



NY CONNECTS AND HOSPITALS: INSTITUTING SUCCESSFUL TRANSITIONS IN CARE

AGING CONCERNS UNITE US CONFERENCE

JUNE 8, 2010

STACEY AGNELLO, SUPERVISOR, NYS OFFICE FOR AGING

CLAIRE MURPHY, DIRECTOR, WASHINGTON COUNTY CARES

JIM MOODY, LTC COORDINATOR, ORLEANS COUNTY OFFICE FOR THE AGING

Hospital Readmissions Data

- Almost 1/5 of Medicare beneficiaries had unplanned readmissions to the hospital within 30 days of discharge
- More than 1/3 had an unplanned readmission within 90 days of discharge
- Unplanned readmissions were estimated to cost Medicare \$17.4 Billion in 2004.
- New York State readmission rate: 20.7%

Source: Jencks, S.F., Williams, M.V., & Coleman, E.A., 2009. Rehospitalizations Among Patients in the Medicare-Fee-for-Service Program. *New England Journal of Medicine*, 360(14). 1418-1428.

Care Transition Programs Reduce Avoidable Readmissions By:

- improving discharge and transition planning;
- improving care coordination between care settings; and
- enhancing coaching, education, and support for patient self-management.

Supporting Smooth Care Transitions: Plan from the Start

- Provide consumers, families and caregivers with information that promote knowledge and awareness of full array of available resources and options in the community
- Focus on communication and collaboration
- Importance of involving family members and support systems





Community Navigator *Warren-Washington Counties Health Angels*

Collaboration and Engagement Across Counties

Claire Murphy, Director
Washington County CARES

IPRO Pilot Grant

- Local Hospital, CHHA's and Nursing Homes participated in a grant from CMS to follow-up on discharges with nursing visits to ensure medication management and medical visits as well as education on symptom management and community engagement
- IPRO brought Navigator Discussion to the Washington County LTCC for discussion
- LTCC embraced Navigator Program and discussed ways to carry-on the program after the conclusion of the grant.

Community Partners

- Glens Falls Hospital – serves both counties, was instrumental in bringing together representatives from both counties
- NY Connects – Warren and Washington Counties and corresponding LTCC
- RSVP – Volunteer Recruitment
- Independent Living Program – young disabled, community educators
- IPRO – programmatic experience and usage
- NYSOFA – ADRC Navigator Grant Resources

Additional Partners Identified

- Caritas – Patient Advocate and Support Program known in the area for the provision of volunteer support of individuals.
- Senior Organizations – volunteer sources and feedback on program design

Draft Structure

- GFH to identify and refer individuals who are interested in and agree to participate in Navigator Program
 - Medicare Consumers not eligible for traditional home care services post discharge
 - Previous Hospitalization in the past 30 days
 - High Risk Diagnosis – CHF, Cardiac, Pneumonia
 - Additionally, Alert x 3, No Mental Health Diagnosis, with a phone and in a safe environment

Feedback Received

- Survey Conducted with Senior Groups identified as potential volunteer sources
 - Volunteers are specific in wanting a dedicated agency to support them – where volunteers get housed is very important
 - Training will be key to ensuring ongoing support
- Buy in from Medical Providers is important

Challenges

- Structures of NYConnects in each County
 - Connection is to NYConnects not an “Agency”
 - Making Access seamless
- Volunteer Housing
 - Resources and Capacity – Priorities of individual organizations
- Medical Buy-in
 - Hospital experience with IPRO Grant
- The use of Volunteers
 - Medical Versus Non-Medical Tasks

Program Characteristics

- Non-medical Coaching only
- Program participation from 6 weeks to 3 months
- Primary MD is aware of and supports individual's participation

Role of the *Health Angel*

- Initiate follow-up phone call, post discharge
- General introduction, review key messages regarding discharge plan, follow up and patient education
- Facilitate individual's scheduling/follow through with primary MD appointment
- Education and assist in completion of Advanced Directives
- Introduce Personal Health Diary and help complete as able
- Discuss emergency plans – refer for additional community supports – ie – Transportation, access to NY Connects

Where are we now?

- We have identified 2 volunteers – both retired nurses who are interested in participating
- Develop and deliver training
- GFH to screen individuals in both Warren and Washington Counties



Orleans County Office for the Aging

Orleans NY Connects and Orleans County Care Transitions

Jim Moody, Long Term Care Coordinator
Orleans NY Connects, Choices for Care

Orleans NY Connects Is...

- Offering access to information and assistance about long term care services
- Empowering individuals to make informed choices
- Supporting the right to independent living through choice and opportunity
- Linking long term care providers to residents
- Planning for long term care solutions through the engagement of a Long Term Care Council

Key Areas of Information Provided

- Caregiver/Family Support
- Health Insurance Counseling
- Medicare / Medicaid
- Personal Emergency Response System
- Senior Ride Programs (medical and non-medical)

Statistics*

- Total Contacts = 3,972
- Phone = 75%, Walk-In = 25%
- Age 60+ = 95%, Birth to Age 59 = 5%
- Female = 70%, Male = 30%

* Since January 1, 2009

Orleans County Care Transitions

- Funding received from the Community Health Foundation of Western and Central New York
- Orleans County one of 14 teams whose collective purpose is to Improve Transitions of Care through Effective Family Caregiver Partnerships
- Grant period: April 2009 – November 2010

Care Transitions Goals

- Identify patients with dementia and those who have dementia relative to symptoms
- Document a coaching process
- Offer coaching services to identified patients and their families
- Create helpful print and electronic tools

Why Dementia?

What we know (2009)*

Older Americans were 12% of our population and represented:

- 26% of all physician visits
- 33% of all hospital stays and prescriptions
- 40% of medical emergency responses
- 90% of nursing home residents

* 2010 Alzheimer's Disease Facts and Figures

What We Also Know (2009)*

In New York:

- 729,796 people provided unpaid care for someone with dementia
- 820,842,714 hours of unpaid care
- Cost of nearly 9.4 billion dollars
- New case of Alzheimer's every 70 seconds

* 2010 Alzheimer's Disease Facts and Figures

What We Also Know

In Orleans County:

- In OFA, 2,650 caregiver units of support over 36 months. 40% annual increase
- 80% of caregivers are dealing with a dementia related situation
- Increasing number of caregivers live out of state
- One 30 bed Memory Care Unit in the county
- Limited county programs available to manage dementia patients with behavior problems

Care Transitions Team

- Three OFA Staff
- Four Area Physicians
- Two Area Hospitals
- One Healthcare Clinic
- Orleans County Long Term Care Council

Resources

- www.orchestrasnyconnects.wordpress.com
- www.sharingyourwishes.org
- www.nextstepincare.org
- www.alz.org/wny
- www.caregiver.com

- Caregiver Guide
- EssentiALZ Care Package
- Health File
- Home Safety Booklet
- OFA Directory of Services

Measurement

- 3 trained coaches
- 34 patients; average age = 84
- 68% = 80 years old or older
- 74% = female
- Average days of support to family = 21

Impact

- Coached 34 new family units
- Developed new relationships with 4 doctor's and 3 health care systems
- Integrating advance care planning and other OFA services into the community
- Increasing awareness to the community through public education

Survey Results

- 25% had hospital visit after coaching
- 33% used OFA services used after coaching
- Education and assistance was helpful to 74 % of the patients / caregivers
- 100% felt more confident because of the support received from Transitions coach

Together in Service ...

Orleans NY Connects

- I & A about long term care options
- Always available
- Empowerment
- Choice and opportunity is key
- Provides links to services

Care Transitions

- Trained Coach
- Short term support; typically 30 days
- Empowerment
- Hands on education
- Link to NY Connects

Considerations for developing a Care Transitions Program

- Determine the need
- Create a scope of service
- One consideration, volunteers or paid staff?
- Many tools available
- Establish a supportive network
- Celebrate small successes
- Expect support to change
- Everyone's priorities are not your own
- Consider measures and sustainability

What are we learning?

- Care Transitions families today could use Orleans NY Connects tomorrow
- There is a defined gap in service to caregivers who has a loved one with dementia. Care Transitions helps manage the gap
- Statistics and measures reflect that (1) care receivers are older than anticipated (2) care receivers are often long distance (3) the need for updated tools is extremely valuable (4) trained coaches is a must and (5) small group discussions to understand prevalence of dementia in our community is needed

What are we learning?

- Experience shows that engaging other resources is needed to manage care transitions
 - Alzheimer's Association
 - Villages of Orleans Memory Care Unit
 - Local faith communities
- Survey shows there is a cost benefit to the coaching process
- Orleans NY Connects is actively involved throughout the 21 day coaching process and beyond, largely to support families and consider the impact on local long term care services



Thank you!

Jim Moody, Th.M
Long Term Care Coordinator
Orleans NY Connects, Choices for Care

Orleans County Office for the Aging
14016 Route 31 West, Albion, NY 14411

585-589-3102 * moodyj@orleansny.com

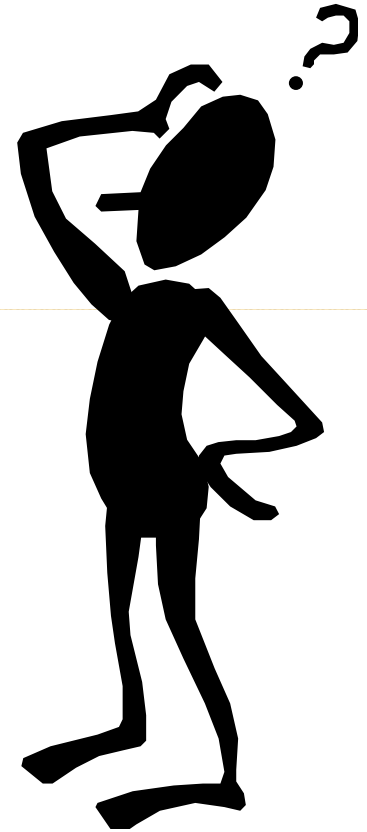
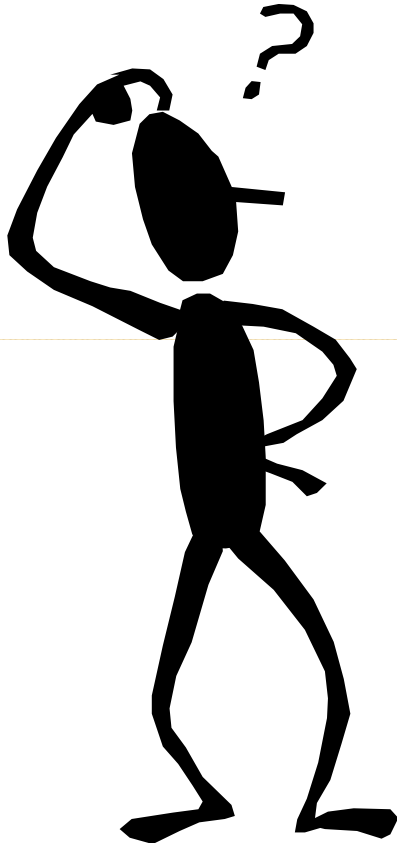
Summary

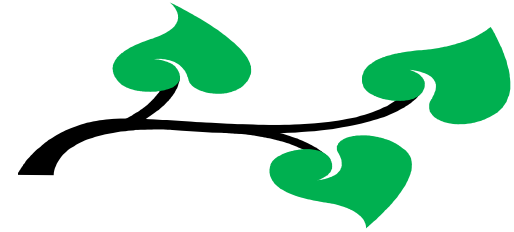
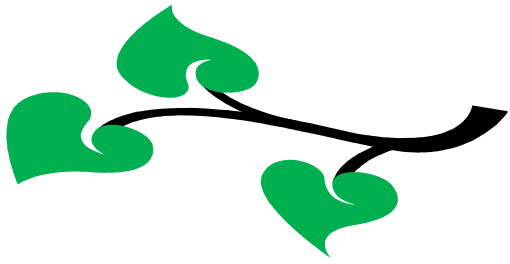
- Link care transitions with NY Connects
- Identify partners –get buy in
- Identify model-paid vs. volunteer

Summary Continued

- Invite critical pathways providers to be part of NY Connects advisory committees and councils
- Develop formal referral protocols with critical pathways providers
- Assign specific NY Connects staff to operate out of critical pathway locations

Questions?





We are going GREEN!

For copies of this presentation, contact:

Stacey Agnello

Stacey.Agnello@ofa.state.ny.us

