Indiana's No Wrong Door Business Case Development Grant

Administration for Community Living
U.S. Department of Health and Human Services

AAA Transitions Project

Project Team

IU School of Medicine

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Area Agencies on Aging

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Division of Aging, Indiana Family and Social Services Administration

- **Elizabeth Peyton, MPH, RN**, Innovation & Clinical Practice Director
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ACL Grant Goals

- $1.2 million over 2 years (Sept 2018 – Aug 2020)
- ACL's Goal: Help sustain state and national momentum for system change that increases access to community living and reduces unnecessary healthcare utilization
- Indiana's Goal: Contribute to producing a business case for hospital-to-home transitions programs
  - ✓ Evidence-based models delivered by AAA staff in collaboration with health system:
    - Care Transitions Intervention®
    - GRACE Team Care™
  - ✓ Aged & Disabled Waiver (ADW) participants

ACL Grant Partners

- Division of Aging, Indiana FSSA
- Center for Health Innovation & Implementation Science (CHIIS), IU School of Medicine
- Aging & In-Home Services of NE Indiana (AIHS)
  - Parkview Regional Medical Center
  - Parkview Hospital Randalia
- CICOA Aging & In-Home Solutions (CICOA)
  - Eskenazi Health
  - IU Health Methodist
- Preferred Population Health Management, Inc.
- HCBS Strategies, Inc.

ACL Results

- AIHS Transition Coaches
  - Parkview Regional Medical Center
  - Parkview Hospital Randalia
- 6 Month Pilot (July 2019 – December 2019)
- 83 discharges involving 66 waiver participants
- 69% aged 65 or older; 66% women

- **43% reduction in 30-day readmission rate**
  - 9.6% AAA transition group (8 of 83)
  - 16.8% comparison group (95 of 564)*

**Comparison Group: All other hospital discharges to home of Allen County waiver participants over the same time period*

Program Enhancements

- AAA Care Manager training in Care Transitions Intervention® (CTI)
- 4 AIHS and 4 CICOA Care Managers trained in CTI
- Goal: AAA Care Managers provide care transition support to their hospitalized waiver participants
  - Expanded hospital admission notifications
  - Implemented care transitions by trained AAA Care Managers
  - Virtual transition support beginning in March 2020
  - Monthly Care Manager meetings for process improvement
  - Lesson Learned: Transition support was well received by waiver participants and AAA Care Managers

AAA Transitions Project
(No Cost Extension – Year 3)

Hospital-to-Home Transitions in Waiver Participants

Typical Scenario

- Hospital admitted and discharged
- Hospital staff not aware of AAA involvement with patient
- 1 of 5 readmitted within 30-days
- AAA Care Manager finds out 2 months later

Ideal

- AAA notified of hospital admission
- AAA Care Manager coordinated transition with hospital staff
- Discharged home with AAA Care Manager follow-up
- Readmission avoided

AAA Transitions Project
(No Cost Extension – Year 3)

Goal: Greater integration of AAAs with local hospitals

1. Improve care transitions of waiver participants
2. Streamline referral processes for options counseling

Strategies

- ✓ Provide technical assistance (TA) to each AAA
- ✓ Develop AAA communication tools (e.g., flyer)
- ✓ Match hospitals with designated "AAA Liaison"
- ✓ Develop standardized processes and documentation guidelines
- ✓ Facilitate AAA NCQA accreditation in transitions
- ✓ Support additional AAA Care Manager training in the Care Transitions Intervention®

Sample Flyer

(Insert AAA Name/Logo)

(Insert AAA Name) coordinates a range of long-term support needs to help older adults and individuals with disabilities remain safe in their home.

Home and Community Services

- ✓ Non-medical personal care (e.g., bathing and dressing)
- ✓ Housekeeping, meal preparation, and shopping assistance
- ✓ Home-delivered meals
- ✓ Home safety modifications
- ✓ Housing referrals
- ✓ Transportation
- ✓ Chronic disease self-management programs
- ✓ Caregiver support services
- ✓ General information and referrals to community resources

Call ***(AAA Liaison Name)*** ***at*** ***(Phone Number)*** ***to***

- ❑ Coordinate care for a current patient
- ❑ Make a new referral

Hospital AAA Liaison

Roles and Responsibilities*

1. Conduct initial assessments in hospital/clinic setting
2. Develop care plans for clients including formal and informal supports
3. Develop effective/professional working relationships with doctors, social workers, discharge planners and other interdisciplinary team members
4. Participate in daily case conferencing and daily rounds
5. Must work as a member of multiple teams
6. Maintain flexibility in scheduling assessments to meet client and caregiver schedule
7. Provide staff education on AAA services and community resources
8. Develop a process for referrals within the clinical setting
9. Maintain daily, weekly, and monthly tracking system
10. Work independently and be a “go-getter”

*Based on CICOA job description for Field Options Counselor (Hospital/Clinic-Based)