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)

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

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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
  – Four hospitals – BSWH Memorial, BSWH Hillcrest, Hamilton General, Metroplex Adventist

• Central Texas Care Transition Program
  – BSWH- Temple & Metroplex (2015- Current)
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
Thank You

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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
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