

AWARENESS OF RESOURCES FOR CARE TRANSITIONS



A Report of the Southeast Michigan Joint AAA Advisory
Council Ad Hoc Study Committee

November 2010



Introduction

A regional partnership was established between the Advisory Councils for the Area Agency on Aging 1-B (AAA 1-B) and The Senior Alliance (TSA), Area Agency on Aging 1-C. The intent of this partnership is to form a strong alliance, share resources and work together to improve service delivery for the communities and people these organizations support.

The AAA 1-B was established in 1974 to serve the needs of over 545,000 older adults who reside in the southeast Michigan counties of Livingston, Macomb, Monroe, Oakland, St. Clair and Washtenaw. TSA was established in 1980 to serve older adults and adults with physical disabilities living in the 34 suburban communities in southern and western Wayne County Michigan.

Each Area Agency on Aging (AAA) is a non-profit organization and takes direction from its Board of Directors and Advisory Council. Advisory Councils are comprised of people supported by the area agency, caregivers, advocates, community representatives, provider agencies and local citizens who live or work within the service area of the AAA. The Advisory Council's role is to advise the AAA Board of Directors of the needs and concerns of the older people living in the service area and advocating for them. Advisory Councils also make recommendations on the development and implementation of multi year strategic plans.

The joint Advisory Council partnership identified concerns that many older adults, adults with disabilities, and family caregivers are not aware of the home- and community-based resources that are available to assist them to maintain their health and independence. This lack of awareness contributes to avoidable problems, such as unplanned readmission to hospitals, when individuals experience new needs resulting from an acute healthcare episode, and must transition home after a hospital admission without the assistance needed to achieve a successful recovery.

Unsuccessful hospital transitions are a serious concern that can lead to an unplanned readmission, a problem that cost Medicare \$17.4 billion in 2004 according to a 2009 study published in the *New England Journal of Medicine* (Jencks, Williams and Coleman, *Rehospitalizations Among Patients in the Medicare Fee-for-Service Program*) that found one in five elderly patients who are discharged from a hospital are rehospitalized within 30 days. In March of 2009, The Institute on Healthcare Improvement (IHI) produced a study that identified promising approaches to reduce

avoidable rehospitalizations that include close coordination of care in the post-acute period, early discharge follow-up, enhanced patient education and self-management, proactive end of life counseling and extended clinical resources to people for an extended period of time.

The joint Advisory Council partnership believes AAAs can make a positive impact by decreasing avoidable rehospitalizations and providing coordination and extended care when transitioning from a health system such as a hospital and/or nursing facility. Services provided through AAAs, such as home delivered meals, personal care, homemaking, respite, and chore services can provide valuable support to individuals recovering from an acute health care episode, or adjusting to a disabling injury or disease. Greater coordination of care and public education about available community resources can facilitate more successful transitions and prevent avoidable hospital readmissions. Stronger linkages between aging network programs and hospital discharge planners will increase awareness of resources and assure that older adults and adults with disabilities gain access to critical supports and services.

The joint Advisory Council partnership formed a study committee called *The Awareness for Care Transitions Partnership* to address this need for system improvement. Project plans began with gathering information about the issue from several different sources. Council members met with local health care systems (hospitals, nursing and rehabilitation facilities, home healthcare providers and long term care advocacy and protection organizations) to identify gaps in coordination with aging network programs. Common problems and trends were identified from these discussions and summarized for decision making. The joint Advisory Council partnership made both short term and long term recommendations for system improvements. This document serves as a system improvement plan for AAAs and highlights project findings and recommendations.

If implemented in collaboration with hospital-based health care systems, this project has the potential to increase access to information and services provided through AAAs to individuals transitioning from acute care hospital stays and their family caregivers. Along with the Affordable Care Act demonstration projects and changes in hospital financing to tie Medicare reimbursement amounts to outcomes, the *Awareness of Resources for Care Transitions Project* provides an opportunity secure Medicare funds to support Aging Network activities and services.

FINDINGS

- A 2009 study published in the *New England Journal of Medicine* (Jencks, Williams and Coleman, *Re-hospitalizations among patients in the Medicare fee-for-service program*) found that **one in five** elderly patients who are discharged from a hospital are readmitted within **30 days**.

HR 3590, Sec. 3026.

Community Based Care Transitions Program

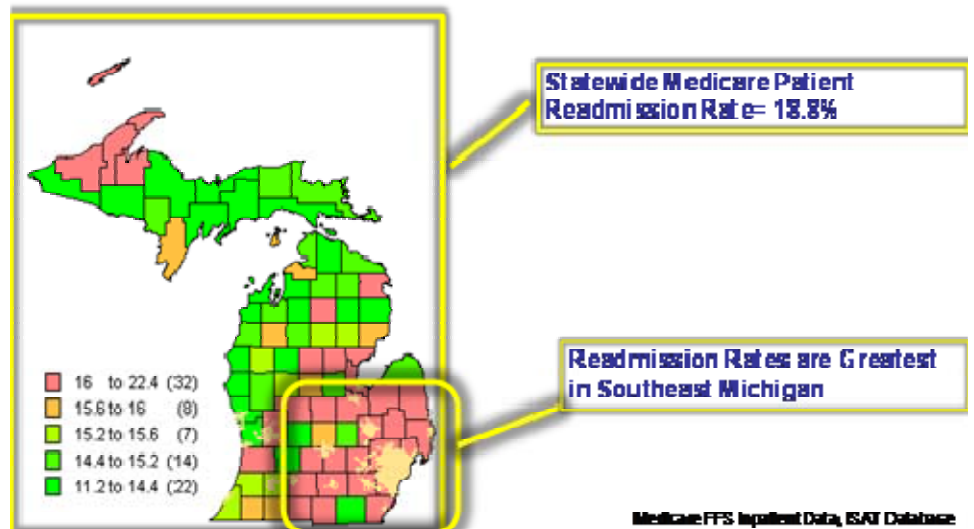
The Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010, establishes a program designed to reduce hospital readmissions by implementing improved care transition services. The Community-Based Transitions program (HR 3590, Sec 3026) encourages eligible hospitals and community based organizations to work together to provide evidence-based care transition services to Medicaid beneficiaries who are at a high risk for hospital readmission. The program is built largely upon the Centers for Medicaid and Medicare (CMS) Care Transitions Intervention program in which 14 states contracted with CMS to reduce the number of hospital readmissions in older adults during the transition process.

Literature Review

In reviewing existing literature regarding care transitions and hospital discharge planning, the joint Advisory Council discovered that rehospitalizations are brought up frequently. Nearly “one-in-five elderly patients who are discharged from a hospital are rehospitalized within 30 days”¹, however, many of these rehospitalizations are avoidable.

Medicare Data from 2009 shows that in the state of Michigan, the 30-day readmission rates for Southeast Michigan are the highest. Countywide 30-day readmission rates (%) are 25.04%, 22.43%, 22.17%, 21.51%, 20.53%, 19.36% and 19.34% for Wayne, Oakland, Macomb, Monroe, St. Clair, Washtenaw and Livingston counties, accordingly.

Michigan Medicare Patient 30-Day All Cause Readmission Rates (%) by County, 2009



The Institute for Healthcare Improvement (IHI) has produced a study of promising approaches to reduce

avoidable rehospitalizations. The findings and conclusions of the IHI survey found that interventions to reduce rehospitalizations seem to fall into four basic categories:

1. Enhanced care and support during transitions;
 - a. Improved discharge processes
 - b. Early post-discharge follow-up
 - c. Front-loaded home care visits
 - d. Remote monitoring
 - e. Nurse-led transition care services
2. Improved patient education and self-management;
 - a. Patient education and self-management support
 - b. Disease management or case management
3. Multidisciplinary team management; and
4. Patient-centered care planning at the end of life.

“The majority of our older discharged patients do not have the family support they need at home. They have some, but not enough.”

- Hospital Discharge Planner

The survey of literature also revealed that there is an abundance of researchers and institutions studying and testing ways to reduce avoidable hospitalizations, and that the promising approaches include close coordination of care in the post-acute period, early post-discharge follow-up, enhanced patient education and self-management training, proactive end of life counseling, and extending clinical resources to patients for an extended period of time after discharge.

Summary of Discussions

One-on-one meetings were held with hospital discharge staff and social workers from five hospital-based health systems representing 12 area hospitals. At these meetings, overviews of the Aging Network and its resources were provided, questions were asked about challenges the discharge system faced, community resources the discharged population needed, and how the Aging Network could better assist hospitals in the discharge planning process.

Stakeholder organizations in the discharge process were also invited to meetings to discuss their perspective, MPRO (Michigan’s Quality Improvement organization) presented on their MI*STAAR (State Action on Avoidable Rehospitalizations) project, and nursing home, home care, and assisted living facilities provided their perspective on care transitions and rehospitalization. Consumer perspectives were gained through anecdotal evidence presented by Advisory Council members, as well as through a survey disseminated throughout the service areas of the AAA 1-B and TSA. The key findings from this investigation are noted below:

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- *Area Agencies on Aging and Community-Based Resources need to build awareness of services.*

Through conversation with the 12 area hospitals that participated in this study, it was discovered that a majority of the hospital discharge planners and social workers were aware of some, but not all services available through AAAs. Those who were familiar with AAAs knew that services came with extensive wait lists, or did not clearly understand the scope of services available, eligibility requirements, waiting lists, or minute differences of each AAA.

The AAA 1-B offers some programs that TSA does not provide, and vice versa, which in part accounts for this confusion. Although AAAs follow the same federal program guidelines and state minimum standards, each region is different, so there are slight variances in similar programs offered, as well as differences in the scope and array of services.

- *Area Agencies on Aging and Aging Network providers are often too slow to respond to discharge needs.*

Many services provided by AAAs are not available immediately upon discharge. Most home- and community-based services have a waiting list, and regardless of whether an individual is to be placed on a waiting list, or is eligible for an available program, individuals may be required to undergo an assessment and intake process before service can be delivered.

Most services are not provided directly by the AAA, which can slow response time as outside organizations are brokered and referrals are made. For example, if a discharge planner starts with the AAA seeking home delivered meals, they must then be transferred to the meal provider who will verify basic eligibility requirements, then an in-home assessment of the individual will be conducted which assesses ADLs (Activities of Daily Living), IADLs (Instrumental Activities of Daily Living), and nutritional risk. Depending on the home delivered meal provider, this process can take up to two weeks before meal delivery is started.

- *Hospital Discharge Planners and Social Workers need resources made available to them in a convenient manner.*

Hospital discharge planners and social workers indicated that they do not have the time to pursue resources that require multiple phone calls and conversations. Hospital discharge planners operate under large caseloads with short timeframes to discharge individuals.

- *Patients who are discharged often do not follow their care plan.*

Among the problems that contribute to patients being non-compliant with their discharge plans are:

- Patients are discharged to many different social and economic environments, with many different diagnoses. Each individual's separate set of circumstances can impact the outcome of a hospital discharge plan.
- Patients who have inaccessible guardians, or who need but do not have guardians, can create problems when decisions and arrangements are needed for treatment or discharge. There are many patients who do not have family member contacts or Powers of Attorney to authorize treatment. Those patients with family member contacts may live alone with a family member out of state, or may live with a caregiver; however in either case discharged patients may be unable to follow their care plan as the person actually responsible for their care was not involved in the plan of care process, or is not made aware after the fact.
- Some patients suffer from poor nutrition because they cannot afford meals. This lack of nutrition may contribute to rehospitalization. Similarly, some patients are discharged with prescription medications that are unaffordable,

“Discharge was too hasty...being the last patient in the evening...they did not confirm [my ability to do certain things]...had to return to emergency at 3:00 a.m.”

“The family should be kept informed during the process...the family wishes should be respected.”

“[This hospital] provided detailed, written directions with time to read independently. Later a staff member reviewed the written documents verbally with us and asked if we had any questions. She was extremely knowledgeable & fully answered all questions. I felt we were well informed and prepared for discharge.”

“[There is] not enough notice when you are being discharged...discussion with the social worker is limited...they just hand out paperwork.”

“We had to advocate on her behalf with physicians and discharge planners. They gave us some names but we had to call around and investigate homes, then homecare agencies...very complicated when caring for seriously ill parent.”

“It is not just the discharge personnel that act with no sense of urgency, it is the other agencies that take up to six months or more to provide the service...the process as I have seen in action needs some major overhauling.”

resulting in them not taking medications as prescribed or foregoing medications. Even for those individuals who can afford their new medications, medication lists frequently go without being updated, and so individuals continue taking medications that are no longer needed, resulting in possible drug interactions and health and safety issues.

- Individuals tend to think that they have comprehensive health care insurance coverage, and the system is too difficult for them to understand. There is no part of the discharge process that asks patients what their goals are, which can lead to greater non-compliance.

➤ *Hospitals are responding.*

Hospitals and their staff recognize the need to collaborate with community partners. They also recognize the reality of the growing older adult populations, and shared that a majority of their emergency room cases are older adults. In response, the Trinity Healthcare System has begun to introduce “Senior Emergency Rooms” in their southeast Michigan hospitals to accommodate the needs of older adults, their caregivers, and provide them with specialized support from trained physicians, nurses, social workers, and other staff. The Henry Ford Health System is piloting a geriatrician-led senior care unit in one of their Macomb County hospitals, as a method to achieve improved geriatric patient outcomes.

“Last year we had over 6,000 hospital admissions, 80% were older adults”

- Hospital Administrator

Survey Results

The AAA 1-B and TSA administered a survey electronically via www.surveymonkey.com in order to obtain information and input from individuals that may have experienced the discharge process. The survey link was shared with the region’s senior centers and service networks requesting that they encourage people to share their hospital discharge experience by completing the survey online or on paper.

Of the 83 respondents, almost 50% were over the age of 60 and only 10% were over the age of 85. Fifty-seven percent of those responding to the survey indicated that they were a caregiver. Overall, the satisfaction of the discharge process, rated from 1-10, was between a 5 and 6.

Many of the respondents indicated that their hospital discharge experience was “too confusing”, that there was a lack of communication, and that there was a need for disease specific education for discharge planners. Education was referenced the most

in regards to those individuals with dementia or Alzheimer's disease, and who may experience sundowners or other conditions that affect a care transition.

A vast majority of respondents indicated they had Medicare or private insurance, and 43% of respondents transitioned home had a caregiver or family member to support them after leaving the hospital. Sixty-eight percent of respondents were not readmitted. Of those who were, it was mixed in terms of age, challenges, where they were discharged to, etc.

About half of the respondents were not familiar with AAA services, with half having used AAA services. However, nearly every respondent indicated they were familiar with or are utilizing services that are typically funded or provided by AAAs. This indicated a need for better education and awareness of AAA and community-based services.

RECOMMENDATIONS

Short Term Recommendations

1. The AAA 1-B and TSA shall submit a report to their respective Advisory Councils and Boards of Directors by November 2011 that documents progress made in implementing recommendations of this report.

The Advisory Council members invested considerable effort, thought, and foresight into the development of this report, and the recommendations represent a viable business plan that will create tangible benefits for hospitals, payers, area agencies on aging, and Medicare beneficiaries. It is now the responsibility of AAA staff to follow through on implementation of the recommendations, and be accountable for positive action, to the extent feasible.

2. Identify hospitals and partners through discussion that may be interested in developing a pilot care transition program with the AAAs.

The AAAs should initiate discussions with southeast Michigan hospitals for the purpose of collaborating in the development of pilot care transition projects that link AAA and Aging Network services with hospital discharge planning processes. For Older Americans Act and state funded services not readily available, it is expected that new sources of revenue will be identified to pay for needed services provided to discharged hospital patients.

3. The AAA 1-B and TSA should participate in meetings that focus on transitional care issues, such as the St. Mary's nursing home forum and the Washtenaw County Transitional Care Coalition, and decide on long term participation.

The above mentioned community collaborations address care transitions, but have not involved their respective AAAs. AAA staff should participate in these collaborations and evaluate whether it is appropriate for the AAA to become a permanent member of each coalition.

4. The AAA 1-B and TSA should provide hospital social workers and discharge planners with general in-service training on AAA programs, resources and services; customized for their service area and offered first to those hospitals that participated in the discovery portion of this study.

Representatives from every hospital that participated in this study indicated that they do not know as much as they need to know about resources available through their AAA, as well as other AAA funded services, and expressed an interest in in-service training for discharge planning staff.

5. Hospitals should partner with the emerging Aging and Disability Resource Centers (ADRC) to strengthen their ability to link with community-based resources to support discharge planning for older adults and persons with a disability.

Many of the resources that hospital discharge planners identified as needed to enhance their ability to perform their work successfully are part of the core functions of Michigan's ADRC design, including :

- *Information and Assistance (I&A)*
- *Streamlined Access*
- *Options Counseling*
- *Person-Centered Hospital Discharge Planning*

Long Term Recommendations

1. The AAA 1-B and TSA should collaborate with hospitals in the formation of Patient-Centered Medical Home partnerships as defined under the national health care reform Affordable Care Act, or through Accountable Care Organizations (ACOs), for the provision of supported services to applicable discharged patients.

The Affordable Care Act encourages the development of Patient-Centered Medical Home partnerships and ACOs because these integrated care models have demonstrated the potential for delivering high quality care cost effectively. These models allow for the coordination and integration of health-related services into their care models, including many of the home- and community-based long term care services available through AAAs. The AAA 1-B and TSA should reach out to forming Patient-Centered Medical Home and ACO partnerships and explore the potential for creating partnership or contractual relationships that include the provision of AAA supported services.

2. The AAA 1-B and TSA should develop a mechanism with hospital social workers and discharge planners to assure that discharged patients who are referred to the AAA will have contact with information and assistance staff. This may be accomplished through:

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- Developing a mechanism to allow a live “warm transfer” of a hospital caller to the AAA.
 - Allowing hospital staff to notify the AAA when a patient has been referred, allowing the AAA to initiate contact with the patient.
 - Ability for discharge planners to make an electronic referral to AAAs for patients.
 - Designating a specific point person in AAA I&A units for discharge planning.

A hospital discharge is often a stressful and confusing event to patients and family members, who are bombarded with a vast array of information and instructions for their aftercare. It is not unusual for patients to be non-compliant in following up on treatments and securing needed resources. Many referrals for help are not followed up on for a variety of reasons, and are “dropped”. Hospital discharge planners have identified this as a common problem, and have asked for a system that assures discharged patients are connected with area agencies when appropriate. The strategies for directly connecting hospital staff and patients with AAA Information and Assistance staff have been suggested for consideration by various hospitals and AAAs.

3. The AAA 1-B and TSA should establish a stronger linkage between hospitals and the Medicare Medicaid Assistance Program (MMAP) – this may be accomplished through the co-location of MMAP representatives onsite at the hospital.

The MMAP program’s role in educating people about their health care benefits and assisting them to access needed health care services, including prescription drugs, is an essential element of the discharge planning process, but a function that hospital discharge staff are unable to perform when extensive education is required, when assistance is needed after the patient leaves the hospital, or when the circumstances are so complicated that a significant amount of time is needed to successfully solve the patient’s problem. Hospital staff have expressed an interest in engaging the assistance of the MMAP program in assisting certain patients who need more assistance than can be provided while in the hospital in order to assure there is follow-up on resolving issues and accessing needed benefits.

4. The AAA 1-B and TSA shall enhance the familiarization of hospital social workers and discharge planners about community resources by initiating the following activities:

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- Provide real-time information on the availability status of relevant TSA/AAA 1-B supported services, including wait list status, which may be done through a *professionals-only* AAA website for discharge planning.
 - Assist hospital discharge planners to collaborate with community-based professional supports, such as senior housing service coordinators, resource advocates, and AAA care managers, to engage them in aftercare service and monitoring arrangements of individuals whom both entities serve.

Most hospital staff are not confident that the community resource information that they have is comprehensive and accurate, and it is believed that the information and referral databases of the AAA 1-B and TSA are much more extensive. Many hospitals expressed an interest in accessing resource information that was up-to-date and comprehensive. A second aspect of resource information that is very important to hospital discharge planners is status information on access to community resources. They need to know whether a program is open to new referrals, length of time to initiate service, and the scope of service, such as whether the services accommodate people with unique and special needs. In addition, when individuals who are the recipients of in-home assistance from AAA programs or live in senior housing with service coordinators present, these professionals should be engaged to assist in assuring that needed follow-up service arrangements are made and monitored.

5. The AAA 1-B and TSA should develop a care coordination pilot which may include the following:
 - Collaboration with a selected hospital, MPRO, Medicare Advantage Plans, and consumers;
 - Development of a hospital discharge checklist that begins discharge planning at time of intake for high risk of readmission patients, designs interventions that include community supports and incorporates questions that target people returning to home and/or transitioning from nursing home rehabilitation to home and pilots use of same;
 - Development of a “Prescription for Services” form on a tear-off tablet that hospital health care professionals, including physicians, can use to refer patients to community-based services. The tablet would list all of the most common referral resources, including contact information, and allow the health professional to simply check off the services that the patient would need;

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- Evaluation tool that collects readmission data, trends and demographics, tracks desired outcomes and assures effectiveness;
 - Design of wrap-around services for patients at high risk for readmission. Utilizing the hospital discharge checklist tool, level of risk would be evaluated at the time of admission to hospital and those who require interventions could receive wrap around services;
 - Development of grant proposals for these projects and attempt to secure local hospital reimbursement and federal funding for a multiple year project.

"I'd like to see an Area Agency on Aging mini-station on site at my hospital"

- Hospital Administrator

The above mentioned strategies represent the many ideas and suggestions that have emerged from the discussions with hospitals and provider organizations about how to improve the outcomes for individuals discharged from hospitals. Consideration of incorporating these solutions into any collaborative ventures that hospitals and AAAs undertake should be given.

6. The AAA 1-B and TSA should consider co-location of AAA/MMAP representatives onsite at the hospital to facilitate care transitions and access to services.

There are many AAA-supported programs, including Information and Assistance, Care Management, the Medicare Medicaid Assistance Program, Mobility Options Counseling, etc., that would be valuable to hospital patients and visitors, including family members. Consideration should be given to establishing an onsite presence of AAA staff and/or services to facilitate access to assistance.

7. The AAA 1-B and TSA should increase the speed in which community-based services can be assessed by hospital discharge planners and social workers, with the goal of making the initiation of selected services within a time that meets the time constraints of the hospital discharge system.

One of the most often-mentioned issues raised by hospital discharge planners is the short time frame in which hospital discharge plans are made, and patients discharged. Every hospital discharge planner questioned indicated that they have discharged patients to nursing homes, who could have been discharged home instead if AAA supported services could have been present in the home within a 24 or 48 hour basis to supplement skilled homecare and other

resources. AAA supported home- and community-based services clearly can play a valuable role in positively impacting the success of hospital discharges. However, if they are to be effective in assisting discharged patients, they must be able to be engaged much more quickly for this purpose than current programs are designed to respond.

“Sometimes it takes more than a week to get home delivered meals for a discharged patient. That can make or break (a successful discharge home).”

- Hospital Discharge Planner

APPENDICES

APPENDIX A:

**SOUTHEAST MICHIGAN REGIONAL AGEA AGENCY ON AGING ADVISORY COUNCIL AD
HOC STUDY COMMITTEE ON AWARENESS OF RESOURCES FOR CARE TRANSITIONS
COMMITTEE CHARGE**

APPENDIX B:

**SOUTHEAST MICHIGAN REGIONAL AGEA AGENCY ON AGING ADVISORY COUNCIL AD
HOC STUDY COMMITTEE ON AWARENESS OF RESOURCES FOR CARE TRANSITIONS
MEMBERSHIP**

APPENDIX C:

HEALTH SYSTEM AND HOSPITAL PARTICIPANTS

APPENDIX D:

INVITED PRESENTERS AT COMMITTEE MEETINGS

APPENDIX E:

AGING AND DISABILITY RESOURCE CENTER DESCRIPTION

APPENDIX F:

MI*STAAR DESCRIPTION

APPENDIX A: Committee Charge

AWARENESS OF RESOURCES FOR CARE TRANSITIONS AD HOC STUDY COMMITTEE CHARGE

This Committee was established as a regional partnership of the Area Agency on Aging 1-B and The Senior Alliance Advisory Councils to address issues affecting older adults and adults with disabilities in southeast Michigan. The Advisory Councils are concerned that many older adults, adults with disabilities, and family caregivers are not aware of the home- and community-based resources that are available to assist them to maintain their health and independence. This lack of awareness contributes to avoidable problems when individuals experience new needs resulting from an acute health care episode, and must transition home after a hospital admission without the assistance needed to achieve a successful recovery. Unsuccessful hospital transitions are a serious concern that can lead to an unplanned readmission, a problem that cost Medicare \$17.4 billion in 2004. Services provided through area agencies on aging, such as home delivered meals, personal care, homemaking, respite, and chore services can provide valuable support to individuals recovering from an acute health care episode, or adjusting to a disabling injury or disease. Greater coordination of care and public education about available community resources can facilitate more successful transitions and prevent avoidable hospital readmissions. Stronger linkages between aging network programs and hospital discharge planners will increase awareness of community-based resources and assure that older adults and adults with disabilities gain access to critical supports and services.

The Committee will conduct its investigation during the summer months of 2010 and produce a final report with findings and recommendations for approval by the Area Agency on Aging 1-B and The Senior Alliance Advisory Councils and Boards of Directors by November, 2010.

RESPONSIBILITIES

- Investigate national and local practices relating to discharge planning and the coordination of hospital transition care
- Learn about hospital discharge planner responsibilities, identify their challenges and needs, and identify strategies to facilitate greater coordination of transitional care
- Identify best practices in the coordination of care for hospital transitions to home settings
- Develop recommendations to improve knowledge of and access to home and community-based services for older adults and adults with disabilities when transitioning to home after a hospitalization

DELIVERABLES

- Documentation of hospital discharge planning needs and challenges
- Recommendation of strategies for facilitating more successful hospital transitions to home
- Report on committee findings, conclusions, and recommendations

A New England Journal of Medicine article reported that 1 in 5 hospitalized patients had to be re-hospitalized within a month, about 20% of Medicare fee-for-service patients who were discharged from the hospital had to be re-hospitalized within 30 days, and 34% had to be re-hospitalized within 90 days.

APPENDIX B: COMMITTEE LEADERSHIP, MEMBERSHIP AND STAFF

Committee Co-Chairpersons:

Elaine Taverna, TSA Advisory Council
Community Living Services

Tiffany Reo, AAA 1-B Advisory Council
Signature Home Care/ Premier Physicians Care

Committee Staff:

Jason Maciejewski, TSA
Chief Information and Planning Officer

Margaret Watson, TSA
Planning and Programs Manager

Jim McGuire, AAA 1-B
Director of Research, Policy Development

June Ullman, TSA Intern

TSA Committee Members:

Sandra Abbott

Jacqueline Bousha

Lisa Boyd

Mike Chappelle

David Graham

Tom Jankowski

Jaclyn Kochis

Sharon Miller

Dianne Neihengen

Ann Randolph

Pat Randolph

Joan Siavrakas

Rosemarie Shim

Amne Talab

AAA 1-B Committee Members:

Laura Champagne

Dennis Griffin

Robert Hull

Linda Patton

Tom Rau

Dan Sier

Sue-Anne Sweeney

Nancy Vecchioni

APPENDIX C: PARTICIPATING HOSPITALS

The Area Agency on Aging 1-B and The Senior Alliance are indebted to the following hospital staff for agreeing to meet with Committee leadership to discuss the challenges and needs of hospital discharge planners:

Beaumont Hospitals

- Beaumont Hospital Royal Oak
- Beaumont Hospital Troy

Henry Ford Health System

- Henry Ford Macomb Hospital – Clinton Township Campus
- Henry Ford Macomb Hospital – Warren Campus

Oakwood Healthcare System

- Oakwood Annapolis Hospital (Wayne)
- Oakwood Heritage Hospital (Taylor)
- Oakwood Hospital and Medical Center (Dearborn)
- Oakwood Southshore Hospital and Medical Center (Trenton)

St. John Providence Health System

- Providence Hospital (Southfield)
- Providence Park Hospital (Novi)

Trinity Health

- St. Joseph Mercy (Ann Arbor)
- St. Mary Mercy (Livonia)

APPENDIX D: COMMITTEE GUEST PRESENTERS

The Area Agency on Aging 1-B and The Senior Alliance Advisory Councils would like to thank the following guest who participated in the study process by presenting information at Committee meetings:

Lori Apple
CSN

Sharon McDowell
MARO

Michelle Baylor, Ann Kramer
Citizens for Better Care

Sharon Powell
Sanctuary at Villa Marie

Diane Bodell
National Church Residences – Canton Place

Nancy Vecchioni
Michigan Peer Review Organization
(MPRO)

Linda Bolling
SHCS

Nancy Dillon
Mercy Home Care

Steve Falconey
Senior Village Management

Kathy Graham
Wayne County Senior Legal Services

Maesha Hadden
Wayne County Senior Citizen Services

Kathy Hannah
Assured Home Nursing

Jyothi Joseph
The Baptist Manor

APPENDIX E: Aging and Disability Resource Centers (ADRC)

Aging and Disability Resource Centers (ADRCs) serve as a “no-wrong door” of entry into the long-term supports and services system for older adults and people with disabilities. By coordinating existing resources and services, ADRCs assist people of all ages, incomes and disabilities access information about the full range of long-term care options. ADRCs raise awareness about available options, provide objective information and counseling, empower people to make informed decisions about long term care supports and help individuals more easily access public and private supports and services.

The vision for ADRC partnerships in Michigan:

ADRC Partnerships in Michigan provide trusted information to individuals, families, and caregivers so they are able to make informed decisions, according to their culture, values, and preferences, regarding their long-term support needs.

ADRCs operate with the following values:

- Providing the individual and family/caregivers with inclusive services and initiatives.
- Honoring the person’s preferences, values, and circumstances.
- Being inclusive of all incomes, all ages, and all disabilities.
- Providing accurate, complete and understandable information.
- Demonstrating cultural competence and asking the individual and others involved how to make the services provided as culturally competent as possible.
- Embracing “Nothing About Us, Without Us” – older adults and people with disabilities have meaningful roles and input into the ADRC partnerships.
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In 2009, the State of Michigan Office of Services to the Aging (OSA) received a grant to administer the development of ADRCs in Michigan. OSA designated the Area Agencies on Aging (AAAs) and Centers for Independent Living (CILs), which serve persons with disabilities, as the conveners of the local ADRC partnerships. Each of the 16 AAAs in Michigan has been charged by OSA to convene an ADRC with their CILs. As of October 20, 2010, a Letter of Intent to become an ADRC has been submitted to OSA by 10 AAAs and their partners, including the AAA 1-B and TSA. Four have taken the next step, applying to be designated as an Emerging ADRC. The Senior Alliance, AAA 1-C, is one of those four. The deadline to achieve fully-functional ADRCs in Michigan is September 30, 2014.

ADRCs in Michigan are comprised of partners that range across the aging and disability spectrum. OSA requires that ADRC partnerships include organizations from nine different categories:

- Area Agency on Aging (AAA)
- Center for Independent Living (CIL)
- Medicaid/Medicare Assistance Program, Inc. (MMAP)
- Local Long-Term Care Ombudsperson
- Benefits Enrollment Center
- State of Michigan Department of Human Services (DHS)
- Providers
- Hospitals

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- Consumer/Caregivers

Multiple partners can come from the Providers, Hospitals and Consumers/Caregivers category. ADRC partnerships decide their own leadership roles and divisions of labor, and will be empowered to customize processes that meet the unique needs of their community. Support from the Michigan Office of Services to the Aging (OSA) will be provided through technical assistance, training, the creation of an information technology infrastructure, and the development of quality management standards.

The ADRC partners have the responsibility to develop consistent practices and procedures, and highly visible and trusted services in their community. Core ADRC functions, as defined by the Administration on Aging (AoA), include:

- Information and Assistance (I&A)
- Streamlined Access
- Options Counseling
- Person-Centered Hospital Discharge Planning
- Quality Assurance and Evaluation

The core ADRC function of Person-Centered Hospital Discharge Planning is closely related to the research, findings and recommendations outlined in this report. ADRCs will need to collaborate with hospitals and their discharge planners to develop a Person-Centered discharge process. A dialogue between ADRCs and hospitals about the flow of information, accessibility to services and person-centered thinking are essential to a successful discharge planning process. The study conducted by The AAA 1-B and The Senior Alliance is an important step in developing a successful relationship between our ADRC partnerships and some of the hospitals in our service areas.

APPENDIX F MI*STAAR - STATE ACTION ON AVOIDABLE REHOSPITALIZATIONS



MI STAAR:

On May 1, 2009, the Institute for Healthcare Improvement (IHI) launched the State Action on Avoidable Rehospitalizations (STAAR) initiative. This is a grant funded initiative supported by The Commonwealth Fund to provide technical assistance to state-level coalitions committed to reducing avoidable rehospitalizations.

Michigan is one of three states selected to participate in this four-year initiative. Through supporting the strategy and leadership of state-level steering committees in Michigan, Massachusetts and Washington, the IHI aims to help states reduce statewide 30-day rehospitalization rates by 30 percent and to increase patient and family satisfaction with transitions and coordination of care. In Michigan, the Michigan Health & Hospital Association (MHA) Keystone Center for Patient Safety & Quality has joined MPRO, Michigan's Quality Improvement Organization, to convene a steering committee of executive leaders from organizations that can impact rehospitalizations. Specifically, this multi-stakeholder coalition will develop and shepherd state-specific strategies for reducing avoidable rehospitalizations and will drive results in the project. Twenty-eight Michigan hospitals and their community partners are participating, with statewide rollout scheduled for Spring of 2011.

For more information on MI STAAR and the program initiatives listed, please contact:

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MPRO developed the following collaboratives to assist healthcare providers to reduce rehospitalizations:

TICKET TO RIDE

Ticket To Ride encourages and fosters the standardization of information between acute and post-acute care settings in order to successfully manage the care of the patients.



DETROIT CAAR

Detroit Community Action to Reduce Rehospitalizations (CARR) is a community collaborative to identify barriers that impact safe transitions and implement interventions to reduce rehospitalizations.



ReWaRD

Rehospitalization Workgroup for Reporting Data (ReWaRD) is a partnership between MPRO and health plans to report rehospitalization rates to healthcare organizations.



HeLPeR

Healthcare Link to Prevent Rehospitalizations (HeLPeR) collaborative connects healthcare providers with community resources to reduce rehospitalizations.

