Interprofessional Geriatric Transitions of Care and Discharge Planning Toolkit

Authors:

Melissa L. Freedman MSW, Research Assistant, Lynn Hutchings, PhD, Tarae Waddell-Terry, MS

Toolkit Workgroup:

Christine Arenson, MD, Jennifer Bellot, PhD, RN, MHSA, Mary Ellen Bolden, BSW, Cecilia Borden, EdD, RN, Nancy L. Chernett, MA,MPH, Emily R. Hajjar, PharmD, BCPS, CGP, E. Adel Herge, OTD, OTR/L, Leigh Ann Hewston, PT, MEd, Christine Hsieh, MD, Ina Li, MD, Veronica Rempusheski, PhD, RN, FAAN, Janet Townsend, MD, Tracey Vause-Earland, MS, OTR/L, Valerie Weber, MD

ACKNOWLEDGEMENT

INTRODUCTION

Hello and welcome to the EPaD GEC Interprofessional Geriatric Transitions of Care and Discharge Planning Toolkit.

This toolkit contains various resources for providers, clinicians, consumers, and caregivers. It is designed to assist you in accessing current information as well as recommended tools, resources and identified best practices of care specific to the processes of transitions of care and discharge planning.

The toolkit is divided into sections and addresses the areas outlined in our curriculum. You will find information on assessment tools, specific models of transition and discharge planning, and an array of additional resources that include, but are not limited to: hospice, advance directives, clinical services, state specific agencies and networks. The following information should provide you with a comprehensive understanding of the basic elements of the multiple systems and areas involved in successful transitions and discharge planning.

TABLE OF CONTENTS

1. **Aging and Disability Resource Center (ADRC): Technical Assistance Exchange**

Emerging Evidence-Based Care Transition Models

Several care transition models are emerging, supported by research and evaluation, and aim to improve coordination among health care providers and to help individuals better understand their post-hospital care. Some models emphasize the use of a nurse or nurse practitioner as a coordinating entity and others include social workers and other human services professionals as potential transitions coordinators. Other models utilize physician-led teams to help coordinate care for individuals. ADRCs can play important roles in implementing or facilitating these care transitions efforts in local communities across the country.

http://www.adrc-tae.org/tiki-index.php?page=EvidencebasedCTModels

a. **The Care Transitions Program**

The aim of the Care Transitions Program is to:

- o support patients and families
- o increase skills among healthcare providers
- o enhance the ability of health information technology to promote health information exchange across care settings
- o implement system level interventions to improve quality and safety
- o develop performance measures and public reporting mechanisms
- o influence health policy at the national level

http://www.caretransitions.org/

b. **Guided Care**

Guided Care is a practical, interdisciplinary model of health care designed to improve the quality of life and efficiency of resource use for persons with medically complex health conditions. A Guided Care Nurse works in partnership with several primary care physicians to provide coordinated, patient-centered, cost-effective care to 50-60 of their chronically ill patients.

http://www.guidedcare.org/pdf/GC_FAQs.pdf

c. **Transitional Care Model (TCM)**

The Transitional Care Model (TCM) provides comprehensive in-hospital planning and home follow-up for chronically ill high-risk older adults hospitalized for common medical and surgical conditions. The heart of the model is the Transitional Care Nurse (TCN), who follows patients from the hospital into their homes and provides services designed to streamline plans of care, interrupt patterns of frequent acute hospital and emergency department use, and prevent health status decline. TCM emphasizes coordination and continuity of care, prevention and avoidance of complications, and close clinical treatment and management – all accomplished with the active engagement of patients and their family and informal caregivers and in collaboration with the patient's physicians.

http://www.transitionalcare.info/

❖ **Try this: Best Practices in Nursing Care to Older Adults**
From The Hartford Institute for Geriatric Nursing, New York University, College of Nursing
The Transitional Care Model (TCM): Hospital Discharge Screening Criteria for High Risk Older Adults
This evidence-based practice approach addresses needed hospital discharge assessment that should be completed by registered nurses or advanced practice nursing staff managing the complex care of hospitalized older adults.
http://consultgerirn.org/uploads/File/trythis/try_this_26.pdf

❖ **National Health Policy Forum**
Presentation: The Transitional Care Model for Older Adults
http://www.nhpf.org/library/handouts/Naylor.slides_04-03-09.pdf

d. **Geriatric Resources for Assessment and Care of Elders (GRACE)**

Social worker/nurse practitioner teams collaborate with a larger interdisciplinary team and primary care physicians to develop and implement individualized care plans for low-income seniors. The social worker/nurse team also proactively manages and coordinates the patient's care on an ongoing basis through regular telephone and in-person contact with both patients and providers. The program has led to significant improvements in measures of general health, vitality, social functioning, and mental health; reduced emergency department visits and hospital admissions; and generated high levels of physician and patient satisfaction.

http://www.innovations.ahrq.gov/content.aspx?id=2241

❖ **Team-Developed Care Plan and Ongoing Care Management by Social Workers and Nurse Practitioners Result in Better Outcomes and Fewer Emergency Department Visits for Low-Income Seniors**

http://www.innovations.ahrq.gov/content.aspx?id=2066

e. **Better Outcomes for Older Adults through Safe Transitions (BOOST)**

The BOOSTing (Better Outcomes for Older adults through Safe Transitions) Care Transitions Resource Room is the online version of the Care Transitions Implementation Guide. The suggested approach is based on eight essential elements for improving the discharge process. The resource room discusses designing, implementing and evaluating an intervention. Other resources include: educational resources (review of key literature, teaching slide sets, patient education and more) and clinical tools. Finally, for a refresher on Quality Improvement basic principles, visit QI Basics.

http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm

❖ **Project RED (Re-Engineered Discharge) integrated with Project BOOST (Better Outcomes for Older Adults through Safe Transition)**

http://patientsafetycouncil.org/uploads/Discharge_20checklist2_1_.pdf

❖ **Rush University Medical Center**

Presentation: Readmissions Tools: An Enhanced Discharge Planning Program and Project BOOST

http://www.ehcca.com/presentations/readsummit2/golden_pc.pdf

f. **The Bridge Model**

The Bridge Model is a social work based transitional care model designed for older adults discharged home from an inpatient hospital stay. Bridge helps older adults to safely transition back to the community through intensive care coordination that starts in the hospital and continues after discharge to the community. Model consists of three intervention phases: Pre-discharge, Post-discharge, and Follow-up.

http://www.transitionalcare.org/the-bridge-model/

2. **Boston University School of Medicine**

   Project RED (Re-Engineered Discharge)

   Project Re-Engineered Discharge is a research group at Boston University Medical Center that develops and tests strategies to improve the hospital discharge process in a way that promotes patient safety and reduces re-hospitalization rates. The RED (re-engineered discharge) intervention is founded on 11 discrete, mutually reinforcing components and has been shown to reduce rehospitalizations and yield high rates of patient satisfaction

   http://www.bu.edu/fammed/projectred/

3. **Home Health Quality Improvement**

   Best Practice Intervention Package - Transitional Care Coordination

   The purpose of this package is to assist home health agencies to:

   - Understand the concept of transitional care coordination and its potential role as a best practice in decreasing avoidable acute care hospitalizations.
   - Recognize the necessity for home health to assert its role in the evolution of transitional care coordination.
   - Implement transitional care coordination strategies to promote collaboration with other providers to improve care coordination.

     http://www.homehealthquality.org/hh/ed_resources/interventionpackages/tcc.aspx

4. **Interventions to Reduce Acute Care Transfers (INTERACT)**

   INTERACT is a quality improvement program designed to improve the early identification, assessment, documentation, and communication about changes in the status of residents in skilled nursing facilities. The goal of INTERACT is to improve care and reduce the frequency of potentially avoidable transfers to the acute hospital. Such transfers can result in numerous complications of hospitalization, and billions of dollars in unnecessary health care expenditures.

   http://interact2.net/

5. **Institute for Healthcare Improvement**

   The STAAR initiative aims to reduce rehospitalizations by working across organizational boundaries and by engaging payers, stakeholders at the state, regional and national level, patients and families, and caregivers at multiple care sites and clinical interfaces. IHI partners with STAAR states to provide strategic guidance, support and technical assistance to hospitals and cross-continuum teams to improve transitions in care and reduce avoidable rehospitalizations.

   http://www.ihi.org/offerings/Initiatives/STAAR/Pages/default.aspx

6. RARE: Reducing Avoidable Readmissions Effectively

   5 Key Areas Known to Reduce Avoidable Readmissions

   The campaign calls upon hospitals and others in the care continuum to focus on five key areas known to reduce avoidable readmissions. By implementing and spreading these best practices, hospitals can become more effective, more rapidly, in reducing avoidable readmissions. Through the RARE Campaign, hospitals can choose to work on any of the following five key areas:

   - Comprehensive discharge planning
   - Medication management
   - Patient and family engagement
   - Transition care support
   - Transition communications

   http://www.rarereadmissions.org/areas/index.html

7. Hospital at Home Toolkit

   Hospital at Home is an innovative model that provides hospital-level care in a patient's home as a full substitute for acute hospital care. The model was developed by researchers at the Johns Hopkins Schools of Medicine and Public Health. The toolkit includes an implementation manual, financial planning and evaluation tools, patient recruitment and education tools, measurement tools, patient-tracking mechanisms, and other tools to support implementation and operation.

   http://www.hospitalathome.org/develop-your-program/toolkit.php

8. **U.S. Department Of Health And Human Services, Administration on Aging: The Aging Network and Care Transitions: Preparing your Organization Toolkit**

   http://www.aoa.gov/AoA_programs/HCLTC/ADRC_CareTransitions/Toolkit/index.aspx

   - Toolkit Introduction
       o   Chapter One: Getting Started
       o   Chapter Two: Taking Time to Plan
       o   Chapter Three: Developing Effective Partnerships with Health Care Providers
       o   Chapter Four: Measuring for Success
       o   Chapter Five: Building Organizational Capacity
       o   Chapter Six: Implementation and Day-to-Day Operations

   http://www.aoa.gov/AoA_programs/HCLTC/ADRC_CareTransitions/Toolkit/chapters/CareTransitionsToolkitIntro.pdf

9. U.S. Department Of Health And Human Services, Administration on Aging: Aging & Disability Resource Centers Evidence-Based Care Transitions

http://www.aoa.gov/AoA_programs/HCLTC/ADRC_CareTransitions/index.aspx

10. Department of Health: Achieving timely simple discharge from hospital: A toolkit for the multi-disciplinary team
Provides best practice guidance to simple discharge from the hospital. It focuses on practical steps health that social care professionals can take to improve discharge.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4088366

Additional Resources to Supplement Models of Transitions of Care and Discharge Planning

1. Long-Term Quality Assurance

http://www.ltqa.org/

- Quality Improvement Workgroup Update

  http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//Quality-Improvement-Workgroup-Update.pdf

- Quality Measurement Update

  http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//Quality-Measurement.pdf

- Nursing Homes & Care Transitions

  http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//Nursing-Homes-Care-Transitions.pdf

- Community Based Settings & Care Transitions

  http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//Community-Based-Settings-Care-Transitions.pdf

- Workforce Education on Care Transitions

  http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//Workforce-Education-and-Care-Transitions.pdf

- Implementation of Care Transitional Models

  http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//Implementation-of-Transitional-Care-Models_final.pdf

2. **Collaboration for Home Care Advances in Management and Practice (CHAMP)**

   Establishing a National Framework for Geriatric Homecare Excellence: Care Coordination, Management and Transitions : Table of Article Descriptions

   http://www.champ-program.org/static/Care_Coordination_Table.pdf

3. **Archives of Internal Medicine**

   Article: The Care Transitions Intervention: Results of a Randomized Controlled Trial

   http://archinte.jamanetwork.com/article.aspx?volume=166&issue=17&page=1822

4. **British Medical Journal (via National Center for Biotechnology Information)**

   Article: Reduction in hospital readmission stay of elderly patients by a community based hospital discharge scheme: a randomised controlled trial

   http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1840357/?tool=pubmed

5. **American Medical Directors Association**

   Practice Guidelines: Transitions of Care in the Long-Term Care Continuum

   http://www.amda.com/tools/clinical/TOCCPG/index.html

6. **Portal of Geriatric Online Education (Transitions of Care Resources)**

   http://www.pogoe.org/litlinks/aging-related/transitions

7. **Journal of the American Dietetic Association**

   Article: Nutrition Concerns in Discharge Planning for Older Adults: A Need for Multidisciplinary Collaboration

   http://nutritionandaging.fiu.edu/Center_Initiatives/publications/JADA%20Baker%20Case%20Mgr.pdf

8. **Journal of Social Work Education**

   Article: Transitional Care

   http://www.cswe.org/File.aspx?id=16950

9. Journal of Hospital Medicine

   Article: Transition of Care for Hospitalized Elderly Patients - Development of a Discharge Checklist for Hospitalists

   http://caretransitionsprogram.net/documents/Transition%20of%20care%20for%20hosp%20elderly%20-%20JHM.pdf

10. Seamless Care: Safe Patient Transitions from Hospital to Home

    http://www.ahrq.gov/downloads/pub/advances/vol1/Spehar.pdf

11. Professional Case Management

    Article: Hospital to Home: A Transition Program for Frail Older Adults

    http://journals.lww.com/professionalcasemanagementjournal/Fulltext/2012/05000/Hospital_to_Home__A_Transition_Program_for_Frail.5.aspx

12. Intensive, Nurse-Led Care Management During and After Hospitalization Reduces Readmissions and Costs for High-Risk Seniors

    Article: http://www.innovations.ahrq.gov/content.aspx?id=2674

13. A Quality Improvement Intervention to Facilitate the Transition of Older Adults from Three Hospitals Back to their Homes

    Article:http://www.geisinger.org/info/innov_conf/medicalHomeConf/references/2009_September%20Transitions%20of%20Care.pdf

14. Long-Term Quality Assurance Innovative Communities Summit (December 2010)

    Report: Innovative Communities: Breaking down barriers for the good of consumers and their family caregivers

    http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//Innovative-Communities-Report-Final-0216111.pdf

15. University of Kansas School of Medicine

    Presentation: Continuity of Care and the Geriatric Patient

    http://www2.kumc.edu/coa/Education/AMED900/CONTINUITY%20OF%20CARE.pdf

16. **U.S. Department Of Health And Human Services, Administration on Aging**

   Presentation: Care Transitions in Action: From Hospital to Home in Two Communities (March 30, 2011)

   http://www.aoa.gov/aging_statistics/docs/AoA_ACA_CT_slides_033011.pdf

17. **Council on Social Work Education Gero-Ed Center**

   Teaching Module: Ethical Dilemmas in Discharge Planning for Older Adults

   http://www.cswe.org/CentersInitiatives/GeroEdCenter/Programs/MAC/GIG/Arizona/37517.aspx

1. **Mini-Cog Test**

   The Mini-Cog test is a 3-minute instrument to screen for cognitive impairment in older adults in the primary care setting. The Mini-Cog uses a three-item recall test for memory and a simple scored clock-drawing test (CDT). The latter serves as an "informative distractor," helping to clarify scores when the memory recall score is intermediate. In comparative tests, the Mini-Cog was at least twice as fast as the Mini-Mental State Examination. The Mini-Cog is less affected by subject ethnicity, language, and education, and can detect a variety of different dementias. Moreover, the Mini-Cog detects many people with mild cognitive impairment (cognitive impairment too mild to meet diagnostic criteria for dementia).

   http://geriatrics.uthscsa.edu/tools/MINICog.pdf

2. **Confusion Assessment Method (CAM)**

   The Confusion Assessment Method (CAM) includes two parts. Part one is an assessment instrument that screens for overall cognitive impairment. Part two includes only those four features that were found to have the greatest ability to distinguish delirium or reversible confusion from other types of cognitive impairment. **Article:** http://consultgerirn.org/uploads/File/Confusion%20Assessment%20Method%20(CAM).pdf

3. **Confusion Assessment Method for the ICU (CAM-ICU)**

   Tool adapted for use in nonverbal ICU patients from the Confusion Assessment Method (CAM), designed to be a serial assessment tool for use by clinicians. Typically takes less than 2 minutes to complete and requires minimal training.

   http://www.mc.vanderbilt.edu/icudelirium/assessment.html

4. **Short Portable Mental Status Questionnaire (SPMSQ)**

   Instrument used to test cognition when there is a clinical suspicion of cognitive impairment or a screening test. Easy to administer ten-item questionnaire is typically completed in less than 5 minutes. Adjustments must be made for education level.

   http://www.healthcare.uiowa.edu/igec/tools/cognitive/SPMSQ.pdf

5. **Medication Discrepancy Tool (MDT)**

   Tool designed to facilitate reconciliation of medications across settings and prescribers.

   http://www.ipro.org/index/cms-filesystem-action/care/cti/mdt_050708.pdf

6. **Fulmer SPICES: An Overall Assessment Tool for Older Adults**

Framework for assessing older adults provides a snapshot of clients' overall health. It focuses on six common conditions:

- sleep problems
- problems with eating and feeding
- incontinence
- confusion
- evidence of falls
- skin breakdown

Article: http://consultgerirn.org/uploads/File/trythis/try_this_1.pdf

7. **The Geriatric Depression Scale (GDS)**

Geriatric Depression Scale has been tested and used extensively with the older population. Screening tool takes five to seven minutes to complete. The GDS may be used with healthy, medically ill and mild to moderately cognitively impaired older adults. It has been extensively used in community, acute and long-term care settings. It takes about 5 to 7 minutes to complete.
Article: http://consultgerirn.org/uploads/File/trythis/try_this_4.pdf

8. **Braden Scale for Predicting Pressure Ulcers (PUs)**

The Braden Scale for Predicting Pressure Sore Risk, available in several languages, is among the most widely used tools for predicting the development of PUs. Assessing risk in six areas (sensory perception, skin moisture, activity, mobility, nutrition and friction/shear), the Braden Scale assigns an item score ranging from one (highly impaired) to three/four (no impairment). Use Braden Scale scores as part of comprehensive clinical assessment and decision-making to determine pressure ulcer risk. The Braden Scale is commonly used with medically and cognitively impaired older adults. It has been used extensively in acute, home, and institutional long-term care settings.
Article: http://consultgerirn.org/uploads/File/trythis/try_this_5.pdf

9. **Fall Risk Assessment for Older Adults: The Hendrich II Fall Risk Model**

The Hendrich II Fall Risk Model is quick to administer and provides a determination of risk for falling based on gender, mental and emotional status, symptoms of dizziness, and known categories of medications increasing risk. This tool screens for primary prevention of falls and is integral in a post-fall assessment for the secondary prevention of falls. Model intended to be used in the acute care setting to identify adults at risk for falls. **Article:** http://consultgerirn.org/uploads/File/trythis/try_this_8.pdf

10. Katz Index of Independence in Activities of Daily Living (ADL)

The Katz Index of Independence in Activities of Daily Living is the most appropriate instrument to assess functional status as a measurement of the client's ability to perform activities of daily living independently. Clinicians typically use the tool to detect problems in performing activities of daily living and to plan care accordingly. The Index ranks adequacy of performance in the six functions of bathing, dressing, toileting, transferring, continence, and feeding.

Article: http://consultgerirn.org/uploads/File/trythis/try_this_2.pdf

11. Instrumental Activities of Daily Living Scale (IADL)

The Lawton Instrumental Activities of Daily Living Scale (IADL) is an appropriate instrument to assess independent living skills. The instrument is most useful for identifying how a person is functioning at the present time, and to identify improvement or deterioration over time. There are eight domains of function measured with the Lawton IADL scale. Intended to be used among older adults, and can be used in community or hospital settings. The instrument is not useful for institutionalized older adults. It can be used as a baseline assessment tool and to compare baseline function to periodic assessments.

Article: http://consultgerirn.org/uploads/File/trythis/try_this_23.pdf

12. Falls Prevention & Risk Assessments

Reference booklet contains the following scales and relevant information concerning instructions, scoring, and references:

- Activities Specific Balance Confidence (ABC) Scale
- Berg Balance Scale (BBS)
- Five Times Sit To Stand
- Modified Multi Directional Upper Extremity Reach Test
- Upper Extremity Reach Test
- Single Leg Stance (SLS)
- Timed Up And Go (TUG)
- Vestibular Screening

http://www.chfwcny.org/Tools/BroadCaster/Upload/Project13/Docs/Falls_Prevention___Risk_Assessments.pdf

13. **Pain Assessment for Older Adults**

   The most widely used pain intensity scales used with older adults are the Numeric Rating Scale (NRS), the Verbal Descriptor Scale (VDS) and the Faces Pain Scale-Revised (FPS-R). The most popular tool, the NRS, asks a patient to rate their pain by assigning a numerical value with zero indicating no pain and 10 representing the worst pain imaginable. The VDS asks the patient to describe their pain from "no pain" to "pain as bad as it could be." The FPS-R asks patients to describe their pain according to a facial expression that corresponds with their pain.

   Article: http://consultgerirn.org/uploads/File/trythis/try_this_7.pdf

14. **National Palliative Care Research Center**

   Measurement and Evaluation Tools (Multiple tools identified under each section)

   - Pain and Symptom Management

     http://www.npcrc.org/resources/resources_show.htm?doc_id=376168

   - Functional Status

     http://www.npcrc.org/resources/resources_show.htm?doc_id=376169

   - Psychosocial Care

     http://www.npcrc.org/resources/resources_show.htm?doc_id=376170

   - Caregiver Assessment

     http://www.npcrc.org/resources/resources_show.htm?doc_id=376172

   - Quality of Life

     http://www.npcrc.org/resources/resources_show.htm?doc_id=376171

15. **Improving Healthcare for the Common Good (IPRO)**

   Tool: Discharge Criteria (Assessment for appropriate level of care)

   http://www.ipro.org/index/cms-filesystem-action/care/discharge-planning-tools/high_risk_discharge_flyer1_tools.pdf

Additional Resources to Supplement Assessment Tools

1. **Nursing Times. Net**

   Article: Examining assessment tools for discharge planning

   http://www.nursingtimes.net/examining-assessment-tools-for-discharge-planning/1910945.article

2. **ACP Medicine (American College of Physicians)**

   Article: Geriatric Assessment

   http://www.acpmedicine.com/bcdecker/pdfs/acp/1156.pdf

3. **ConsultGeriRN.org (Hartford Institute for Geriatric Nursing)**

   Article: Assessing Cognitive Function

   http://consultgerirn.org/topics/assessing_cognitive_function/want_to_know_more

4. **The Internet Journal of Allied health Sciences and Practice**

   Article: Incorporating Patient and Carer Concerns in Discharge Plans: The Development of a Practical Patient-Centered Checklist

   http://ijahsp.nova.edu/articles/vol4num1/grimmer.pdf

5. **Alzheimer Disease Research Center (Washington University School of Medicine)**

   Presentation: Dementia Screening

   http://www.alz.washington.edu/NONMEMBER/SPR07/galvin.pdf

III.   ADDITIONAL RESOURCES

1. **The John A. Hartford Foundation**

   The John A. Hartford Foundation is committed to health care training, research and service system innovations that will ensure the well-being and vitality of older adults. Its mission is to improve the health of older Americans.

   http://www.jhartfound.org/

2. **American Health Quality Association/Quality Improvement Organizations**

   The American Health Quality Association represents Quality Improvement Organizations (QIOs) and professionals working to improve the quality of health care in communities across America. QIOs share information about best practices with physicians, hospitals, nursing homes, home health agencies, and others.

   http://www.ahqa.org/pub/inside/158_716_2487.CFM?CFID=134489719&CFTOKEN=35182659

3. **Assessing Care of Vulnerable Elderly (ACOVE): Improving Quality of Health Care for Older Adults**

   Quality indicator measurement set to assess the care being provided to older adults by primary care physicians in several large health care systems nationwide.

   http://www.rand.org/health/projects/acove/about.html

4. **Improving Healthcare for the Common Good (IPRO)**

   IPRO is a national organization providing a full spectrum of healthcare assessment and improvement services that foster more efficient use of resources and enhance healthcare quality to achieve better patient outcomes.

   http://www.ipro.org/

5. **National Association of Professional Geriatric Care Managers**

   Information about Geriatric Care Managers (GCMs), including the services GCMs provide, guidelines for selecting and working with a GCM, and a library of resources for consumers.

   http://www.caremanager.org

6. **National Transitions of Care Coalition (NTOCC)**

   NTOCC is a group of concerned organizations and individuals who have joined together to address problems associated with transitions of care: the movement of patients from one practice setting to another. During these transitions, poor communication and coordination between professionals, patients and care givers can lead to serious and even life-threatening situations.

   http://www.ntocc.org/

7. **National Guideline Clearinghouse at the Agency for Healthcare Research and Quality (US Department of Health & Human Services)**

   Site is a public resource for multiple evidence-based clinical practice guidelines.

   http://www.guideline.gov/

8. **Emergency Preparedness for Older Adults: Planning for Recovery and Transition (Centers for Disease Control and Prevention)**

   This portal provides links to information, tools, and resources to assist in multi-sector planning for older adults in all-hazard emergencies.

   http://www.cdc.gov/aging/emergency/planning_tools/recovery_planning.htm

9. **National Patient Safety Foundation**

   Website provides an array of resources to support health care professionals in their critical role in creating and maintaining a safe health care environment.

   http://www.npsf.org/for-healthcare-professionals/

10. **University of Maine Center on Aging**

    The mission of the Center On Aging is to promote and facilitate activities on aging in the areas of education, research and evaluation, and community service.

    http://mainecenteronaging.umaine.edu/

11. **Marquette University (College of Nursing)**

    Article: Age-Related Differences in Perception of Quality of Discharge Teaching and Readiness for Hospital Discharge

    http://epublications.marquette.edu/cgi/viewcontent.cgi?article=1071&context=nursing_fac

IV.   POPULATION SPECIFIC RESOURCES

Cardiac

1. **Institute for Healthcare Improvement**

   Tool: Transforming Care at the Bedside How-to Guide: Creating an Ideal Transition Home for Patients with Heart Failure

   http://www.ihi.org/knowledge/Pages/Tools/TCABHowToGuideTransitionHomeforHF.aspx

2. **The Journal of the American Medical Association**

   Article: Comprehensive Discharge Planning with Postdischarge Support for Older Patients with Congestive Heart Failure (A Meta-Analysis)

   http://jama.ama-assn.org/content/291/11/1358.full

Lesbian, Gay, Bisexual, and Transgender

Clearinghouse Review: Journal of Poverty Law and Policy

Resource: Asserting Choice Health Care, Housing, and Property—Planning for Lesbian, Gay, Bisexual, and Transgender Older Adults

http://medicareadvocacy.org/InfoByTopic/LGBT/ChinetalM-A2010.pdf

Developmental Disabilities

1. **Sonoran UCEDD (University of Arizona)**

   Website provides information about the Aging and Transitions Project. The project with three major objectives: describe and address barriers to effective late life transitions for aging caregivers of adults with developmental disabilities (DD); promote effective late life transitions for adults with DD; and improve aging-related and end-of-life care for people with DD.

   http://sonoranucedd.fcm.arizona.edu/projects/aging_and_transitions_project

2. **University of Illinois, Chicago, Rehabilitation Research and Training Center (RRTC) on Aging with Developmental Disabilities: Lifespan Health and Function**

   Website designed to provide information on the latest research, model programs, and policy issues for aging adults with developmental disabilities. Also describes training and technical assistance opportunities, conferences, and available resources.

   http://www.rrtcadd.org/

3. **Ontario Partnership on Aging and Developmental Disabilities**

Aging with a Developmental Disability: Transition Guide for Caregivers

http://www.opadd.on.ca/Documents/transitionguide-final-sept0105_001.pdf

Dementia and Delirium

1. **National Health Service (NHS)**

   Clinical Guideline for the Care and Treatment of Older People with Dementia in a General Hospital Setting

   http://www.iow.nhs.uk/uploads/Mental/Older/Dementia%20Guideline.pdf

2. **Victorian Government Health Information**

    "The Toolkit"

   Developed to assist health services identify tools and resources that can assist them in improving care for older people in hospital and throughout the patient's journey through the care continuum.

   The aim of "The toolkit" is to assist clinical staff to minimize the functional decline of older people in hospital.

   http://www.health.vic.gov.au/older/toolkit/index.htm

   - Dementia

     http://www.health.vic.gov.au/older/toolkit/06Cognition/02Dementia/index.htm

   - Delirium

     http://www.health.vic.gov.au/older/toolkit/06Cognition/01Delirium/index.htm

   - Depression

     http://www.health.vic.gov.au/older/toolkit/06Cognition/03Depression/index.htm

3. **Age and Ageing Journal**

   Article: Capacity and Coercion: Dilemmas in the Discharge of Older People with Dementia from General Hospital Settings   http://ageing.oxfordjournals.org/content/early/2004/10/20/ageing.afh228.full.pdf

4. **Cleveland Clinic Journal of Medicine**

   Article: Perioperative care of the elderly patient: An update (Discusses post-operative cognitive risk and preventive strategies)

   http://www.ccjm.org/content/76/Suppl_4/S16.full.pdf+html

5. **The Hospital Elder Life Program (HELP)**

   Website provides information about delirium and describes a program that prevents delirium in hospitalized older adults by keeping these individuals oriented to one's surroundings, meeting needs for nutrition, fluids, and sleep and keeping them mobile within the limitations of their physical condition.

   http://www.hospitalelderlifeprogram.org/public/public-main.php?pageid=01.00.00

1. **Rosalynn Carter Institute for Caregiving**

   The goal of the Care Transitions Program is to improve care transitions by providing consumers and their caregivers with tools and support to encourage them to more actively participate in the transition from hospital to home.

   http://www.rosalynncarter.org/caregiver_intervention_database/miscellaneous/care_transitions/

2. **The Clearinghouse for Home and Community Based Services**

   Moving from Place to Place: A Consumer Navigation Guide for Seniors Involved in Health Care Transitions Guide serves as a resource for seniors and caregivers when making decisions about transition. The guide can be used as a tool to help think about many important aspects of transitions from hospitals, nursing homes, assisted living facilities, and community based living.

   http://www.hcbs.org/moreInfo.php/nb/doc/2000/Moving_from_Place_to_Place:_A_Consumer_Navigation_

3. **Aging and Disability Resource Center (Technical Assistance Exchange)**

   The U.S. Administration on Community Living which includes the Administration on Aging sponsors this Exchange to make information and resources available to states and community organizations. ACL is committed to supporting states' efforts to develop and sustain a person-centered, self-directed national long term supports and services system. Website provides a forum to allow a diverse community of stakeholders involved in making changes to their long term services system to exchange ideas, knowledge, and best practices.

   http://www.adrc-tae.org/tiki-index.php?page=HomePage

4. **Transitional Care Model (TCM)**

   Information about TCM for consumers and families http://www.transitionalcare.info/Pati-1788.html

5. **Family Caregiver Alliance**

   Hospital Discharge Planning: A Guide for Families and Caregivers

   http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=2312

6. **National Transitions of Care Coalition**

   NTOCC has developed information to help patients and caregivers better understand issues associated with transitioning from one health care setting to another and tools to help consumers as they navigate transitions.

   http://www.ntocc.org/WhoWeServe/Consumers.aspx

7. **Hospice Association of America (HAA): Consumer Information**

   Website provides general information and publications about hospice to consumers.

   http://www.nahc.org/HAA/consumerInfo.html

8. **National Patient Safety Foundation**

   Provides helpful resources that patients can use when they see a doctor or other health care provider, or when they are admitted to the hospital for care. Also in this section are fact sheets for consumers.

   http://www.npsf.org/for-patients-consumers/tools-and-resources-for-patients-and-consumers/

9. **Medicare: Planning for Your Discharge – Publication 11376**

   Your Discharge Planning Checklist: For patients and their caregivers preparing to leave a hospital, nursing home, or other care setting.

   http://www.medicare.gov/Publications/Pubs/pdf/11376.pdf

10. **Medicare: Nursing Home Comparisons** - http://www.medicare.gov/nhcompare/

11. **Medicare Rights Center** - http://www.medicarerights.org

12. **The Centers for Medicare & Medicaid Services (CMS)**

    http://www.medicare.gov

13. **Eldercare Locator**

    Eldercare Locator, a public service of the Administration on Aging, U.S. Department of Health and Human Services, is a nationwide service that connects older Americans and their caregivers with information on senior services.

    http://www.eldercare.gov

14. **Elder Law Answers**

    Website provides consumers and caregivers information on legal issues facing older adults. Consumers may find attorneys by searching by area code or city. Information also includes tools and checklists relevant to planning for care and personal needs.

    http://www.elderlawanswers.com/Default.aspx

| VI. | ADVANCE DIRECTIVES |

1. **Advance Directives**

- Living Will – Allows a person to document wishes concerning medical treatments at the end of life.
- Before a living will can guide medical decision-making, two physicians must certify:
  - A person is unable to make medical decisions
  - A person is in the medical condition specified in the state's living will law (such as "terminal illness" or "permanent unconsciousness")
  - Other requirements also may apply, depending upon the state
- Before a medical power of attorney goes into effect a person's physician must conclude that they are unable to make their own medical decisions. In addition:
  - If a person regains the ability to make decisions, the agent cannot continue to act on the person's behalf.
  - Many states have additional requirements that apply only to decisions about life-sustaining medical treatments.

http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3285

2. **POLST (Physician Order for Life Sustaining Treatment)**

The Physician Orders for Life-Sustaining Treatment (POLST) Paradigm program is designed to improve the quality of care people receive at the end of life. It is based on effective communication of patient wishes, documentation of medical orders on a brightly colored form and a promise by health care professionals to honor these wishes.

Resources for POLST http://www.aging.pitt.edu/professionals/resources-polst.htm

POLST Form for Pennsylvania

http://www.ohsu.edu/polst/programs/documents/POLSTForm2010sample.pdf

http://www.ohsu.edu/polst/

3. **Delaware Department of Health & Human Services: Advance Directives/Living Wills**

Website provides information about advance health care directives in Delaware. Also available is a copy of Delaware's Advance Health Care Directive Form.

- MOLST (MEDICAL ORDERS for life-sustaining treatment) Form for Delaware

  http://dhss.delaware.gov/dph/ems/files/molst_de.pdf

  http://www.dhss.delaware.gov/dhss/dsaapd/advance.html

VII.   CLINICAL SERVICES

Delaware

1. **Christiana Care Health System**

   http://www.christianacare.org/

Pennsylvania

1. **Albert Einstein (Philadelphia) Healthcare Network Geriatric Services**

   http://www.einstein.edu/yourhealth/geriatrics/index.html

2. **Geisinger Life Program**

   LIFE Geisinger provides additional independence for older individuals and their caregivers. The program can help individuals stay in their homes while taking advantage of comprehensive daily living and health services.

   http://www.lifegeisinger.org/

3. **Jefferson University Hospitals Geriatric Psychiatry Program**

   Recognized as a Top Hospital for Aging by Philadelphia magazine, the Geriatric Psychiatry Program at Jefferson offers inpatient services that are dedicated exclusively to caring for the unique psychiatric and neurological disorders of older adults. Physicians provide expert diagnosis and individualized state-of-the-art treatment for chronic age-related psychiatric, medical and neurological conditions such as depression, dementia, Parkinson's disease or stroke.

   http://www.jeffersonhospital.org/departments-and-services/geriatric-psychiatry-program.aspx

4. **Mercy LIFE**

   An approved PACE (Program of All-inclusive Care for the Elderly) program that helps older adults continue to be independent at home and in the community.

   http://www.mercyhealth.org/mercylife/

5. **University of Pennsylvania Life Program**

   LIFE is a Program of All-Inclusive Care for the Elderly (PACE). This model of care is centered around the belief that it is better for older adults and for their families if their chronic care needs are provided in the community whenever possible.

   http://www.lifeupenn.org/

1. **Hospice Association of America (HAA)**

   HAA represents thousands of hospices, caregivers and volunteers who serve terminally ill patients and their families.

   http://www.nahc.org/HAA/

2. **National Hospice and Palliative Care Organization**

   Organization represents hospice and palliative care programs and professionals in the United States and advocates for the terminally ill and their families.

   http://www.nhpco.org/templates/1/homepage.cfm

3. **National Hospice Foundation**

   Provides resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services, and information.

   http://www.nationalhospicefoundation.org/home.cfm

4. **National Palliative Care Research Center (NPCRC)**

   The mission of the National Palliative Care Research Center (NPCRC) is to improve care for patients with serious illness and the needs of their families by promoting palliative care research.

   http://www.npcrc.org/

Pennsylvania

    Pennsylvania Department of Health: Hospice Agencies

    http://www.portal.state.pa.us/portal/server.pt/community/home_health_services_and_hospices/14153/hospice_agencies/558564

    Pennsylvania Hospice Network - http://www.pahospice.org/

Delaware

    Hospice and Palliative Care Network of Delaware http://www.hpcnd.org/

    Delaware End-of-Life Coalition - http://deolc.org/wordpress3.0.1/hospices-in-delaware/

Pennsylvania

1. **Pennsylvania Department of Aging**

   http://www.aging.state.pa.us/portal/server.pt/community/department_of_aging_home/18206

2. **Pennsylvania Association of Area Agencies on Aging**

   Website provides information about area agencies, defined in regions 1 – 8 across Pennsylvania. Under each region, users will find county-specific information concerning:

   - Home & Community Based Services
   - Aging Waiver Services

   http://www.p4a.org/agencies.htm

3. **Pennsylvania Office of Mental Health and Substance Abuse Services**

   http://www.dpw.state.pa.us/dpworganization/officeofmentalhealthandsubstanceabuseservices/index.htm

Delaware

1. **Delaware Division of Services for Aging and Adults with Physical Disabilities**

   Information available includes, but is not limited to the following:

   - Assistance for Caregivers
   - Home and Community-Based Services
   - Information and Supports
   - Residential Care
   - Rights and Protections

   http://www.dhss.delaware.gov/dsaapd/

2. **Delaware Aging Network (DAN)**

   Network consists of more than 50 agencies across the entire state of Delaware committed to improving the quality of services older adults receive. DAN provides and coordinates services for seniors as well as advocates for state-wide policies benefiting the aging population. Information includes, but is not limited to the following:

   - Care Management Services
   - Transportation
   - Public Policy
   - Senior Centers
   - Collaborating Agencies

   http://www.delawareagingnetwork.org/CollaboratingAgencies.htm

3. **Delaware Division of Substance Abuse and Mental Health**

   http://www.dhss.delaware.gov/dhss/dsamh/

X.	ENTITLEMENTS / PUBLIC BENEFITS PROGRAMS

1. **Medicare**

   http://www.medicare.com/

2. **Medicare Helpful Contacts**

   http://www.medicare.gov/contacts/

3. **Medicaid**

   Centers for Medicare and Medicaid Service

   http://www.cms.gov/home/medicaid.asp

4. **Veteran's Services**

   US Department of Veteran Affairs

   http://www.va.gov/

   Federal Benefits for Veterans, Dependents and Survivors (website):

   http://www.va.gov/opa/publications/benefits_book.asp

   State Veteran Affairs Offices (website):

   http://www.va.gov/statedva.htm

5. **Social Security**

   Social security administration (website) (online applications, descriptions of benefits):

   http://www.ssa.gov/

   Benefit Eligibility Screening Tool (website):

   http://www.benefits.gov/ssa

1. **EPaD GEC Resources**

   Eastern Pennsylvania-Delaware Geriatric Education Center's links to resources for healthcare professionals and the community related to geriatric care and education.

   http://epadgec.jefferson.edu/resources2.cfm#1

2. **NEPA AHEC (Northeast region of Pennsylvania AHEC)**

   AHECs' goal is to enhance access to health care through education and provides community experiences for health professions students, promotes health careers, has preceptor / health practitioner support, and provides support to community partners.

   http://www.nepaahec.org/

3. **SEPA AHEC (Southeast region of Pennsylvania AHEC)**

   AHECs' goal is to enhance access to health care through education and provides community experiences for health professions students, promotes health careers, has preceptor / health practitioner support, and provides support to community partners.

   http://www.sepaahec.org/

4. **Pennsylvania Area Health Education Center Program**

   The PA-DE AHEC increases access to primary health care services through a training model of community-based health professions education. Through this training model, the PA-DE AHEC program has developed partnerships with participating medical schools in the Commonwealth.

   http://www.paahec.org/about_us/access.asp