Healing@Home

Area Agency on Aging, Region One

John C. Lincoln North Mountain Hospital, West Valley Hospital,
Scottsdale Healthcare Osborn Medical Center, John C. Lincoln Deer Valley Hospital,
Arizona Physician's IPA (APIPA), Sunwest Pharmacy

Healing@Home

OUR COLLABORATION

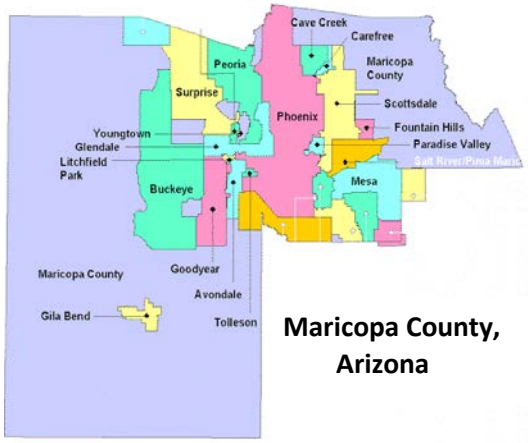
John C. Lincoln North Mountain and West Valley Hospitals are high-admission-rate hospitals. Scottsdale Healthcare Osborn Medical Center and John C. Lincoln Deer Valley Hospital, while not high-admission-rate hospitals, are committed to reducing their readmission rates. APIPA is a Medicaid Acute Care Plan that will involve dual-eligible members in the program. Sunwest Pharmacy will deliver prescription drugs to program participants.

OUR PREVIOUS EXPERIENCE

The Area Agency on Aging, Region One is currently providing care transition services through an Administration on Aging-funded Care Transitions mini-pilot program, started in October 2010, which targets medically underserved populations. The pilot serves Medicare beneficiaries discharged from Banner Del E. Webb Medical Center who are determined by the Discharge Team to be at risk for readmission.

In addition, in August 2010, the Agency partnered with Care 1st, a Medicare Advantage Special Needs Plan which serves dually enrolled Medicare and Medicaid beneficiaries in Maricopa County. The in-home Otago Exercise Program was incorporated into the project.

OUR COMMUNITY



Maricopa County, Arizona

OUR TARGET POPULATION

The Healing@Home program will target Medicare FFS beneficiaries residing in Maricopa County, Arizona, who are discharged from the partner hospitals with at least one qualifying diagnosis, with or without a comorbidity, of congestive heart failure (CHF), acute myocardial infarction (AMI), or pneumonia, and/or a past history of repeat admission. Beneficiaries will be invited to participate in the program if: (1) they are not enrolled in a Medicare Advantage Plan; (2) they are discharged to their own home and not to a step-down facility; and (3) they are discharged with at least one of CHF, AMI, or pneumonia and/or past history of repeat admission.

OUR IMPLEMENTATION STRATEGY

Healing@Home is designed as an *enhanced* Coleman Model. It builds on the Coleman Model Four Pillars and provides more intensive services to have a greater impact. Activities include:

- 3 face-to-face visits by a Transition Coach:
  - 1 at the hospital within 24 hours prior to discharge
  - 1 at the beneficiary's home within 24-48 hours after discharge
  - 1 at the beneficiary's home within 7 days of discharge
- Follow-up telephone coaching
  - 1 or 2 phone calls by the Transition Coach as needed
- Follow-up telephone reassurance
  - Additional calls by a Senior Care Advocate as needed

Enhanced services include:

- Use of a Team Model that includes English/Spanish, bilingual/bicultural Senior Care Advocates
- Assistance with medication pick-up or delivery and transportation options for medical appointments
- Depression screening and, if indicated, referral to the Area Agency's licensed behavioral health program
- Performance of a mini-care assessment and home safety check and linkage to additional services as needed and available