Resource/Service Categories

### Home Care

Adult Day Care  
What is Adult Day Care  
Bath Only Services  
CCP Services  
Private Homemaker Services  
How to Choose a Homemaker  
Bathroom Safety  
Home Safety

### Care Coordination Unit

Aging Care Connections  
12 additional CCU's

### Food

Home Delivered Meals  
Congregate Meals  
Special Diet Program  
Private Pay Meals  
Grocery Delivery

### Adaptive Equipment

EHRs  
Assistive Devices  
Durable Medical Equipment

### Benefits

Home Weatherization  
Medicaid  
Medicare  
VA  
Pharmaceutical Assistance  
Circuit Breaker  
LIHEAP

### Transportation

Driving Evaluation  
Resource List  
Web Resources

### Caregiver Support

Respite -In Home  
Respite - Out of Home  
Caring for the Caregiver

### Long Term Care

Housing Options  
How to Evaluate  
Retirement Communities  
Assisted Living  
Nursing Homes  
Ombudsman

### Household Care

Chore services  
Cleaning Services  
Handyman Services  
Snow Removal

### Mental Health

Counseling  
Neuropsych Evaluation  
Support Groups: Community  
Support Groups: ACC  
Support Groups: Online

### Medical

Medication Management  
Geriatricians  
Home Visit Physicians  
Assessment Centers  
Other

### Health Information

### Elder Law/Finance

### Housing

Homeless Prevention  
Temporary Housing/Shelters  
Other

### Home Health

Home Health Services  
Hospice

### Other

Disability Resources  
Ethnic Resource Centers  
Home Hair Care  
Volunteer Activities  
Socialization  
Other

# Establishing an ARC

- Time frames for developing the ARC
- Outreach to hospital
  - Through existing programs or contracts already established
- Begin contacting individuals at the hospital who are supportive of the model.



# Establishing a Partnership

1. Evaluate Potential Partners
2. Make the “ASK”
  - Identify what you are asking the partner to contribute
3. Establish the basic structure of the partnership prior to launching the project
  - Keep parameters loose enough to allow for growth development
4. A Memorandum of Understanding (MOU) at a minimum should be in place prior to the start date of the project

# Establishing a Partnership (continued)

- Legal agreements should be created broadly defining the service provision, the recipient of the service and duties of each partner in the relationship including:
  - Purpose of the program
  - Responsibilities of both parties
  - Individual responsibilities of the partners
  - Financial liabilities
  - Confidentiality and **data sharing**
  - Termination

**Annually review agreement!**

# Lessons Learned

- Integrate at all levels of the hospital system
  - Front desk reception to Regional Director
- Be patient and persistent
  - Guest versus Team Member
- Troubleshoot challenges before they become barriers
- Learn both cultures and languages
  - Network, network, network

# Community-Hospital Partnerships

- Aging Care Connections (CCU - Suburban Chicago)
  - Adventist LaGrange Memorial Hospital
- Shawnee Alliance for Seniors (CCU – Rural, downstate Illinois)
  - Carbondale Memorial Hospital
  - Herrin Hospital
- Solutions for Care (CCU – Suburban Chicago)
  - Mac Neal Hospital
- Central West (CMU – Chicago)
  - Rush University Medical Center

# Building the Business Case

- The evidence must be translated into a business case

*(M. D. Naylor and J. A. Sochalski, Scaling Up: Bringing the Transitional Care Model into the Mainstream, The Commonwealth Fund, November 2010)*

- Identifying clinical and economic outcomes
- Comparing quality and cost outcomes
  - Reduced hospital readmissions and Emergency Department (ED) visits
  - Appropriate outpatient follow-up
- Isolating essential program elements to create efficiencies



# Building the Business Case (continued)

- Making case for improving quality and reducing cost to position as “compelling solution for the payer community”<sup>1</sup>
  - Private purchasers
  - Insurers
  - Public payers
- Providers
- Get consumer to ask for program
  - Need to know they should expect transitional care



# Influencing and Interpreting Policy

- Evidence and business case create platform for advocacy and policy change
- New health care policies include transitions, but require interpretation and innovation
  - Community Based Care Transitions Programs
  - Reducing 30-Day Readmissions
  - Piloting Bundled Payments
  - Creating Accountable Care Organizations
  - Encouraging Medical Homes

# Bundled Payments

- Bundled payment pilot to begin by 2013
  - Single Medicare payment will cover all services for an episode of care to be distributed among care providers:
    - Acute hospital services
    - Physicians' services
    - Care coordination and transitional care services
    - Post-acute services
      - Home health care
      - Skilled nursing facility services
      - Inpatient rehabilitation services



# Accountable Care Organizations

- Medicare Shared Savings Program creates incentive for the establishment of Accountable Care Organizations (ACOs)
  - Networks of physicians and other providers
  - Share savings resulting from the ACOs coordinated care
    - Reduced Medicare expenditures
    - Improved beneficiary health outcomes

# Medical Homes

- Encouraging Medical Homes
  - Interdisciplinary teams contracting with primary care physicians to provide supportive services to eligible patients:
    - Care coordination
    - Case management
    - Health promotion
    - Transitional care
    - Patient and family support
    - Referral to community services



# CMS and AoA Grants

- AoA made grant funding available for states
  - Strengthen the role of Aging and Disability Resource Centers (ADRCs) in implementing evidence-based care transition models
  - Meaningfully engage older adults and people with disabilities and their caregivers in care transitions
  - Illinois is a grant recipient
- CMS Transitions grant

# Thanks to...

- The Bridge Model would not be possible without the support of:
  - Administration on Aging
  - Community Memorial Foundation
  - Sanofi Aventis
  - New York Academy of Medicine
  - Harry and Jeanette Weinberg Foundation
  - Michael Reese Health Trust
  - Retirement Research Foundation

# Contact

- Robyn Golden, Rush Older Adult Programs  
[robyn\\_golden@rush.edu](mailto:robyn_golden@rush.edu)
- Robert Mapes, AgeOptions [robert.mapes@ageoptions.org](mailto:robert.mapes@ageoptions.org)
- Walter Rosenberg, Rush Older Adult Programs  
[walter\\_rosenberg@rush.edu](mailto:walter_rosenberg@rush.edu)
- Ilana Shure, Aging Care Connections  
[ishure@agingcareconnections.org](mailto:ishure@agingcareconnections.org)

**For more information about the Illinois Transitional Care Consortium, visit <http://www.transitionalcare.org>**

# Questions?





# Care Transitions in Akron

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# Area Agency on Aging Transitions

- How did we get here?
- Acute care setting
- Nursing facility setting

# How Did We Get Here?

- With an IDEA!
  - **I**dentify Key Stakeholders
  - **D**evelop Relationships
  - **E**xplore Common Interests
  - **A**lign efforts to achieve mutually desired outcomes

# Identify Key Stakeholders

- Consumers
- Taxpayers
- Payors
  - Policy-makers
  - Managed Care Organizations
- Long Term Care Providers (nursing and assisted living facilities, home health agencies, AAA provider network)
- Hospitals
- Physician Leaders

# Develop Relationships

- Initiate dialogue with key players within stakeholder organizations (use Board Members to identify and gain entrée)
- Use Board membership as a vehicle to build engagement and commitment to mission and vision
- Make Board Governance (strategic direction and policy-making) a meaningful experience

# Explore Common Interests

- Historically...
  - Promote consumer choice
  - Medicaid cost containment (taxpayer value)
  - Reduce permanent nursing facility placement
  - Increase length of stay in home and community-based programs (i.e., waivers)

# Explore Common Interests (continued)

- Paradigm Shift: New Medicare Initiatives aimed at reducing utilization (Health Care Reform)
  - Reduce hospital admissions and readmissions
  - Reduce length of stay
  - Reduce emergency room visits

# Align Efforts to Achieve Mutually Desired Outcomes

- Develop Hospital Transition Programs
- Develop AAA provider incentive payment plan to achieve desired Medicare outcomes (ACO model)
- Integrate care planning with Medicare Advantage Plans
- Provide I&A to patients at physician practices

# Acute Care Setting Transitions

## Hospital Based Assessments

- Building on S.A.G.E. Hospital program success, AAA placed nurses in Summa Akron City Hospital
- Further capitalizing on that success, we have nurse consultants stationed weekly at 8 acute hospitals and a specialty hospital and the Cleveland Clinic Wooster Campus, a large physician practice that sees 800 Medicaid patients a day
- Nurse consultants work with patient care coordinators, discharge planners, and physicians to create a bridge to home in consultation with the patient and family
- Nurses also screen older adults for any AAA offered services and facilitate the enrollment process as part of discharge planning

# Acute Care Setting Transitions Care Transitions Project

- Key driving force: Affordable Care Act
- Provided Health Coaching through a formal collaboration with two local hospitals to reduce avoidable readmissions
- Built on the Hospital Based Assessor program to provide evidence based health coaching

# Nursing Facility Care Setting Transitions PATH

- Key Driving Force- Limited Waiver Enrollments
- Building on the 2004-05 Administration on Aging grant to integrate care management for common members of PASSPORT and SummaCare Medicare Advantage Plans
- This grant allowed AAA to identify and address barriers to successful integration with a Managed Care Organization (MCO)
- Outcomes of the grant included High Risk Screening tool, Care Management protocols, and a Geriatrician-led Interdisciplinary Team

# Nursing Facility Care Setting Transitions

## PATH (continued)

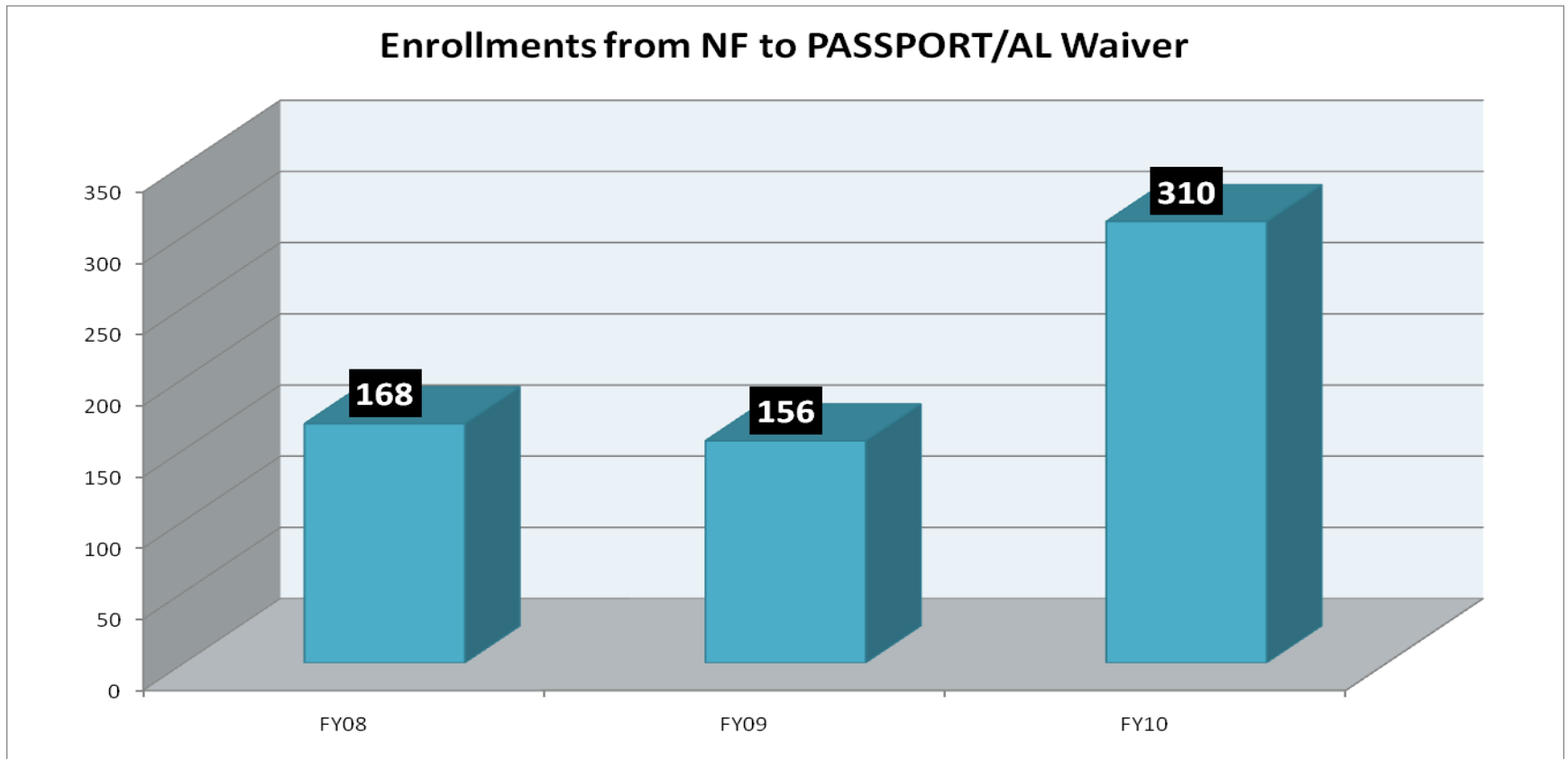
- Building on our care management integration, we developed our PATH Transitions Team which consists of 3 Medical Social Workers in September of 2009
- PATH worked with Summa Care's in panel NF to transition older adults back to home and community based settings
- Notification sent to all nursing facilities informing of PATH Team

# Nursing Facility Care Setting Transitions

## PATH (continued)

- Began meeting with staff at targeted nursing facilities to discuss our agency being an extension of their discharge planning team
- Follow individuals identified by Pre-Admission Review as being 60+ years of age and Medicaid eligible
- The PATH Team spends time in nursing facilities talking with residents who wish to return to the community regardless of age and assessing them for eligibility into PASSPORT and Assisted Living programs

# Results of PATH



# Next Steps

- SummaCare/Summit Physicians, Inc.-Geriatric Medicine/Area Agency on Aging Health Coaching partnership
- Additional transitions staff certified in Dr. Coleman's evidence-based model
- Evaluate impact on discharge to permanent nursing facility placement, hospital admissions and readmissions, emergency department visits, etc.
- Continue developing relationships with nursing facilities and other partners

# **Improving Care through Collaboration: Integration of the Aging Network and Acute and Post Acute Medical Care Services**

# The Partnership



# The S.A.G.E. Project

(Summa Health System/Area Agency on  
Aging, 10B/Geriatric Evaluation Project: A  
Successful Health Collaborative  
(Est. 1995)

# The SAGE Project

- A 15 year collaboration partnership
- Multiple initiatives, a “cast of thousands” (well, maybe 100s, but you get the point)
- Common goal to improve the health, well being and functional status of Akron region frail older adult population
- Identified major gaps in the continuum and care processes from each partner
- Searched and defined mutual benefits
- Shared mutual threats and concerns
- Built trust
- Grew and multiplied to other regional systems
- Communication, communication, communication
- Vision, Vision, Vision, Vision

# SAGE Goal

- **Goal:** To integrate a comprehensive geriatric hospital-based clinical program with the community aging network to improve the health, functional status, and to prevent institutionalization of older adults at risk for nursing home placement.
- **S.A.G.E. Project is an example of how to partner with a community agency:**
  - Acute hospital and medical care services and
  - A community-based Area Agency on Aging

# Area Agency on Aging Programs

- *Mission: To provide older adults and their caregivers long-term care choices, consumer protection and education so they can achieve the highest possible quality of life.*
- Aging Resource Center
- PASSPORT Home Care Medicaid Waiver
- Assisted Living Medicaid Waiver
- Community Services Division
  - Care Coordination
  - Alzheimer's Respite Program
  - Family Caregiver Support
- Elder Rights Division



# Who were the partners?

## Summa Health System Geriatric Medicine Department

- 6 Hospital System
  - 2,027 licensed beds
  - 61,800 admissions
- Level 1 Trauma
  - 113,059 ED visits
- Community Locations
  - 4 outpatient health centers
  - Wellness Institute –
    - medically-based fitness
- Health Plan
  - 110,000 Covered Lives
  - 16,000 Medicare Risk HMO
- Major Teaching Residency and Fellowship Program
- Post Acute/Senior Service Line
  - 10 Certified Geriatricians
  - 12 Geriatric Certified APNs
- Continuum of Care
  - Acute Care/Acute Rehab/ LTAC/ SNF Beds
  - Home Care/ Hospice/ Home Infusion/ HME

Summa Akron City Hospital



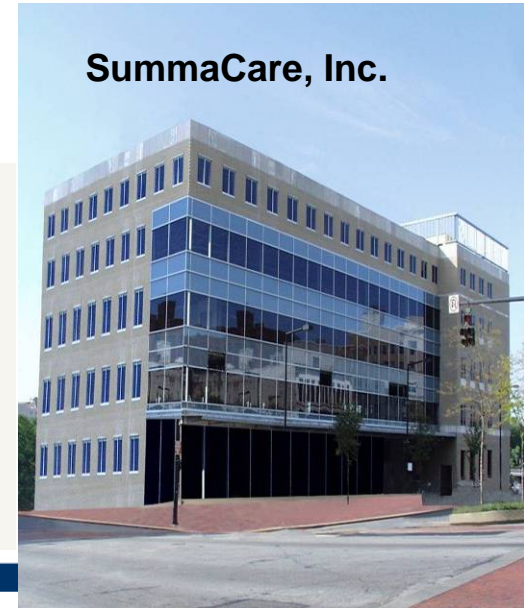
Summa St. Thomas Hospital



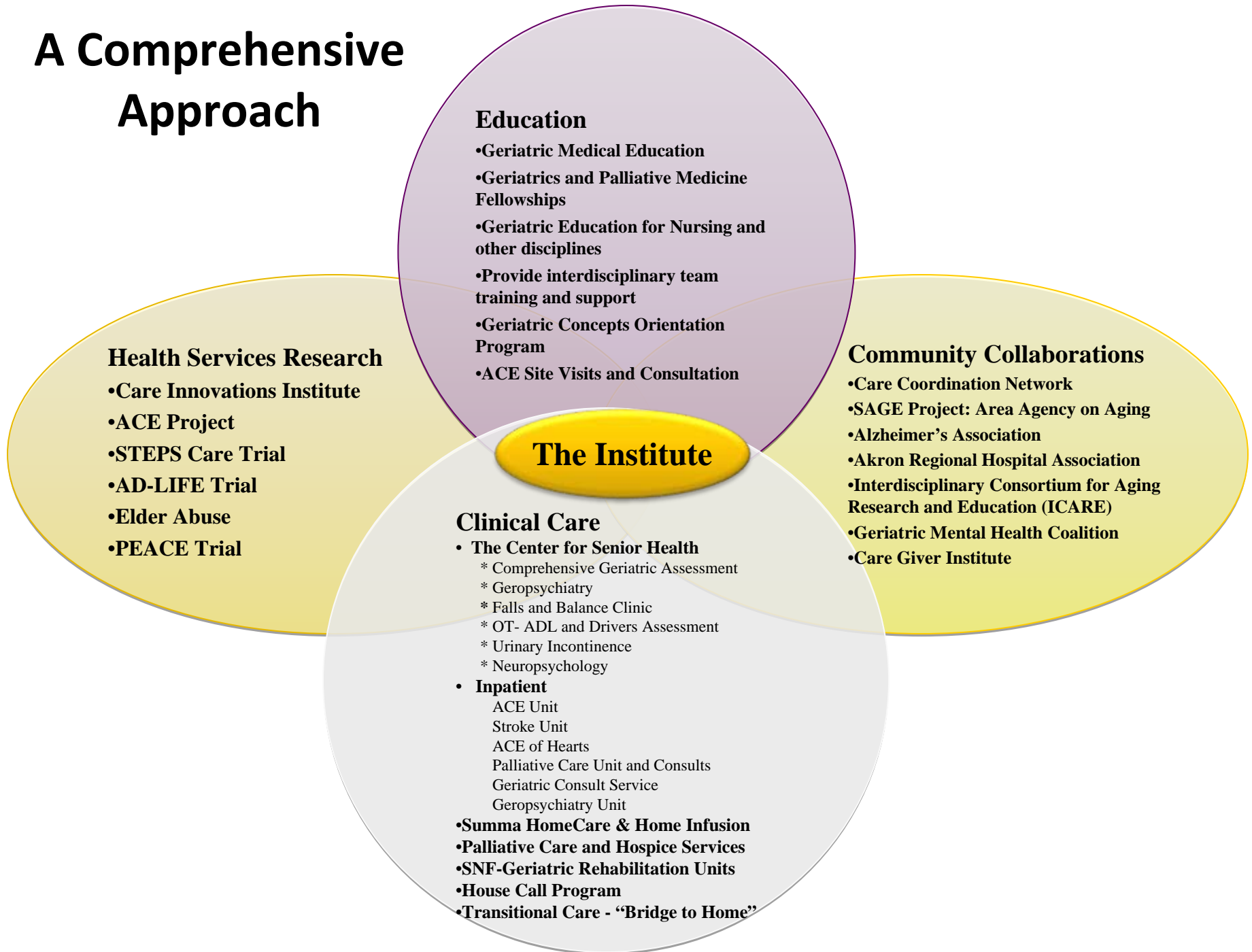
Summa Western Reserve Hospital



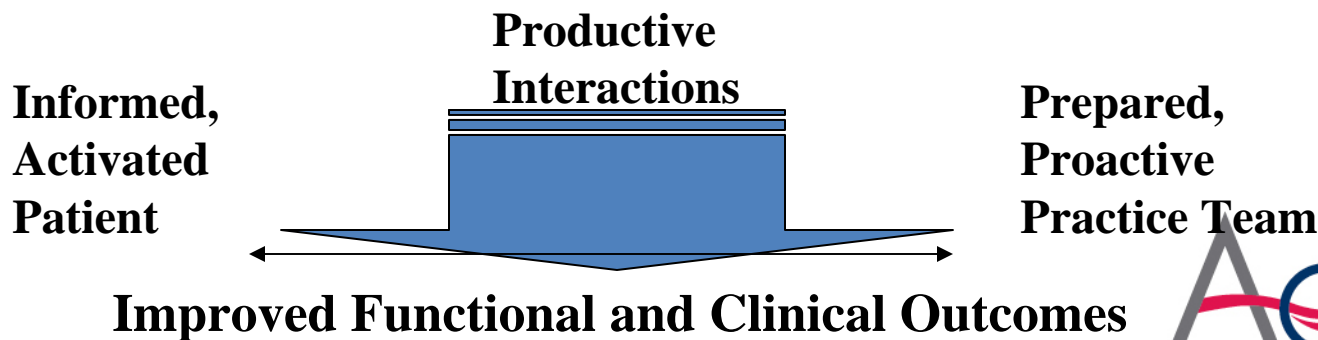
SummaCare, Inc.



# A Comprehensive Approach



# Wagner's Chronic Illness Model: Change That Works



# Key Historical Collaborative Programs

- Interdisciplinary Community Aging Network Committee (ICAN) - forms and communication processes. (1995)
- Imbedding AAA care managers in clinical sites, i.e., Center for Senior Health and Acute Care for Elders (ACE) Unit. (1998)
- Widespread AAA RN Assessor Program. (2000)

# Key Historical Collaborative Programs (continued)

- Area Agency and ODA Grant: Integrated care planning for Medicare Advantage health plan and AAA case managers. Used Appreciative Inquiry technique to build relationship. (2003)
- Care Management Interdisciplinary Team at the AAoA with geriatrician and pharmacist (CMIT). (2006)
- Use of Extended Care Information Network (ECIN) between hospital and AAA case managers. (2008)

# Key Historical Collaborative Programs (continued)

- Integration of AAA RN assessor and case manager to large rural primary care office (2008)
- AHRQ funded - After Discharge Management of Low Income Frail Elderly (AD-LIFE) Randomized Control Trial (RCT) (2005-2009)
- NPCRC funded - Promoting Effective Advance Care in the Elderly (PEACE) RCT Pilot Trial. (2009)

# The AD-LIFE Trial: After Discharge Care Management of Low Income Frail Elderly

*Kyle R. Allen, DO, Summa Health System Health Services Research and Education Institute*

*Kathy Wright, MSN, Summa Health System Health Services Research and Education  
Institute*

*Susan Hazelett, MS, Summa Health System Health Services Research and Education  
Institute*

*Lynn Clough, MA, Summa Health System Health Services Research and Education Institute*

*Dave Jarjoura, PhD, The Ohio State University*

*Eugene Pfister, MD, Akron General Medical Center*

**Agency for Healthcare Research and Quality**

Supported by Grant # R01 HS014539

Supported by Summa Foundation



# AD-LIFE: A Model of Integrated Care

The AD-LIFE Trial will test the effectiveness of interdisciplinary care management that integrates medical and social care to improve patients' overall health and well-being.

# PEACE TRIAL

Promoting Effective Advanced  
Care for Elders

*Kyle R. Allen, DO, Summa Health System, Health Services Research and Education Institute*

*Steven Radwany, MD, Summa Health System, Health Services Research and Education Institute*

*Susan Hazelett, MS, RN, Summa Health System, Health Services Research and Education Institute*

*Denise Ertle, MSN, RN, CNS, Area Agency on Aging 10B, Inc*

*Susan Fosnight, RPh, CGP, BCPS, Summa Health System, Health Services Research and Education Institute*

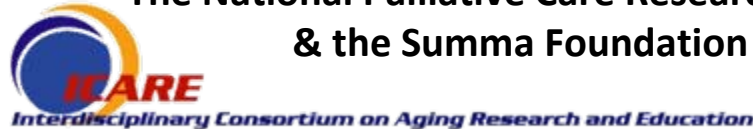
*Pamela Moore, PharmD, BCPS, Summa Health System, Health Services Research and Education Institute*

*Patricia Purcell, MSN, RN, CN, The University of Akron*

*Barbara Palmisano, MA, Northeastern Ohio Universities Colleges of Medicine and Pharmacy*

*Ruth Ludwick, PhD, RN.C, CNS, Summa Affiliate, Robinson Memorial Hospital*

**The PEACE Trial is supported by  
The National Palliative Care Research Center  
& the Summa Foundation**



**Area Agency on Aging, 10B, Inc. | Summa Health System | NEOUCOM  
Kent State University | The University of Akron**

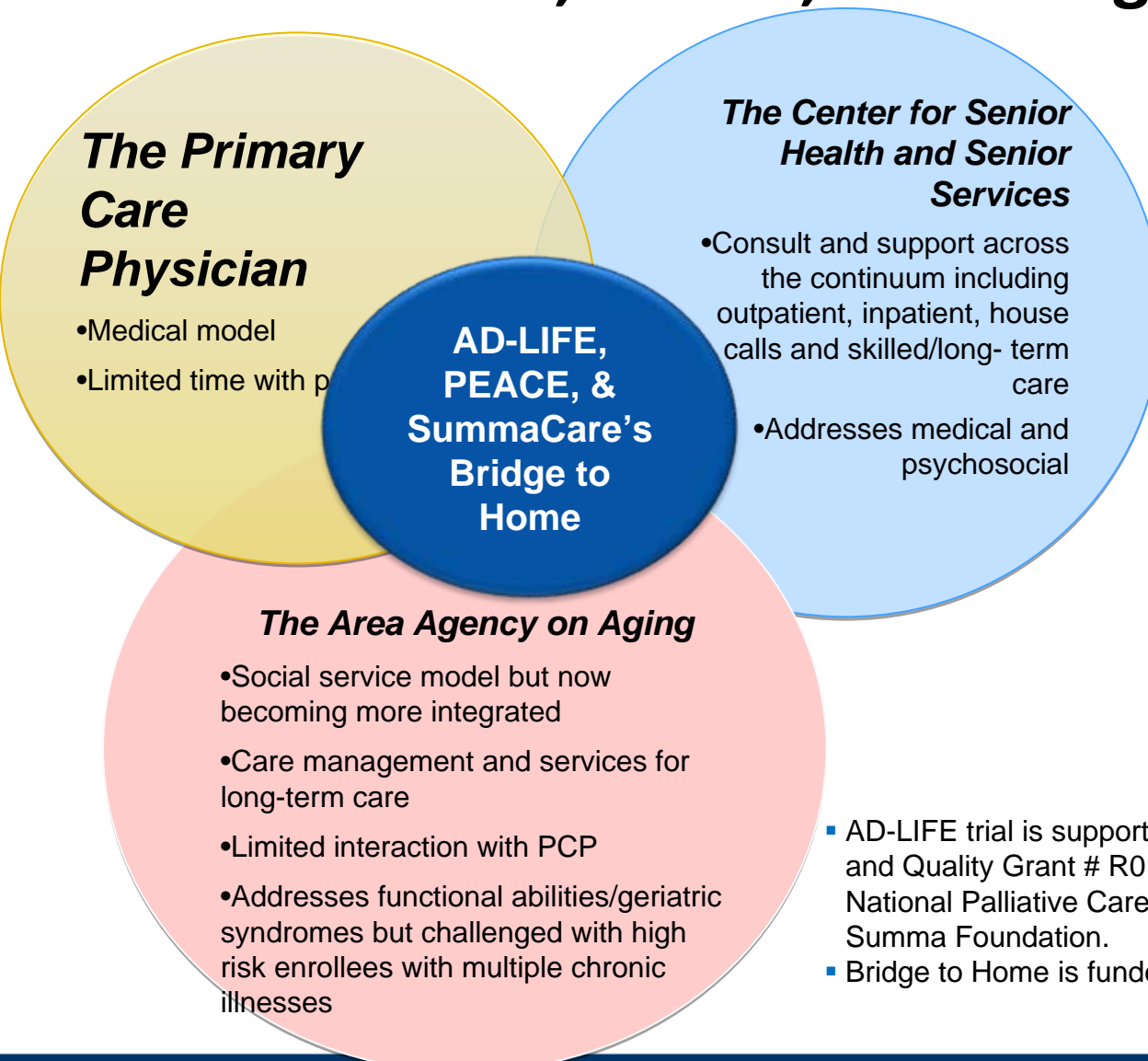


# Purpose of the PEACE Pilot Study

- This randomized pilot study will determine the feasibility of a fully powered study to test the effectiveness of an in-home interdisciplinary geriatric- palliative care management intervention to improve the quality of palliative care for consumers of Ohio's community-based long-term care Medicaid waiver program, PASSPORT.

# Transitions of Care

## AD-LIFE, PEACE, and Bridge to Home



- Post-discharge care management of low income frail elderly
- Nurse care manager activation of client
- Collaboration between a hospital-based interdisciplinary team, Area Agency on Aging, and PCP
- Integration of acute and long-term care
- Transitional care to reduce readmissions

- AD-LIFE trial is supported by the Agency for Healthcare Research and Quality Grant # R01 HS014539. PEACE is funded by the National Palliative Care Research Center. Both are supported by the Summa Foundation.
- Bridge to Home is funded by SummaCare.



# Key Points

- No single organization can tackle complex social, community, human service problems in a silo
- Working in effective collaboration can overcome many obstacles and barriers that lie beyond the scope of any single entity through sharing and combining talents and creative solutions
- When done effectively “the whole is more than sum of the parts”
  - Outputs are greater
  - Synergy builds
  - Energy builds
- Effective collaboration is a team sport between two or more organizations

# Good to Great and the Social Sectors:

## Why Business Thinking is Not the Answer (*Jim Collins*)

- Defining “Great”- Calibrating Success without business metrics
- Level 5 Leadership- Getting Things Done within a Diffuse Power Structure
- First Who - Getting the Right People on the Bus within Sector Constraints
- The Hedgehog Concept- Rethinking the Economic Engine without Profit Motive
  - What are you deeply passionate about?
  - What can you be the best in the world at?
  - What Drives your Resource Engine (time, money and brand)
- Turning the Flywheel- Building Momentum by Building the Brand

# Contact

- Kyle Allen, Summa Health System,  
[allenk@summahealth.org](mailto:allenk@summahealth.org)
- Carolyn Holder, Summa Health System,  
[holderc@summahealth.org](mailto:holderc@summahealth.org)
- Joseph Ruby, Area Agency on Aging 10B, inc.,  
[jruby@services4aging.org](mailto:jruby@services4aging.org)

# 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)
- <http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//Innovative-Communities-Report-Final-0216111.pdf> (Innovative Communities report from the Long-Term Quality Alliance)

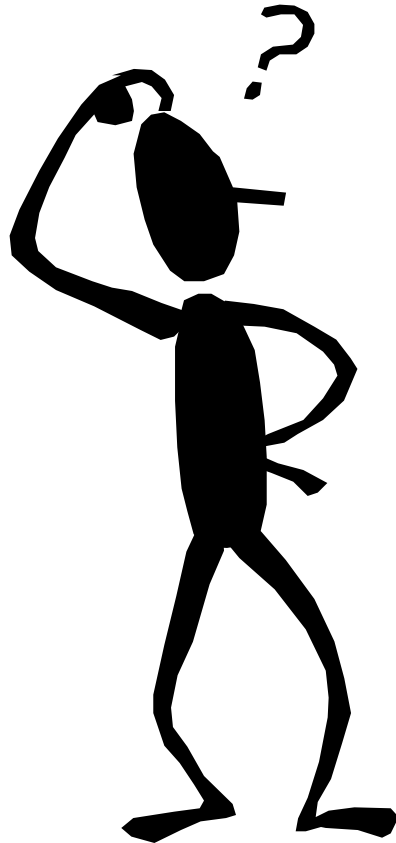
# Resources: **Affordable Care Act**

- [http://www.aoa.gov/Aging\\_Statistics/Health\\_care\\_reform.aspx](http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx) (AoA's Health Reform web page – where webinar recording, transcripts and slides are stored)
- <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

- We will continue our webinar series in April with a continued focus on care transitions
  - Watch your email for date, time and registration information

# Questions?



# Questions/Comments/Stories/ Suggestions for Future Webinar Topics?

Send them to:

[AffordableCareAct@aoa.hhs.gov](mailto:AffordableCareAct@aoa.hhs.gov)