

Center on Aging and Community Living



CENTER ON AGING AND
COMMUNITY LIVING

A Collaborative Between the UNH Institute on
Disability and the Institute for Health Policy and
Practice

VISION:

All New Hampshire residents have access to person-centered options which allow them to live and age in the communities of their choice.

Take Aways

- Integrating/aligning community (social service system) care system with medical model is a comprehensive and integrated approach
- Community based organizations make a difference in health outcomes
- Don't build a program or define payment models in a silo. Community-based organizations exist and have expertise

Step Two (1 / 8 / 15 presentation)

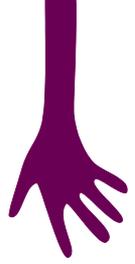
- 100% of step two membership enrolled in care management
- Working with the existing provider network (slide 9)
 - MCOs need to hear how the current network sees their services fitting into the new model
- Comprehensive and Integrated diagram-(slide 10)
 - “existing community relationships and supports”

Person-Centered System

4

- The focus of a person-centered system is on **the individual, their strengths, and their network of family and community support** in developing a flexible and cost effective plan to allow the individual maximum **choice and control** over the supports they need to live in the community

Care coordination definition: seacoast community collaborative



" Care Coordination is an individual and family-centered, team-based activity designed to access and meet the needs of individuals, while helping them navigate effectively and efficiently through the healthcare system and resources in the community. Care coordination addresses potential gaps in meeting individuals' interrelated medical, social, developmental, behavioral, educational, informal support system, and financial needs in order to achieve optimal health, wellness, or end-of-life outcomes, according to individual preferences."

Who am I talking about...

6

- ServiceLink Aging and Disability Resource Centers
 - Counseling in person-centered long-term care, Medicare, and caregiver supports; Certified Information and Referral Specialist (Enhanced I&R)
- Grafton County Senior Citizens Council
 - Meals of Wheels, transportation, evidence-based health and wellness program, day program
- EasterSeals Seniors Count
 - Community Liaison program
 - Emergency respite care
 - Fall clean-up



NH ADRC Person-Centered Transitions Projects

Hospital and Physical Practice:

- Two local NH Aging and Disability Resource Center (ADRC) sites piloted care transitions models (2010-2013)
 - Care Transitions Intervention (CTI) and Modified Better Outcomes by Optimizing Safe Transitions (BOOST)
 - On-site staff
 - All payer sources
 - CTI- Increase linkages with NH's ADRC services (care giver support, information and referral specialist, long term care counselor (options counselor), and Medicaid specialist)
 - BOOST- provide on-site long term care counselor

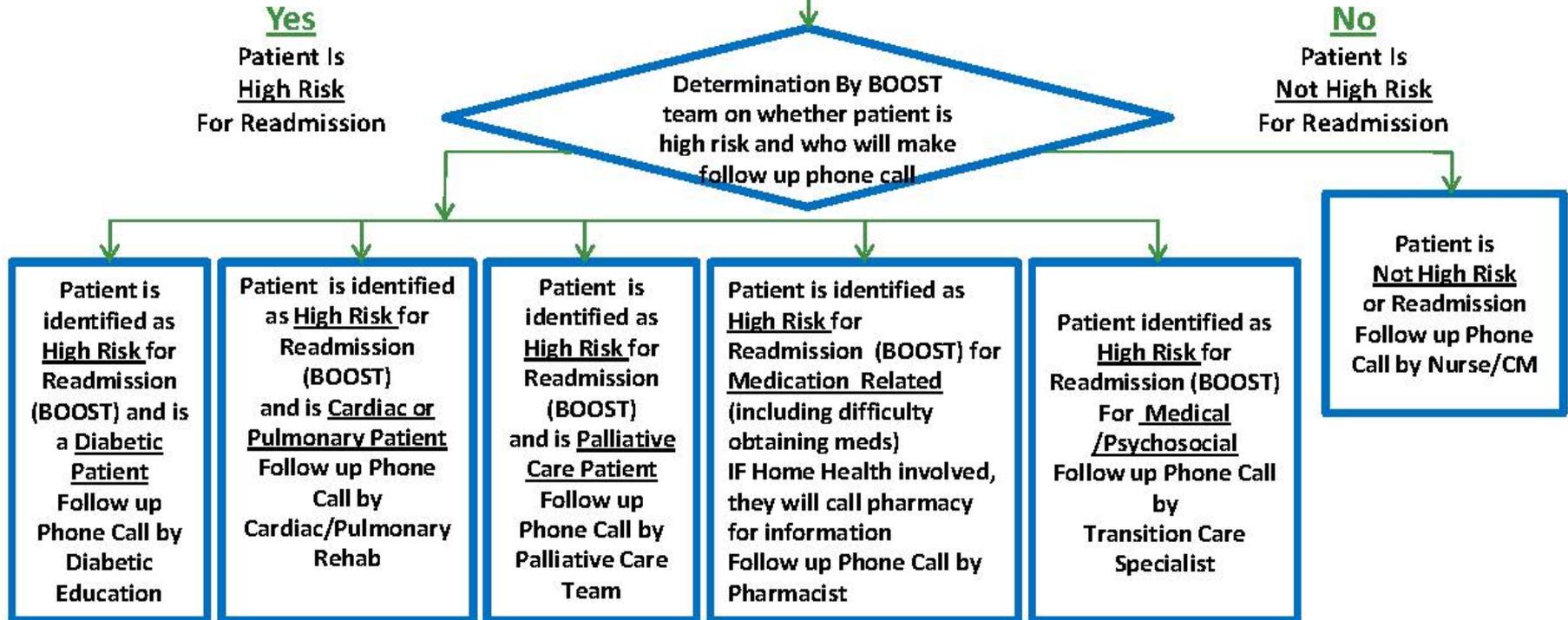


BOOST Follow-Up Phone Call Process

LRGHealthcare

BOOST Patient Risk Assessment Completed On All Patients

Following Information copied on all Patients at Discharge:
 history & physical, medication list, discharge instruction,
 who is doing follow-up phone call, face sheet



1. If patient has care management concern, refer to care manager
2. If the patient has a medication concern, refer to the pharmacist
3. If medical concern, refer to attending physician
4. If patient needs home visit, follow up by Transition Care Specialist (patient w/o Home Health or visit needed in addition to home health)

All patients will be given a number to call (patient care unit) if they can not reach PCP

Outcomes

Person-Centered Hospital Care Transitions pilot (2010-2013)

- Outcome 1: Reduce hospital readmission rates for target population
- Outcome 2: 80% of participants report feeling prepared for discharge
- Outcome 3: 50% of medical and social providers report good communication of medical and social services
- Outcome 4: The referral process to link patients to community resources is improved
- Outcome 5: 80% of participants report confidence in their ability to navigate the medical and social systems

Nursing Facility Transitions

10

- INTERACT (Interventions to Reduce Acute Care Transfers)
- Cultural Change Coalition
- Community Passport model
 - Financial assistance- first/last month rent, security deposit, setting up apartments
 - Home modifications
- Granite State Independent Living- Nursing Facility Transitions Services
 - Individual assessments in order to develop a person centered care plan
 - Long-term counseling
 - Service coordination
 - Life skills training

Take Aways

- Integrating/aligning community (social service system) care system with medical model is a comprehensive and integrated approach
- Community based organizations make difference in health outcomes
- Don't build a program or define payment models in a silo- community-based organizations exist and have expertise