ENABLING COMMUNITY LIVING AND PARTICIPATION: COORDINATION, COLLABORATION, COMMUNICATION, AND COOPERATION ACROSS THE SPECTRUM

Forum on Aging, Disability, and Independence

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"In a time of major changes to the health care delivery and payment systems, connecting clinical work to community partners and resources brings a sense of renewal and hope for the challenges ahead. Going beyond clinical walls to solve complex problems is a prescription for success."

-- The Institute for Clinical Systems Improvement, 2014

Aging and Disability: In Health Care's Blind Spot

- Psychosocial and community factors greatly impact health outcomes and costs
- Yet, person- and family-centered, coordinated care with links to the community are rare in care models
  - Mental health often forgotten
  - Models not "bilingual" or "bicultural" to bridge medical and social systems
- Institute of Medicine recommendation: "community links"
  - Assessing psychosocial issues
  - Delivering services in the community
  - Communicating these issues with medical team

Institute of Medicine. *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America.* September 2012.

The Rush Response

- Rush University Medical Center
  - Not-for-profit health care, education, and research enterprise
  - Located in diverse urban neighborhood in Chicago, IL
  - Inpatient and outpatient services
  - Multiple community service programs
- Health & Aging department offers wrap-around services
  - Health promotion
  - Care management and coordination
  - Social Work clinical services
  - Resource centers
  - Workforce training initiatives

Geriatric Workforce Enhancement Program

- HRSA grant to support the development of community-specific interprofessional geriatrics education and training programs
  - $35.7 million awarded in total
- 44 GWEP initiatives in 29 states across nation
  - Led by health care facilities and by schools of medicine, nursing, social work, and allied health professions
- Rush-led GWEP: CATCH-ON (Collaborative Action Team training for Community Health – Older adult Network)
  - A collaborative GWEP project led by Rush with over 30 educational & community partners across IL
  - www.catch-on.org

HRSA's GWEP Program Requirements

- Form interprofessional collaborations to design and implement the project
- Develop and implement integrated geriatrics and primary care health care delivery systems
- Partner with, or create, community-based outreach resource centers to address the learning and support needs of older adults, their families, and their caregivers
- Provide training to individuals who will provide care to older adults within focus areas above
- Optional: Alzheimer's disease and related dementias (ADRD) education and training

Rush's CATCH-ON: Two Primary Aims

- Education about management of chronic conditions among diverse older adults
  - Interactive, online education for community members & professionals
  - Course Material & Faculty Development
  - Learning Communities
  - Health Education About LGBT Elders, PEARLS, and Healthy IDEAS
  - Health Ambassadors
- Primary care transformation
  - Fully supported implementation of evidence-based programs to best utilize resources
    - Readiness assessment
    - Tailored program development
    - Training and support for clinics
    - Outcome assessment

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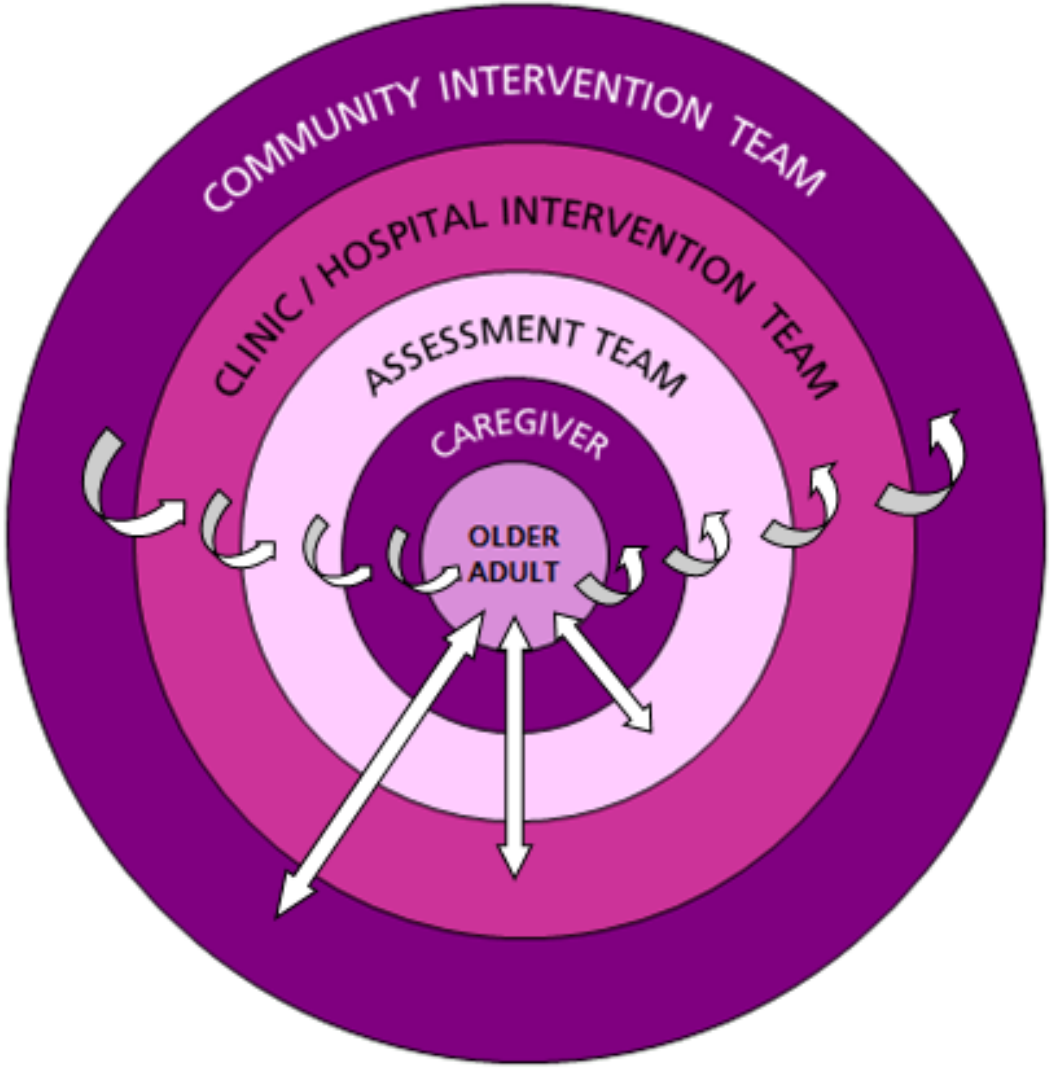
CATCH-ON: A Vision for Collaborative Care



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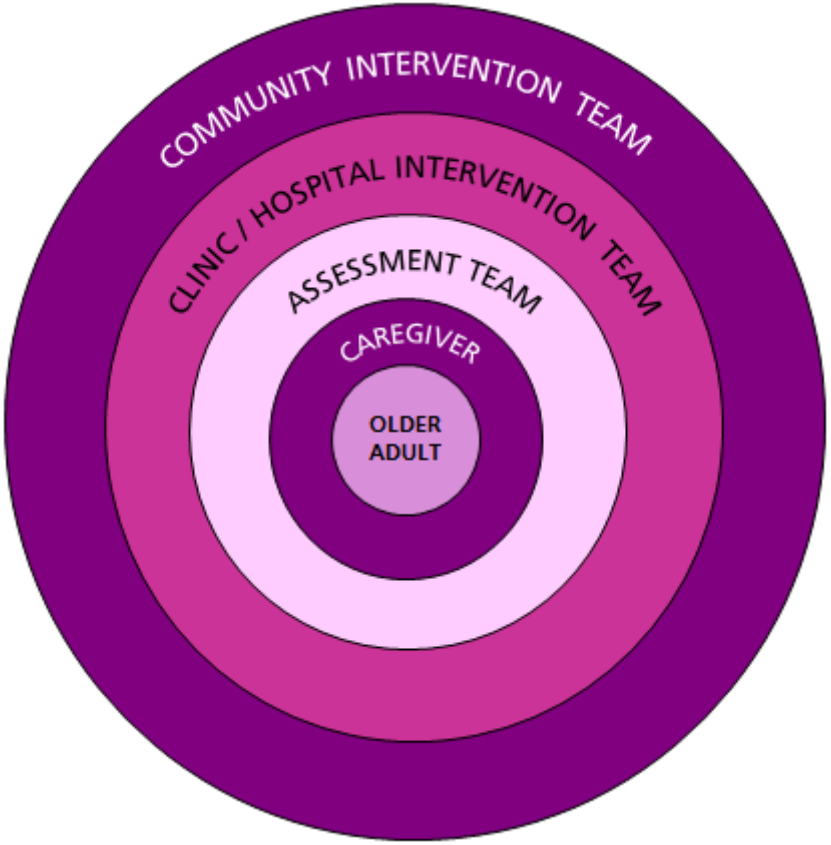
Recognizing Important Roles in the Community



- Older Adult & Caregiver
- Area Agency on Aging
- Chronic condition associations
- Home care providers
- Adult day care staff
- Caregiver supports
- Geriatric Care Managers
- Elder Lawyer
- Accountant/Financial Planner
- Others

Bridge: A Transitional Care Intervention

- The Bridge Model
  - 50+ replication sites around country
  - Works with older adults and adults with disabilities
- EMR review
- Interdisciplinary connections, led by Social Worker
- Bedside visit
- Post-discharge
  - Phone contact
  - Facilitate discharge plan
  - Facilitate connections to community resources
  - Coordinate home health, primary care, hospital

The Bridge Model

www.transitionalcare.org

The Bridge Model of Transitional Care

Overarching principles:

- *Social Determinants of Health*
- *Hospital-Community Collaboration*

Client & Caregiver

Hospital

BCC

Clinical intervention
Comprehensive assessment

Community Agencies

Community-specific focus

Continuous Quality Improvement

Bridge Model Collaborative

Trained supervisor

Bridge Strengths (Boutwell et al., 2015)

- 20% 30-day readmission reductions vs. comparative populations
- Major model strengths
  - Repeated assessments
  - Person-specific tailored interventions
  - Ability to effectively link individuals to services

"Well suited to assess and address the transitional care needs of adults with complex medical, behavioral, and social needs"

- Social work based transitional care model may be of interest for…
  - "addressing social and economic needs of urban, rural, dually-eligible, and/or adult Medicaid populations"

The Bridge Model

www.transitionalcare.org

So… What does it take?

- Person- and family-centered
- Prevention and wellness strategies
- Innovative models of care coordination
- Attention to multiple chronic conditions
- Collaborative team-based care
- Interprofessional education
- Community engagement and partnerships with interoperability

THANK YOU

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