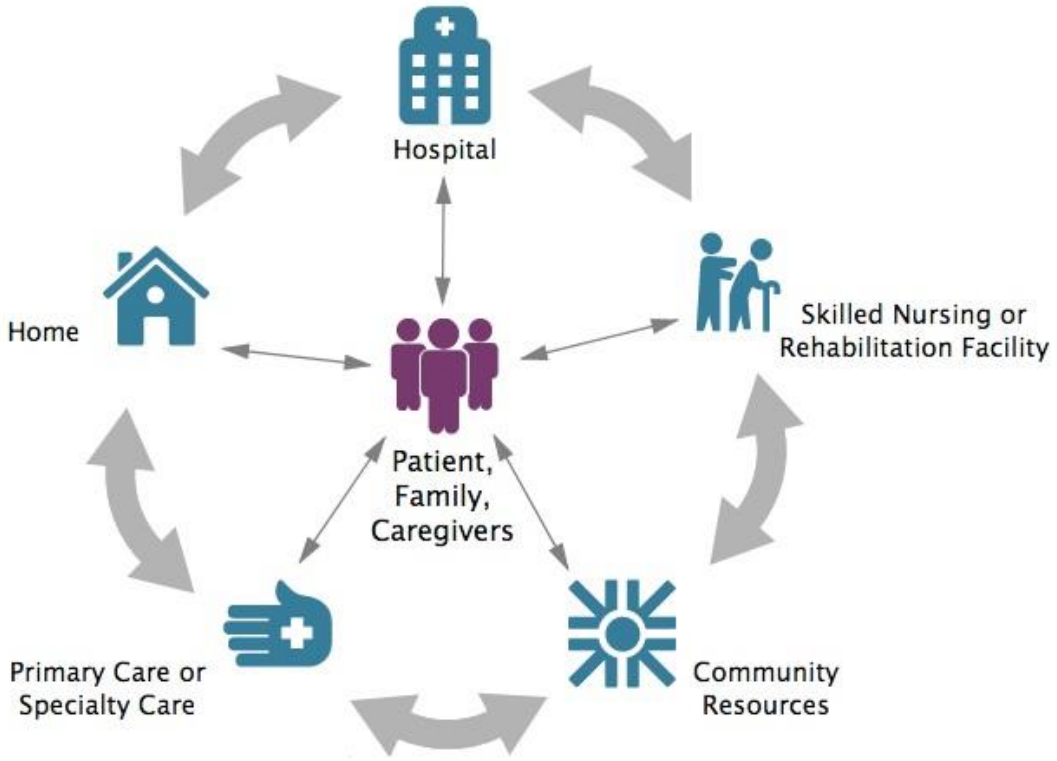
Rappahannock Rapidan Community Services
Presents

The Care Transitions Program
&
Healthy IDEAS Program

Introduced By: Laura Daniel

Care Transitions Program



What is The Care Transitions Program?

An evidence based model designed by Dr. Eric A. Coleman to empower individuals, their families, and caregivers to actively participate in their health care needs to reduce hospital readmissions.

So what does that really mean???

A Care Transitions Coach (Health Coach) will work to transfer skills that will allow an individual to recognize red flags, communicate effectively with their medical providers, identify medication errors, and keep track of important medical information, with the goal of significantly reducing hospital readmissions within 30 days.

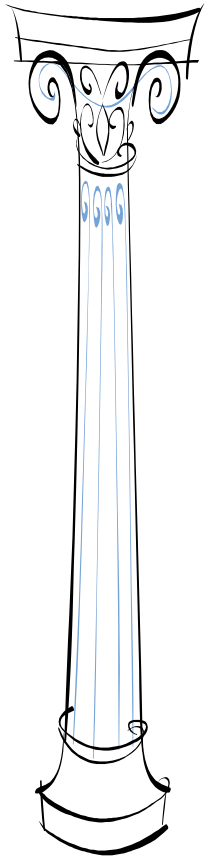
The Care Transitions Program consists of:

1. Hospital Visit
2. Home Visit (If discharging to a SNF, a SNF visit. Then home visit upon discharge from SNF.)
3. 3 Follow Up Phone Calls

All with the focus of Dr. Coleman's 4 Pillars over a 30 day period.

The Coleman Model's 4 Pillars

A proven, evidence-based model of reducing hospital readmissions.



Medication Self-Management so patient becomes knowledgeable about medications and has a medication management system.

Dynamic Patient-Centered Record for patient to improve communication with primary care provider and specialists.

Follow-Up visits with primary care provider and specialists are completed.

Red Flags alerts patient about indications that condition is getting worse and how the patient should respond.

Hospital Visit

Health Coaches begin to work with patients before they leave the hospital.

- This consists of a hospital visit for introductions, confirm contact information, brief education about what to expect, what they should look for when discharging, and a brief assessment of needs.

- Visit conducted with 24-48 hours of receiving referral.

SNF Discharge

- Coach conducts a visit within 24-48 hours from discharge.
- Works with the D/C Planner on assisting with needs/ communication.
- Monitors for discharge to home.

Home Visit

- Completes a home visit within 72 hours of discharge.
- Educates based on 4 Pillars of the Coleman Model.
- Utilizes the Personal Health Record (PHR).
- Connects them with community resources as needed.

Three Follow Up Phone Calls

- One call once a week to follow up with the patient/caregiver.
- Reinforcement of education.
- Ensuring follow up on any potential issues/needs.
- Additional calls/visits can be utilized as needed.

THE KEY IS TO ENSURE A SUCCESSFUL TRANSITIONS FROM THE HOSPITAL TO HOME!!

Why is this important???

Per DARS website: Nearly one in five Medicare patients discharged from a hospital, or approximately 2.6 million beneficiaries, is readmitted within 30 days, at a cost of over $26 billion every year.

Using Root Cause Analysis to Drive Intervention

- Hospitals identify high risk readmission beneficiaries through their root cause analyses.
- Key findings determine/confirm the intervention selection

➢ What hospitals say …	➢ What patients say …
- medication mismanagement	- cannot afford medications
- no follow-up	- lack of transportation
- non-compliance	- confusing directions

- Intervention directly addresses root causes identified.

Care Transitions Program Purpose

- Reduce by 20%, 30-day all-cause hospital readmissions.
- Improve quality of life and healthcare for patients from the in-hospital setting to home or other care settings as community, ***not medical***, partners.
- Use evidence-based Coleman Care Transitions Program® to improve patient health outcomes and document measurable savings to Medicare.
- Activate the patient to ensure **patient-centered** practices.

Why Partner With AAA's??

Assessment and home stabilization strategy

Components

- Assessment
- Medication Reconciliation and Self-Management
- PCP Appointment Adherence
- Red Flags
- Patient Centered Record

Incorporate

- Chronic Disease Self-Management Education
- Fall Prevention
- Diabetes Self-Management Education
- Healthy Ideas / PHQ9
- Advance Care Planning
- Telehealth / Tele-education

Other Services

- Transportation
- Nutrition / Meals on Wheels
- VICAP
- Personal and Companion Care
- Emergency Services i.e. fuel assistance
- Environment Home Modifications & Repair
- Friendly Caller Program
- Adult Day Services

Addressing Social Determinants of Healthcare

Majority are Social – not Clinical

AAAs across the nation are uniquely equipped to address the social needs that directly contribute to poor health, increased hospital readmissions and increased cost of care.

<u>Long-term supports can reverse the trend</u>:

- Meals on Wheels
- Home and Personal Care
- Respite and Caregiver Support
- Chronic Pain Management
- Patient Activation Measure
- Transportation
- Medication Management
- Falls and other Home Risk Assessments
- Telehealth
- Evidence-based prevention solutions through education and patient empowerment
  - Stanford Chronic Disease Self-Management
  - Fall Prevention
  - Behavioral Health
  - Advance Care Planning
  - Healthy Ideas

Healthy IDEAS Program

Healthy IDEAS Program

- An evidence-based program that integrates depression awareness and management into existing case management services provided to older adults.

- **Healthy IDEAS** ensures older adults get the help they need to manage symptoms of depression and live full lives.

- Healthy IDEAS Improves Quality of Life By:
- **Screening** for symptoms of depression and assessing their severity.
- **Educating** older adults and caregivers about depression.
- **Linking** older adults to primary care and mental health providers.
- **Empowering** older adults to manage their depressive symptoms through a behavioral activation approach that encourages involvement in meaningful activities.
- **Assessing** clients' progress.

Core Components

Step 1: Screen and assess clients for depressive symptoms.

Step 2: Educate clients about treatment options and self-management.

Step 3: Refer and link clients to primary/mental health care.

Step 4: Engage clients in Behavioral Activation, an approach to depression management that helps clients combat the inactivity commonly associated with depression.

Step 5: Reassess client progress, supporting their efforts, and encouraging clients to continue to self manage their mood using a behavior change approach.

Program Consists of:

3 Face-to-Face visits.

3 Telephonic visits

All conducted over a 3-6 month period by a certified coach.

Why is this important???

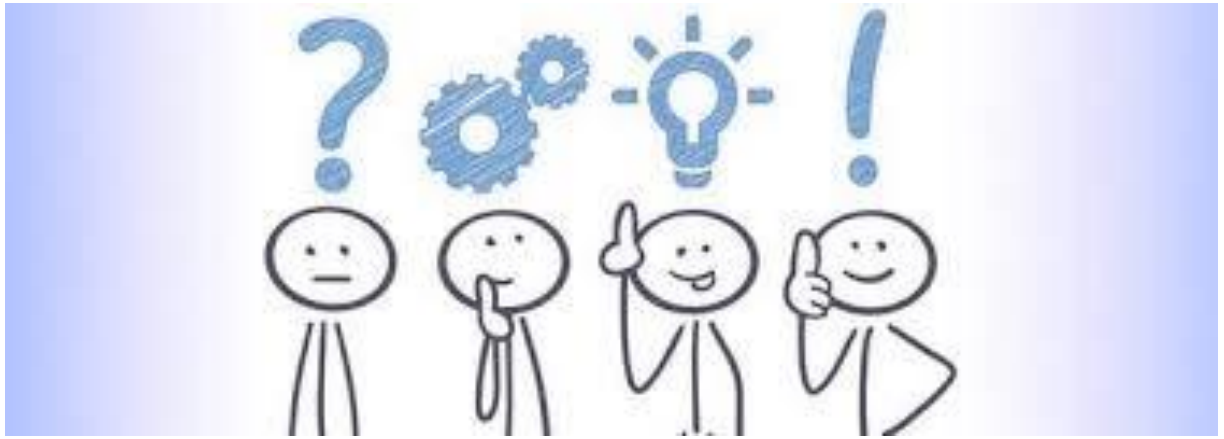
Benefits:

- **For Older Adults:**
- Fewer symptoms of depression
- Decreased physical pain
- Better ability to recognize and self-treat symptoms
- Improved well-being through achievement of personal goals

- **For Service Providers:**
- Expanded capacity to address depression
- Better communication and stronger partnerships with mental health providers
- Opportunity to deliver a proven, successful program that addresses critical client needs
- Improved staff knowledge and confidence in helping clients

- **For Community Mental/Behavioral Health Partners:**
- Increased opportunity to work with diverse populations of older adults
- Strengthened connections to community agencies
- Greater opportunity to reach and help underserved older adults

QUESTIONS???



thank you
gracias
merci
obrigado
danke
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Баярлалаа
спасибо
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