

**Aging and Disability Resource Centers  
Implementing the Affordable Care Act:  
Making it Easier for Individuals to Navigate Their Health and Long-Term Care through Person-  
Centered Systems of Information, Counseling and Access  
Evidence Based Care Transition Program**

**State Agency:** Pennsylvania Department of Aging

**Name of ADRC and Healthcare Partners:**

Delaware County ADRC, Crozer Keystone Health System's Taylor and Springfield hospitals.

**Project Period:** September 30, 2010 to September 30, 2012

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**Evidence Based Care Transitions Model:** Transitional Care Model

**Project Summary:**

The Pennsylvania Department of Aging/Office of Long Term Living proposes to work with the Delaware County Office of Services for the Aging (COSA), to replicate the Transitional Care Model (TCM) providing comprehensive discharge planning and assessment along with intensive in-home follow-up by advanced practice nurses (APNs) with the Crozer Keystone Health System (CKHS). CKHS comprises five hospitals, a comprehensive physician network of primary-care and specialty practices. Building upon the current transitional care program with CKHS' Taylor Hospital, COSA assessors will be housed at the hospital to identify and engage older adults most at risk for re-hospitalizations. The program will expand to CKHS' Springfield hospital in its second year.

**Goal/Objectives:**

The overriding goal for the project will be to prevent re-hospitalizations for a minimum of 235 seniors that are identified as high risk. An APN will monitor patients upon discharge ensuring their needs are met in the transition from acute care to community based settings. Specific objectives are to: Provide early identification and assessment of patients at risk of readmission to the hospital and to avoid long term nursing home placement for at-risk seniors; Provide home visits and daily telephone support by an Advanced Practice Nurse (APN) for a minimum of two months post-hospitalization; Engage in a multidisciplinary approach that ensures continuity of care working with patients, caregivers, families, physicians, in close collaboration with COSA, to ensure that all available supportive services are utilized.

**Anticipated Outcomes/Results:**

The expected outcomes of the project are: To improve care-coordination; Decrease in re-hospitalizations of at-risk patients 65. Significant savings to Medicare and insurers due to decreased hospitalizations; significant long-term savings to Medicaid as a result of nursing home diversions; A more timely on-site hospital assessment and development of a transition care plan; In-home visit by an advanced practice nurse within 24-48 hours of hospital discharge. Continued follow-up and service coordination by AAA Care Manager in AAA long term care system. A final report and evaluation will be provided by the Public Health Management Corporation (PHMC) along with results of consumer

satisfaction surveys. The end result will be a comprehensive TCM program ready for replication across the state.