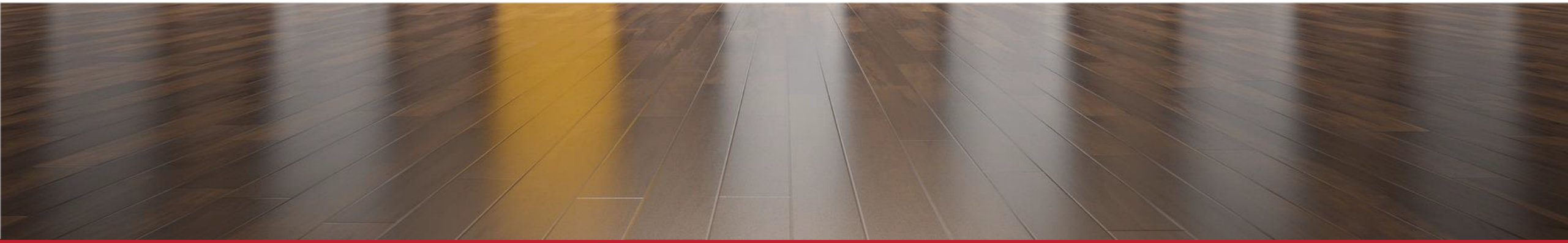
Seamless Transitions: Supporting Patients with Chronic Illness Across Care Settings

JULY 16, 2025

3:00 – 4:00PM ET

Welcome



Agenda

Time	Agenda Topic
1 min	Welcome/Introductions
2 min	Learning Objectives/Zoom Poll
10 min	Didactic presentation: Heather Johnson MSW, MPH, Principal, Facilis Solutions Supporting People with Chronic Illnesses: Streamlining Transitions
15 min	Council on Aging for Southwestern Ohio Ken Wilson, Vice-President of Program and Business Operations Tonya Smart, Program Manager, Care Transitions and FastTrack Home
15 min	Nevada Senior Services Betty Russell, LCSW, Clinical Director
14 min	Q&A with Presenters
3 min	Resources and Closing

General Housekeeping and Ground Rules

- Closed captioning available via Zoom
- We will monitor the Chat for questions

Learning Objectives

At the conclusion of this webinar, participants will be able to:

- Describe the critical intervention points where CBOs can effectively support people with chronic illnesses during hospital discharge planning and the transition back to home, including longer term supports to improve community tenure and avoid readmissions
- Help CBOs understand how to develop a tailored value proposition that demonstrates the unique benefits CBOs provide in addressing both clinical needs and social determinants affecting chronic condition management
- Learn from two models that expanded care transition models to serve a broader population of persons with chronic illnesses

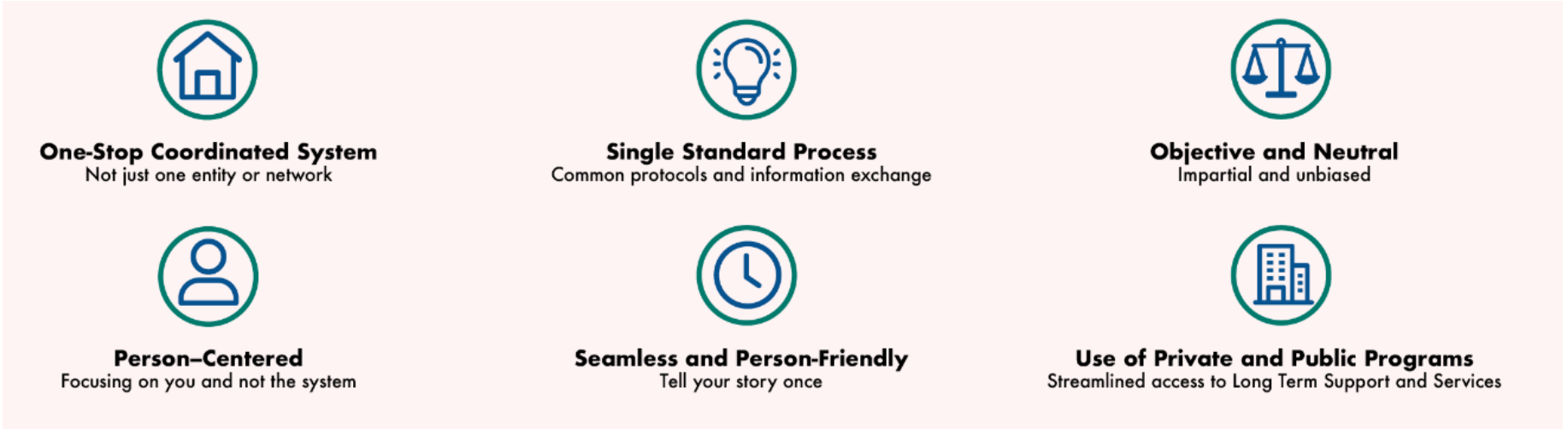
Zoom Poll

What type of organization are you affiliated with?

Select all that apply.

- Area Agency on Aging
- Community Care Hub/Network Lead Entity
- Aging and Disability Resource Center
- Center for Independent Living
- Other community-based organization
- Hospital
- Accountable Care Organization/Accountable Health Community
- Other health care provider

No Wrong Door: Promoting Efficiency in a Fragmented System



Vision that builds on existing infrastructure, not a grant program
Promote efficiency in state and local government by requiring agencies work together to cut red tape
Enhance economic security by providing options for people ***before*** they become Medicaid eligible
Prevent and/or delay costly institutional care paid for by Medicaid
Encourage families to plan for long-term care

National No Wrong Door Resource Center Technical Assistance

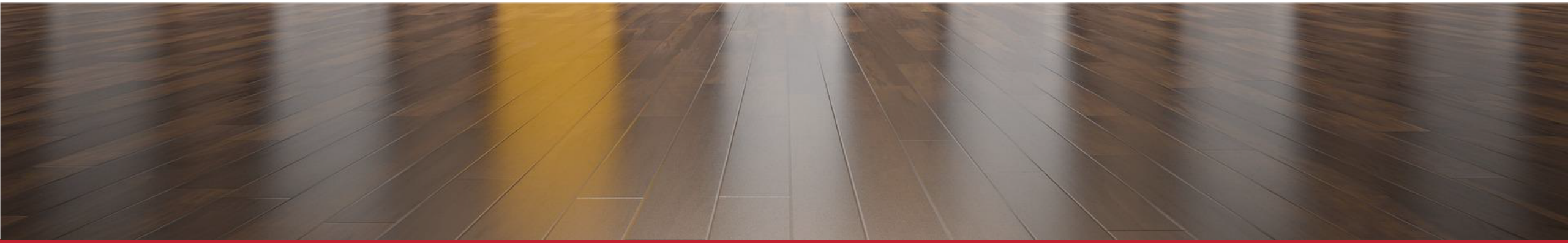
- Social care referrals, technology, and management information systems (IT/MIS), and related interoperability themes
- Improving access to home and community-based services through community care hubs
- Veteran Directed Care
- Care transitions
- Housing, transportation, nutrition, and other related topics

- Governance and leadership
- Policy and regulation
- Medicaid Administrative Claiming
- Public outreach and referral sources
- Workforce (demand, capacity, scaling operations)

- Emergency preparedness, response, recovery, and mitigation
- Person-centered practices
- Healthy aging and age-friendly communities
- Retirement security
- Social connectedness/social engagement

Supporting People with Chronic Illnesses: Streamlining Transitions

Speaker: Heather Johnson, Principal, Facilis Solutions



The Chronic Care Challenge: Why Hospitals Need Community Partners

Approximately 93% of older adults age 65 and over have at least one chronic condition[1]

Nearly 80% have two or more chronic conditions[1]

Chronic conditions account for 90% of healthcare spending[2]

People with multiple chronic conditions have readmission rates nearly 8x higher than those without chronic conditions (24.8% vs 3.2%)[3]

[1] Kathleen B. Watson, et al. Trends in Multiple Chronic Conditions Among US Adults, By Life Stage, Behavioral Risk Factor Surveillance System, 2013-2023. Preventing Chronic Disease. April 17, 2025. Found on the internet at: https://www.cdc.gov/pcd/issues/2025/24_0539.htm

[2] https://www.cdc.gov/chronic-disease/data-research/facts-stats/index.html

[3] https://pmc.ncbi.nlm.nih.gov/articles/PMC5798680/

The Care Gap: What Happens After Discharge

Hospital: Intensive monitoring and 24/7 oversight

Discharge Gap

Home: Person manages alone or with caregiver until next appointment (often 1-2 weeks later)

Common Post-Discharge Challenges

- Medication confusion and non-adherence
- Inability to recognize warning signs
- Social barriers (food, transportation, housing)
- Caregiver overwhelm and burnout

Care Transitions and Chronic Illness: CBOs As Critical Partners

Challenges

- Care Transitions occur when patients move between healthcare settings or providers
- Many patients with chronic illnesses experience care gaps during transitions
- Poorly managed transitions lead to medication errors, missed appointments, and hospital readmissions

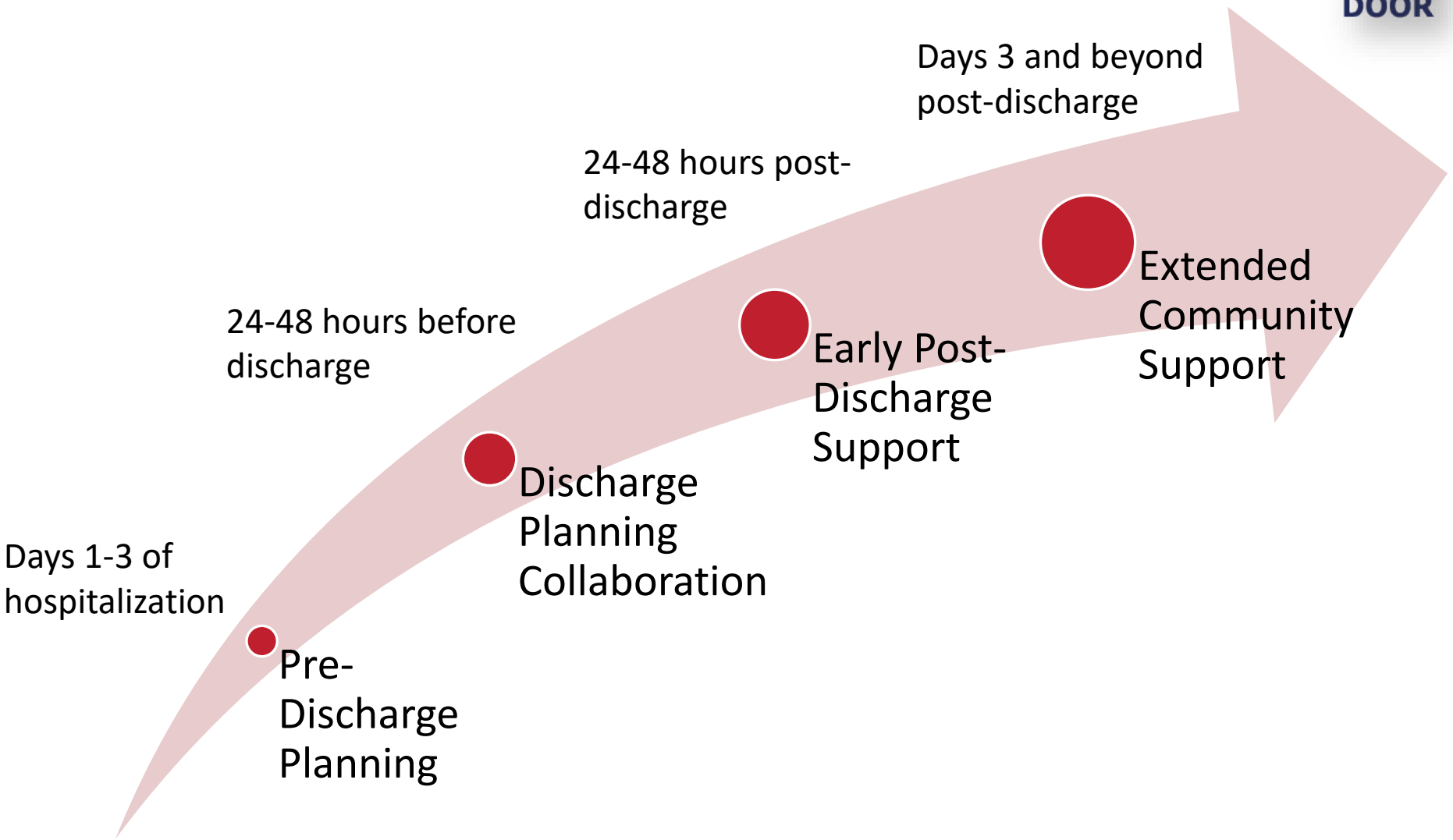
CBOs Help Mitigate Challenges

- Address non-medical needs that clinical teams often miss
- Provide support between clinical visits when vulnerability is highest
- Offer tailored services to diverse community needs
- Build trust with people who may be hesitant with clinical/acute care systems

$1 invested in transition support = $4 saved in healthcare costs
Community-based interventions show ROI of 2:1 to 6:1

(Source: Commonwealth Fund, "ROI Calculator for Partnerships to Address Social Needs (2023)")

Critical Intervention Points Timeline



Hospital-CBO Partnership Impacts

Better patient outcomes

Reduced readmissions

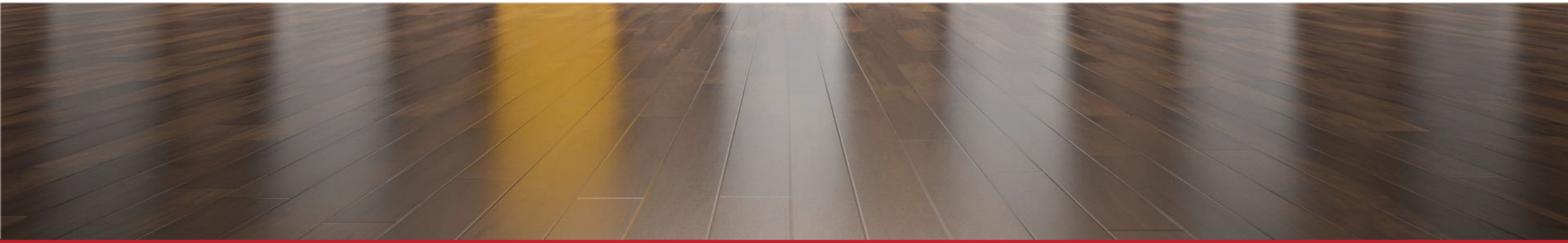
Improved follow-up

Medication adherence

Council on Aging for Southwestern Ohio

Ken Wilson, Vice-President of Program and Business Operations

Tonya Smart, Program Manager, Care Transitions and FastTrack Home



About us

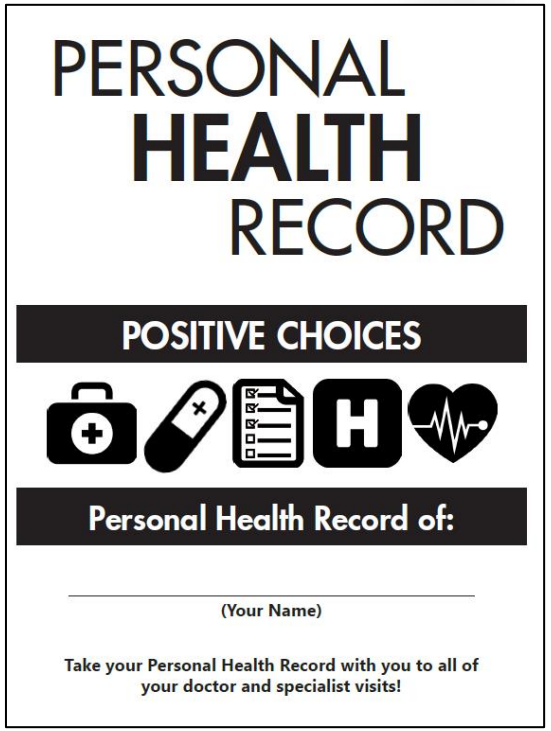
- Council on Aging of Southwestern Ohio
- Area Agency on Aging serving the greater Cincinnati area
- 425 Staff
- $130 Million Budget
- Provide home and community-based care to 27,000 people

Background

- 2009-2010: Care Transition Model (CTI) Piloted at University Hospital
- 2011 - 2016: Round one Community-Based Care Transitions Program (CCTP)
  - EPIC Access to EMR
  - Co-located staff in Hospital Space
- 2017 – FastTrack Home Created, and then expanded
- 2020 COVID Hospital to home model adapted to address hospital surges

Coleman's Four Pillars

- Medication self-management
- Use of a dynamic, patient-centered record: the Personal Health Record
- Timely primary care/specialty care follow-up
- Knowledge of red flags indicating condition worsening – how to respond



Top Service needs (in rank order)

- Home Delivered Meals
- Home Care (Personal Care, Laundry Delivery, Homemaking)
- Home Medical Equipment
- Emergency Response Devices
- Home Modifications, Ramps
- Transportation

Fasttrack Home Value

- Provides help when needed the most – as they leave a hospital or nursing home
- Supports family caregivers
- Temporary support for recovery at home – up to 60 days
- 60% of participants don't need support after FastTrack Home ends
- 8% of clients but accounted for only 3% of program costs

"It's a blessing to get up and down the steps. My worry was falling and with Kathy helping me she wouldn't be able to hold my weight." Bill, FastTrack Home

How is FastTrack Home funded?

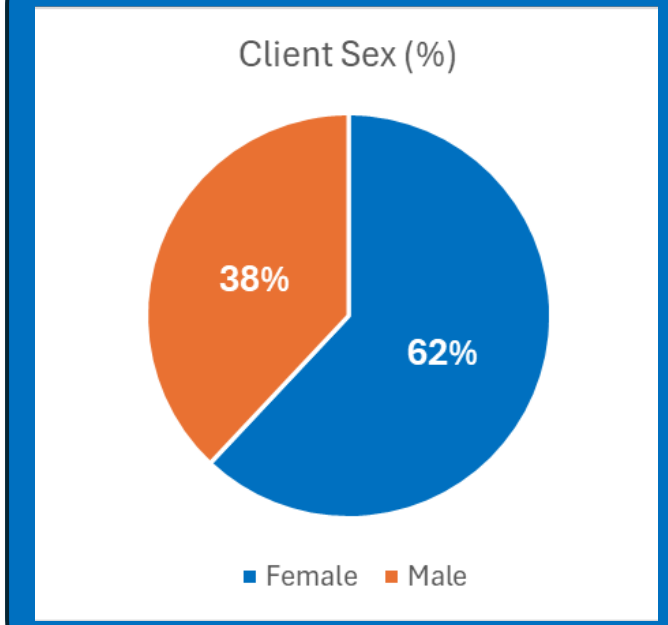
Senior Services Levy and Federal Older Americans Act	80% Local Levy 19% Federal Older American's Act 1% Medicare Plan
2,400 served during 2024	
$2,755,603	1/3 on provider services 2/3 on coaching staff
30 FTEs	

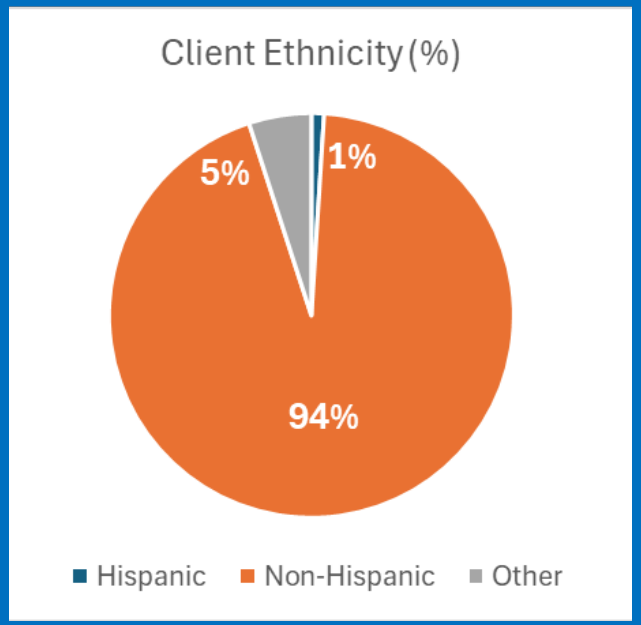
Fast Track Home Eligibility

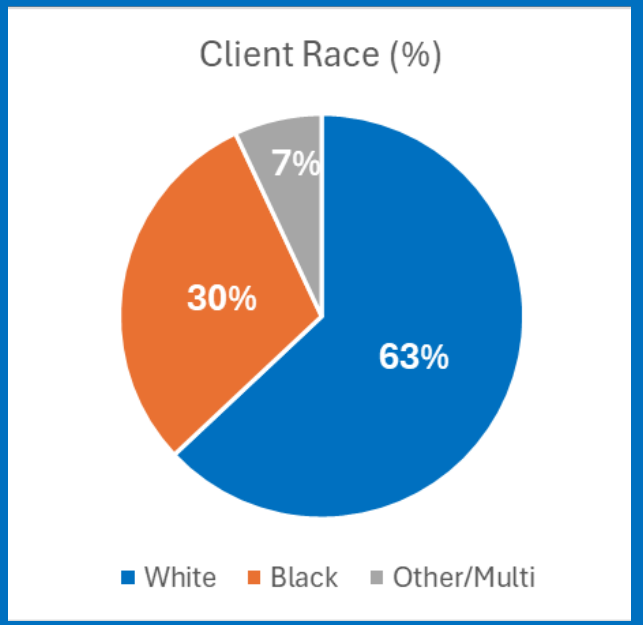
- Residents age 60+
- Discharging from hospital or skilled nursing facility
- Live in one of the five counties we serve
  - Demographics of the counties range from rural farm communities to urban settings with level 1 trauma centers
- Shows deficits in certain ADL/IADL level of care requirements
- Clients who are not eligible for Fast Track Home services include clients who:
  - Leave the hospital Against Medical Advice
  - Require a two person assist
  - Declined Skilled Nursing Facility placement and have inadequate support at home

Fast Track Home Client Profile

Client Demographics







Average age: 76 years

Hospital/Skilled Nursing Facility Intervention

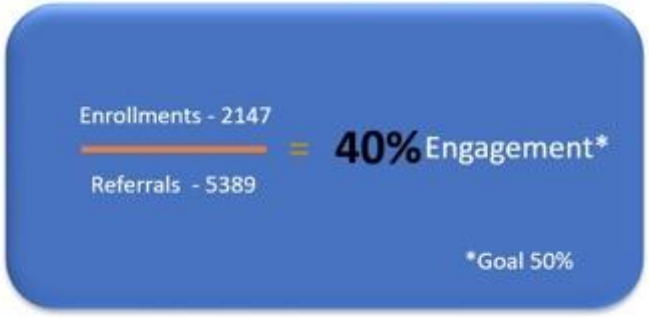
- Case Manager or Fast Track Home Intake department receives referrals from hospital facility social workers and case managers
- There are designated Case Managers for multiple local hospitals and Skilled Nursing Facilities
- Service delivery and Fast Track Home enrollment may begin at the bedside at a time of greatest vulnerability and uncertainty for the client

What makes Fast Track Home effective

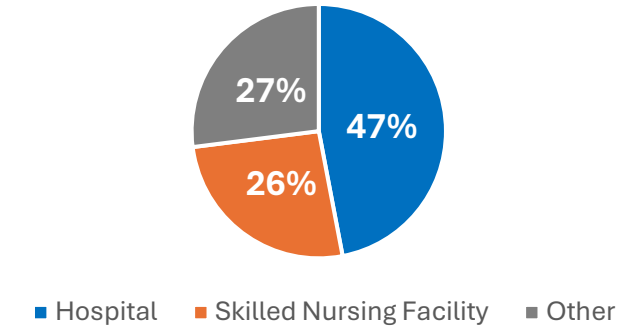
- Engagement that is purposeful and client-centered
- Collaborative discharge planning
- Provides actionable information and support that clients will need to remain safe at home
- Advanced assessment skills to recognize what a client at the bedside looks different from the same client at home
  - Anticipating a client's needs to support their self care at home
  - Exploration of social determinants of health (access to food, transportation, safe environment, social supports) and the availability of community resources
- Intervention to measure the effectiveness of the program on day 45 of the program

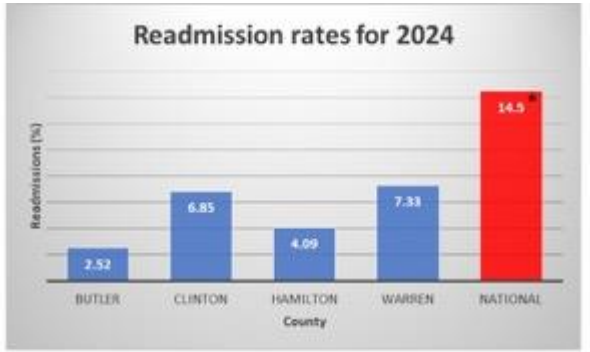
Successful Outcomes

- Fast Track Home received 5,389 referrals in 2024 and we came close to meeting our engagement goal of 50%
- Majority of referrals (and engagements) were from hospital sites
- The readmission rate across counties was well below the 14.5% National Average



Referral Source 2024





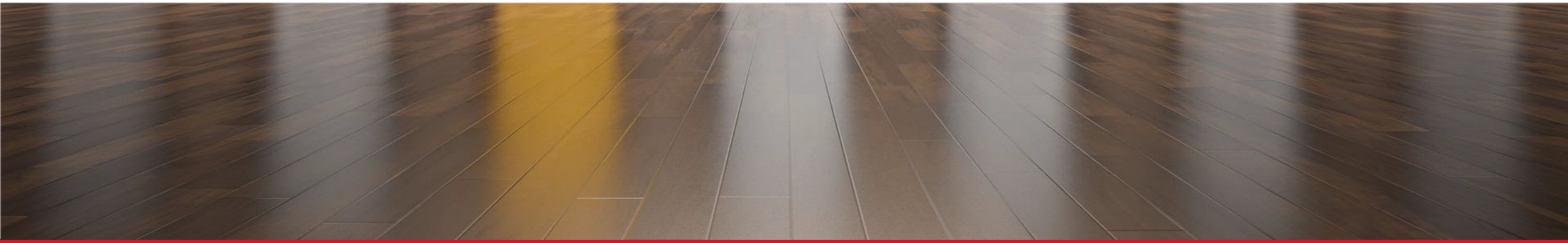
*Definitive Healthcare. (June, 2025). *Average Hospital readmission rate by State.* https://www.definitivehc.com/resources/healthcare-insights/average-hospital-readmission-state

Key Considerations

- Engaging clients at the bedside is a key indicator of successful enrollment into the program
- Care Transitions work requires dedicated staff who are the right “fit” for this work
- Collaboration with community partners is a continuous process given the dynamic nature of hospital and skilled nursing facility settings
- Possible sources of hospital readmissions may not only be due to health conditions but because of non-medical factors (e.g., access to resources in the community, food insecurity, transportation, home accessibility)

Nevada Senior Services

Betty Russell, Clinical Director



Hospital 2 Home

Nevada Senior Services

Clinical Director

Betty Russell, LCSW

What is Hospital 2 Home

Helping Seniors!

HOSPITAL 2 HOME
CARE TRANSITIONS

Helping Caregivers!

- Hospital 2 Home supports adults (18+), adults living with developmental and intellectual disabilities, and their caregivers, those currently in acute care and those looking to avoid hospitalizations.
- This is in effort to let clients and caregivers remain independent with dignity in the community, maintaining the quality of life and avoiding institutionalization.

Who We Serve


Social Complications
Medical and Physical Complications
Mental and Behavioral Health
Lack of Basic Needs
Avoiding Hospitalization
Post Hospitalizations
Reducing Hospital Recidivism
EVERYONE!

Where Hospital 2 Home Started

HOSPITAL 2 HOME
CARE TRANSITIONS

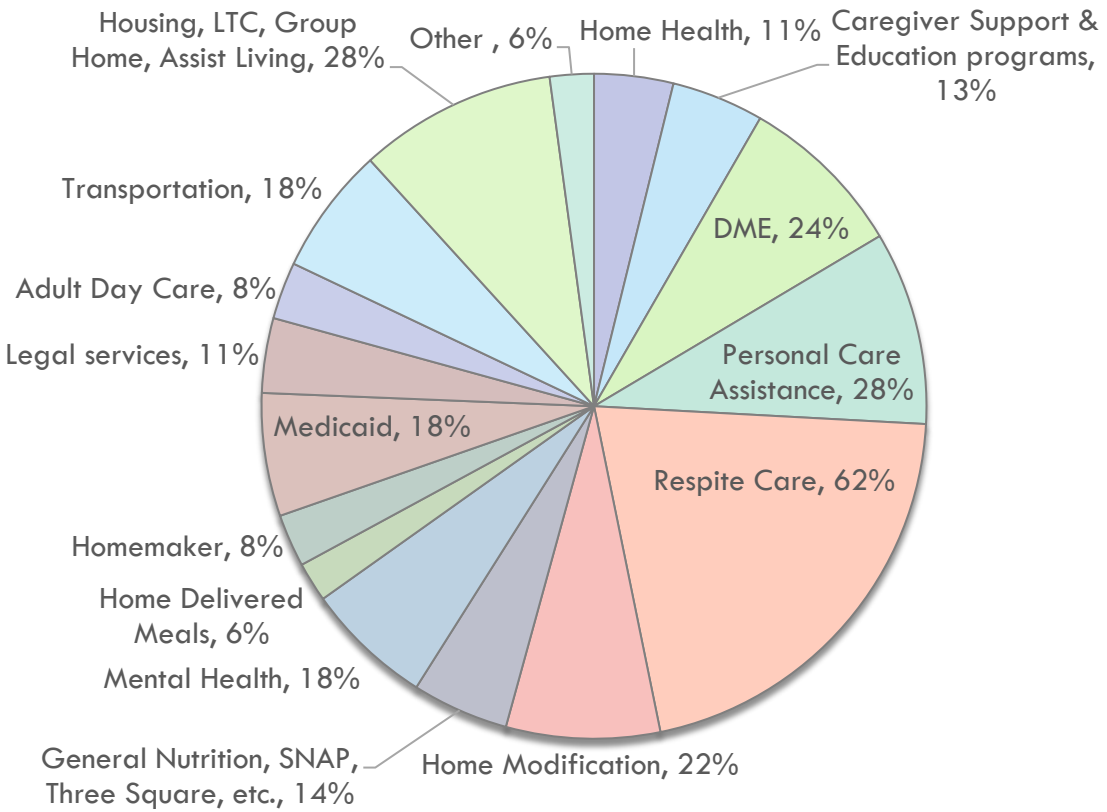
- The H2H program was an ACL Grant funded program brought to Nevada Senior Services in 2017.
- This program was created and researched by the Rush Hospital in Chicago.
- NSS intentionally targeted and included the dementia population.

Hospital 2 Home Through COVID

- COVID increased our ability to help a wider population of community members needing help
- We now serve:
  - 18 and older
  - Those living with Intellectual and Developmental Disabilities
  - Those living alone with and without caregivers
  - Chronic Medical, Mental, Emotional and Behavioral Conditions
  - Clients currently in acute care and those attempting to remain in the community
  - Both caregivers and clients needing intervention
  - Medically complex with more than one vulnerability present

Community Partners

- Accessible Space
- Aging and Disability Services
- Adult Protective Services
- Archwell
- Boulder City Hospital
- Caremore
- Centennial Hills Hospital
- Clark County Social Services
- Clark County Public Guardian
- Cleveland Clinic
- Crisis Response Team of LV
- Desert Regional Center
- Desert Springs Hospital
- Dignity Rehab
- Encompass Rehab
- Henderson Hospital
- Horizon Rehab
- Intermountain Hospitals
- JFSA
- LV Fire & Rescue
- Medicaid/FOCIS
- MGM Resorts International
- Mobile Crisis Unit of Henderson
- Mountain View Hospital
- Mountain Vista Medical Center
- North Las Vegas Fire Department
- Omnicare Home Health
- Optum
- P3 Health
- Palmira Home Health
- Skilled Nursing Facilities of Clark County
- Southern Hills
- Sage Creek
- Southwest Medical
- Spring Valley Hospital
- St. Rose Hospital
- Summerlin Hospital
- Sunrise Hospital
- Trellis Rehab
- United Health Care
- University Medical Center
- US Vets
- Valley Hospital
- 1 Care Home Health



How community partners make a difference

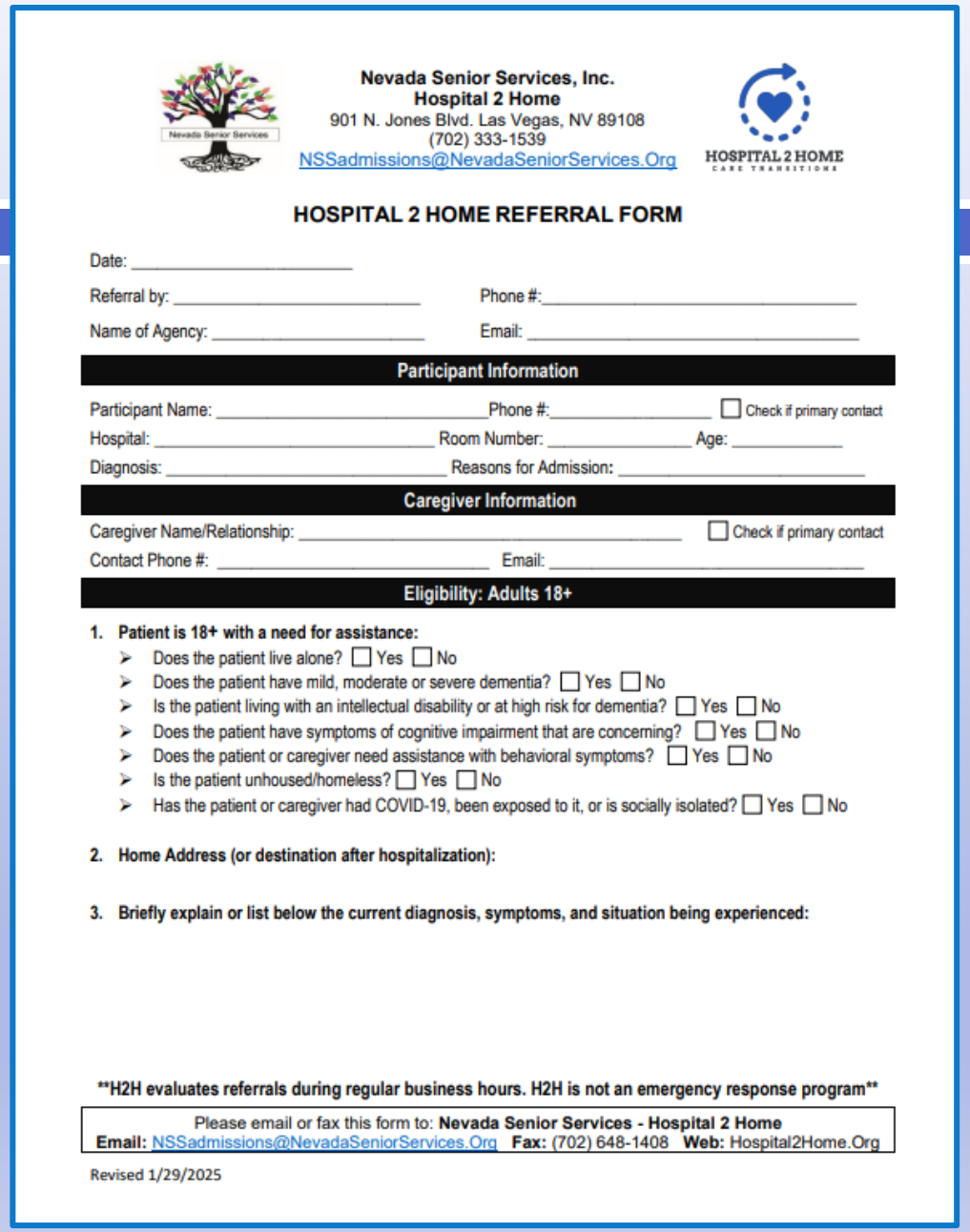
Hospital 2 Home Care Team

- Licensed Clinical Social Worker
- Care Transition Specialist
- Respite Coach
- Nevada Senior Services Program Interventionists as assigned:
  - Home Modification
  - Long Term Respite
  - PCA
  - Geriatric Case Management
  - Education
  - Adult Day Care
- *Number of providers assigned based on need*

Sustainable Funding is Achievable!

- Feeling Brave as a Non-Profit
- Alternatives to Grant Funding
- Community Relationships and Collaboration
- Think Outside the Box

Referral Sheet



Nevada Senior Services, Inc.
Hospital 2 Home
901 N. Jones Blvd. Las Vegas, NV 89108
(702) 333-1539
NSSadmissions@NevadaSeniorServices.Org

HOSPITAL 2 HOME
CARE TRANSITIONS

HOSPITAL 2 HOME REFERRAL FORM

Date: _____

Referral by: _____ Phone #: _____

Name of Agency: _____ Email: _____

Participant Information

Participant Name: _____ Phone #: _____ ☐ Check if primary contact

Hospital: _____ Room Number: _____ Age: _____

Diagnosis: _____ Reasons for Admission: _____

Caregiver Information

Caregiver Name/Relationship: _____ ☐ Check if primary contact

Contact Phone #: _____ Email: _____

Eligibility: Adults 18+

1. **Patient is 18+ with a need for assistance:**
   - Does the patient live alone? ☐ Yes ☐ No
   - Does the patient have mild, moderate or severe dementia? ☐ Yes ☐ No
   - Is the patient living with an intellectual disability or at high risk for dementia? ☐ Yes ☐ No
   - Does the patient have symptoms of cognitive impairment that are concerning? ☐ Yes ☐ No
   - Does the patient or caregiver need assistance with behavioral symptoms? ☐ Yes ☐ No
   - Is the patient unhoused/homeless? ☐ Yes ☐ No
   - Has the patient or caregiver had COVID-19, been exposed to it, or is socially isolated? ☐ Yes ☐ No

2. **Home Address (or destination after hospitalization):**

3. **Briefly explain or list below the current diagnosis, symptoms, and situation being experienced:**

****H2H evaluates referrals during regular business hours. H2H is not an emergency response program****

Please email or fax this form to: **Nevada Senior Services - Hospital 2 Home**
Email: NSSadmissions@NevadaSeniorServices.Org **Fax:** (702) 648-1408 **Web:** Hospital2Home.Org

Revised 1/29/2025

www.hospital2home.org

nssadmissions@nevadaseniorservices.org

Thank You!

HOSPITAL 2 HOME
CARE TRANSITIONS

Nevada Senior Services

Betty Russell, LCSW

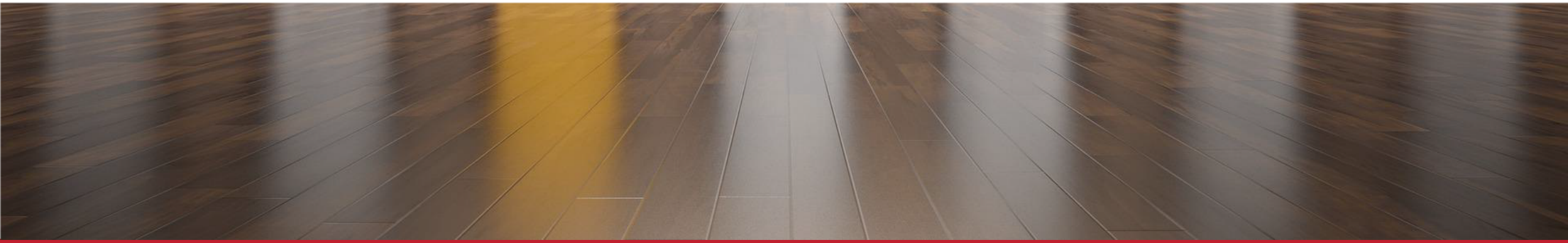
Clinical Director

Nevada Senior Services

brussell@nevadaseniorservices.org

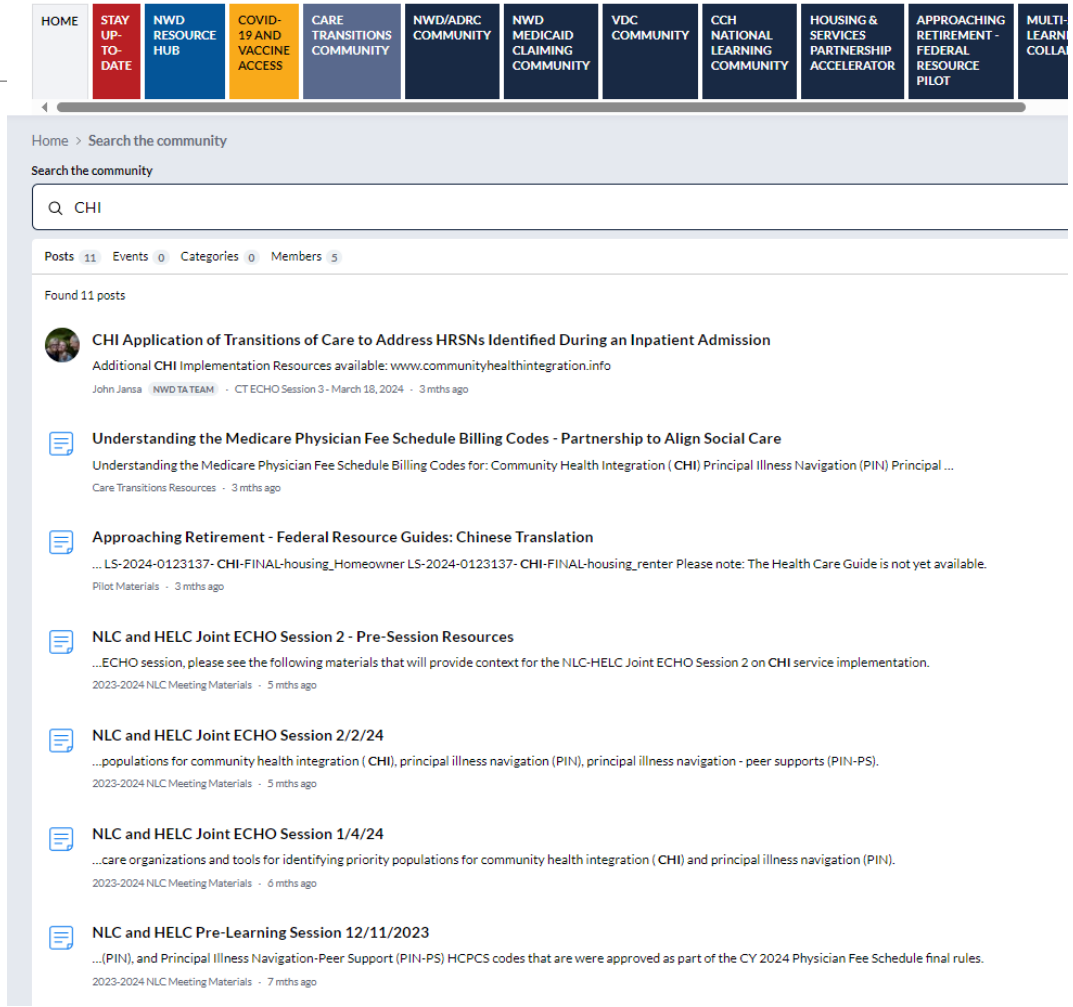
Audience Q&A

Wrap-up and Next Steps!



ACL No Wrong Door TA Community
https://www.ta-community.com

- A collaboration space to stay informed, access resources, and connect with one another
- Features include:
  - Updates on NWD-related announcements and upcoming events
  - Resources and promising practices
  - Discussion board



Future Webinar Topics

Please type in the chat a topic you would like to see covered in a future webinar.

Thank you!

Please reach out to caretransitions@lewin.com