Presentation to Texas Senate Health & Human Services Committee Healthy Aging Study

Baylor Scott & White Health (BSWH)

Central Texas Aging Disability & Veterans Resource Center (AAA/ADVRC)

February 18, 2016

Central Texas Aging, Disability & Veterans Resource Center
An initiative of the U.S. Department of Health and Human Services

CTCOG central texas council of governments

Baylor Scott & White HEALTH

Partnership Between a AAA/ADVRC and Healthcare Systems to Improve the Health of Older Adults and their Family Caregivers

H. Richard McGhee

Director, Area Agency on Aging of Central Texas,

Central Texas Council of Governments

Alan B. Stevens, PhD

Holleman-Rampy Centennial Chair in Gerontology

Director, Center for Applied Health Research

Baylor Scott & White Health

AAA/ADVRC & BSWH Partnership

Provide community-based services to address multiple determinants of health

- Resources for Enhancing Alzheimer's Caregiver Health
  - Published data available
- Chronic Disease Self-Management/Diabetes Self-Management
- Community Living Program
  - Published data available
- Community Research Center for Senior Health
  - Tools and supports to support all communities in evidence-based health programs
  - EvidenceToPrograms.com
  - One of 23 Centers in the US funded by NIH

National leaders in community-based care transitions programs

- Texas ADRC Evidence-Based Care Transitions Program
  - Funded by Administration on Aging Demonstration project at Scott & White Memorial (2011-2013)
- Central Texas Community-Based Care Transition Program
  - Funded by Centers for Medicare and Medicaid Services (2013-2015)
  - Four hospitals – BSWH Memorial, BSWH Hillcrest, Hamilton General, Metroplex Adventist)
- Central Texas Care Transition Program
  - BSWH- Temple & Metroplex (2015- Current)

Baylor Scott & White HEALTH

Central Texas Aging, Disability & Veterans Resource Center

Central Texas Care Transition Program

- Integrates 2 evidence based care transitions models that reduce 30 day readmissions to the hospital -- the **Care Transitions Intervention** and **the Bridge Model**)
- BSWH and ADVRC contribute staff that are co-located in the hospital and community
- 10 BSWH staff (MSW & discharge advocate) complete patient risk assessment using cutting edge technology
  - Patients referred to ADVRC for person/family-centered transitional care
  - Access to Title III in-home services
- Technology is used to facilitate partnership and patient care
  - **Care at Hand**
  - Patient-centered, mobile care coordination platform
  - Enables real-time communication between community-based coaches and nurse consultants to address full breadth of reasons for readmissions

Baylor Scott & White HEALTH

Central Texas Aging, Disability & Veterans Resource Center

Thank You

alan.stevens@bswhealth.org
richard.mcghee@ctcog.org

Community Living Program

- Provide community-based LTC services for older adults at high risk of nursing facility placement and not Medicaid eligible
- Jointly conceived and implemented between Baylor Scott & White Health (formerly Scott & White Healthcare) and the Central Texas Aging and Disability Resource Center
  - Additional support services from community-based aging service providers and other key LTC stakeholders

Baylor Scott & White HEALTH

Central Texas Aging, Disability & Veterans Resource Center

CLP Program Components

- Individualized Plan of Care
- $750/month for 10 months for consumer-directed purchasing of formal care services (respite, homemaker, emergency response, support groups)
- 6 Home Visits + 3 Phone Calls
- If older adult was admitted to hospital, they were offered an evidence-based transitional care program (CTI)
- Caregivers received components of an evidence-based caregiver support program (REACH II)

Findings from CLP

- 191 participants enrolled from hospital and ADRC
- 9/143 (6%) older adults were admitted to a nursing facility at 10 months
- Older adults had fewer physician visits, ER visits, hospital stays and total nights in hospital and improvements in depression at 12 months
- Caregivers had improvements in depression and caregiver burden at 12 months

Implications for Texas

- Our partnership between healthcare and a community-based service organization (ADVRC) was instrumental in the design, implementation and outcome of the program
- Multiple stakeholders from both settings (e.g., hospital discharge planners, home care service providers) were consulted in the design of the program and their input had a direct impact on the services provided

The Care Transitions Intervention® (CTI)

- Developed by Eric Coleman, MD, MPH
  - University of Colorado Denver, School of Medicine
- Evidence-based, patient-centered 30 day intervention
- Designed to improve quality of care and safety for patients during care transitions

Bridge

- Developed by Bridge Model National Office (BMNO; originally known as the Illinois Transitional Care Consortium, ITCC)
- Evidence-based, social work-led, telephone-based intervention
  - Home visit available if patient is at high risk of re-admitting
- Model emphasizes collaboration among hospitals, community-based providers and the aging network

Resources for Enhancing Alzheimer's Caregiver Health II (REACH II)

- Clinical trial sponsored by the National Institute on Aging (NIA), National Institute of Nursing Research (NINR)
- 6-month intervention
- Intervention had a meaningful impact on quality of life and rates of caregiver depression were halved