ADNR Summit
Reaching the Medical Community: Applying Strategies to Build Relationships

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Why Involve Hospitals?

- Where individuals go with acute illness if plan fails or if lacking support— hub for access to many medical services
- Consultations available for complex needs (psych, palliative care, geriatrics)
- Hospital case management is involved in assessing needs and developing a plan for acute and post acute care
- Case Management make referrals to community based services
- Hospital Case Management may serve as resource to PCPs
- Gaps in services may exist because of lack of knowledge/collaborative relationship with community agencies needed post hospital stay
- Hospitals are challenged with readmissions

How to develop relationship with hospitals: where to begin?

- Identify key contacts: Example: hospital case management leadership
- Provide description of services offered
- How can your services reduce trips to the ER or readmissions?
- How can you bridge transitions of care?
- Offer materials and presentations to staff

Build a Relationship

- Identify communication methods that work best between your agency and the PCP/Hospital
- Explore with hospital case management how to gain access to communication with PCPs and office staff
- **Explore opportunities for collaboration**

Summa Health System and the Area Agency on Aging 10b (SAGE) Collaboration

An example of how to build a relationship with Medical Community:

- Acute hospital and medical care services and
- A community-based Area Agency on Aging

Goal: To integrate a comprehensive geriatric hospital-based clinical program with the community aging network to improve the health, functional status, and prevent institutionalization of older adults at risk for nursing home placement.

Summa Health System

- Integrated not for profit health care delivery system
- 4 community teaching hospitals >800 beds
- Health plan including a Medicare-Risk product
- Geriatric Services including outpatient comprehensive geriatric assessment , falls assessment clinic, physician house calls program and geriatric rehab units, and inpatient geriatric unit, geriatric consult service
- Home Care/Hospice/Palliative Care/Acute Rehab Hospital and LTAC
- Behavioral Health and Addiction Medicine acute care and outpatient
- Summa Physicians, Inc.
- The New Health Collaborative
- ***Community Partnerships*** (SAGE and the Care Coordination Network of Nursing Facilities)

Area Agency on Aging Programs

- Mission: to develop a responsive network of services and resources to assist older adults and their families
- Passport Home Care
- Community Services Division
  - Care Coordination
  - Alzheimer's Respite Program
  - Family Caregiver Respite
- Elder Rights Division

Integrated Care Delivery

The Primary Care Physician

- Medical model
- Limited time with patient

The Center for Senior Health

- Consult and Support to primary care physician
- Addresses medical and psychosocial
- Treats whole patient but no access to home environment or long term case management

The Area Agency on Aging ex Passport

- Social model
- Provides case management and services long term
- Limited interaction with PCP
- Addresses function abilities/geriatric syndromes but challenged with high risk clients with multiple chronic illnesses

Building the Relationship

- Started with collaboration between the Center for Senior Health and the Area Agency on Aging
- Both identified lack of continuity in client care due to communication problems, and fragmentation of client care delivery
- Wanted to build on existing strengths of both organizations

Step 1: Task Force Work to Develop Referral and Communication Processes

- Center for Senior Health referrals to Area Agency on Aging Services
- Referral process for Area Agency on Aging referrals to the Center for Senior Health
- Referrals for Area Agency on Aging from the hospital
- Follow-up protocols for AAoA clients admitted to the hospital, or geriatric rehab units
- Follow-up protocols with:
  - Summa's Internal Medicine Center
  - Summa's Home Care
  - Summa's Family Practice Center
  - SummaCare

Step 2: Expanding Services

The In-Hospital Area Agency on Aging Assessor Program

- Assessor screens patients for eligiblity for services in the hospital
- The assessor is an integral member of discharge planning team and other agencies
- This model now in place at all hospitals served by Area Agency on Aging 1ob

Step 3:
Continuing Community Service Collaboration

In addition to the ongoing SAGE process:

- SAGE process expanded to New Health Collaborative
- CCTP program with Transitional Care Coaches
- Alzheimer's Association
- Adult Protective Services/Probate Court
- Care Coordination Network (for profit nursing facilities)
- Community Support Services

Questions?