

Vermont Aging & Disabilities Resource Connection
Enhanced Options Counseling Program

July 8, 2013

**Vermont Aging and Disabilities Resource Connection (ADRC)
Care Transitions Letter of Agreement**

Signatories

This Letter of Agreement is made by and among the Brain Injury Association of Vermont (BIAVT) the Southwestern Vermont Council on Aging (SVCOA), and the Vermont Center for Independent Living (VCIL) representing the VT Aging & Disabilities Resource Connection (ADRC), the VT Department of Disabilities, Aging and Independent Living (DAIL) as the Project Grantee, and the Southwestern Vermont Medical Center, hereinafter referred to as SVMC. SVMC is a participant in OneCareVermont Shared Savings Accountable Care Organization (ACO) and the Vermont Blueprint for Health.

Project Description

Background:

The national ADRC initiative supports State efforts to develop "No Wrong Door" programs at the community level that help people make informed decisions about their service and support options. States are using ADRC funds to integrate and/or better coordinate their existing systems of information, assistance, options counseling, and access and are doing so by forming strong State and local partnerships. The overall goal of the ADRC program is to empower individuals to effectively navigate their health and other long-term support options. Long-term support refers to a wide range of in-home, community-based, and institutional services and programs designed to help individuals access services.

The ADRC is not intended to replace any role or responsibility of its partnering agencies, but rather to help build a better, more coordinated network of support options.

The Vermont ADRC ***Care Transitions Pilot Project*** is funded by a federal grant awarded by the Administration for Community Living (ACL). It is administered by the Vermont Department of Disabilities, Aging and Independent Living (DAIL) and is implemented and staffed by SVMC, SVCOA, BIAVT, and VCIL.

The Federal Vision for ADRCs and Care Transition Programs

The Aging and Disability Resource Center Program (ADRC), a collaborative effort of the ACL and the Centers for Medicare & Medicaid Services (CMS), is designed to streamline access to long-term care services and supports for consumers of all ages, incomes and disabilities, and their supporters.

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ACL and CMS envision strong ADRC partnerships in 'critical pathways', which is defined as the times or places when people make important decisions about long-term services and supports. The ADRC must establish formal linkages between and among the major pathways that people travel while transitioning from one service setting to another or from one public program payer to another. These pathways can include transitions from the community to hospital or nursing home, hospital discharge, preadmission screening for nursing home services, and transitions from skilled nursing facility to other settings. These pathways also represent critical junctures where decisions are made – usually in a time of crisis - that often determine whether a person is permanently institutionalized or transitioned back to their own home.

As part of this project, the ADRC and DAIL agree to be delivering evidence-based care transition program in at least one area of the state

Goals of the Vermont ADRC Care Transitions Pilot Program

- The health and well being of individuals transitioning from SVMC to home is improved;
- There is a reduction in re-hospitalizations for persons who receive the care transitions intervention;
- Health care cost savings and efficiencies are realized;
- The client/individual's experience and satisfaction with services and supports is improved;
- Individuals are able to transition to the least restrictive environment.

Terms of Agreement

The BIAVT, SVCOA, and VCIL, representing the VT ADRC, agree to:

- Provide a project liaison from each agency to coordinate the operational aspects of its involvement in the Care Transitions Pilot Project;
- Provide Neuro-Resource Facilitation/Peer Advocate Counseling/Options Counseling staff from each agency to implement the pilot project, as outlined by the project design using a hybrid of two evidence-based care transition models: Project BOOST and the Naylor Model/ Transitional Care Model;
- Work collaboratively with the ADRC Project Manager and other Signatories on development and implementation of necessary processes and protocols for referring; individuals to the ADRC partner agencies for transition support and other services

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- Provide regular updates and training to agency administrators, Neuro-Resource Facilitators/Peer Advocate Counselors/Options Counselors and others as designated, including the VT ADRC Leadership Team;
- Provide necessary documentation of project activities, data collection, and survey data, as required by the evidence-based models and by the VT Options Counseling Program.

SVMC agrees to:

- Provide a project lead or point person from the hospital to coordinate the hospital operational aspects of the pilot project's hybrid model of the two evidence-based programs: Project BOOST (Better Outcomes for Older Adults for Safe Transitions) and the Naylor Model/Transitional Care Model;
- Work collaboratively with the ADRC Project Manager and other Signatories on development and implementation of necessary processes and protocols for referring individuals to the ADRC partner agencies for transition support and other services;
- Provide regular updates and training to hospital administrators, Care Transition Teams, and others as designated;
- Provide or facilitate provision of necessary training of Signatory staff who will be assisting in the implementation of the evidence-based models;
- Provide necessary documentation of project activities, data collection, and survey data, as required by the evidence-based models;
- Share hospitalization and re-hospitalization data or other agreed upon data that will assist in improving the project or furthering the agreed upon project goals.

DAIL agrees to:

- Provide a project lead and management for the overall design, implementation, and coordination of the pilot project. This individual will be the ADRC Project Manager;
- Secure necessary agreements with outside vendor for project evaluation activities;
- Serve as the Care Transitions liaison to the federal funders, representing the pilot project as necessary and required;
- Coordinate with other necessary State agencies to further the overall project goals;
- Provide support and stakeholder review of the pilot project evaluation;
- Commit to sustainability and expansion if supported by outcomes and availability of resources.

Pilot Project Conceptual Outline

Desired Outcomes:

1. Sustainable evidence-based care transitions programs implemented in partnership among the Signatories and other community partners;

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2. Replicable care transitions infrastructure that can be expanded statewide;
3. Understanding of the value and role of the Aging and Disabilities Resource Connection partner agencies and other home and community-based service supports in the care transitions process, specifically in the implementation of a hybrid of two evidence-based care transition models: Project BOOST and the Naylor Model/Transitional Care Model;
4. Reduced hospitalizations, re-hospitalizations and emergency room utilization;
5. Improve the overall client/individual experience with services received in hospital and post transition.

Proposed Strategy:

- A) Implement a pilot in the southwest region of the state including the following ADRC partner agencies: Brain Injury Association of Vermont, Southwestern Vermont Council on Aging, and the Vermont Center for Independent Living, in partnership with the Southwestern Vermont Medical Center.
- B) Draft and execute a Letter of Agreement among the ADRC partner agencies, DAIL, and SVMC outlining expectations regarding roles and terms of agreement.
- C) Procure evaluation project expertise from desired vendor.
- D) Develop map of desired pilot process and involvement of each ADRC partner agencies inclusive of roles and responsibilities in affecting the evidence-based care transition models chosen.
- E) Educate and train ADRC partner staff in the hybrid design of two evidence-based models that will be a part of the pilot project:
 - a. Project BOOST
 - b. The Naylor Model/Transitional Care Model
- F) Establish a structure and tools for patient/client data sharing that supports continuity of care.
- G) Collaborate with SVMC and evaluation vendor in monitoring and analyzing pilot data submitted, as required by the evidence-based models.
- H) Produce final report inclusive of data for all desired outcomes.
- I) Present findings to all necessary stakeholders including the ADRC Executive Leadership Team, DAIL Advisory Board, ADRC Leadership Team, SVMC Care Transition Teams, among others.

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- J) Make recommendation for expansion of pilot based upon findings that include expansion to other Vermont hospitals and ADRC partner agencies.

Key Measures of Interest/Potential Impact (DRAFT and not complete at this time. Will be completed with evaluation contractor):

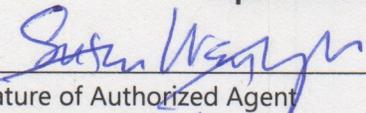
1. SVMC all payer, all cause 30-day Readmission Rate
2. Centers for Living and Rehabilitation(CLR) hospital 30-day Readmission Rate
3. CLR Hospitalization Rate
4. Visiting Nurse Association (VNA) and Hospice Hospitalization Rate
5. SVMC Patient Satisfaction:
 - a. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
 - b. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.
Source: HCAHPS Source: NRCPicker
6. SVMC and CLR Sub-Acute Referrals to ADRC for Options Counseling and Transition Assistance
7. CLR Patient Satisfaction
 - a. Involving you and your family in setting necessary discharge goals
 - b. Helping you arrange for services and equipment you will need when discharged
Source: My Inner View
8. Rate of hospitalizations of patients/clients who receive services that are in the ADRC network

Terms of Agreement

This agreement will be effective as of **July 8, 2013**. It shall remain in effect until terminated by either party with 30 day written notice.

I have read, fully understand, and agree to the terms and guidelines set forth in the Letter of Agreement and am authorized to sign on behalf of the agency listed below.

Department of Disabilities, Aging and Independent Living



Signature of Authorized Agent

SUSAN WEHRY MD

Printed Name

7/8/13

Date

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Southwestern Vermont Medical Center

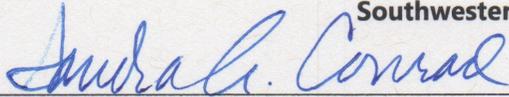
Signature of Authorized Agent

THOMAS A. DEE

Printed Name

7/17/13

Date



Southwestern Vermont Council on Aging

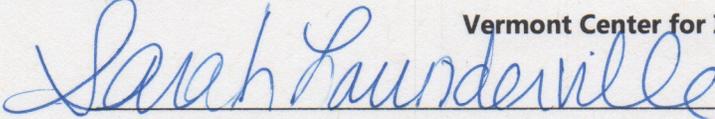
Signature of Authorized Agent

Sandra A. Conrad

Printed Name

7.18.13

Date



Vermont Center for Independent Living

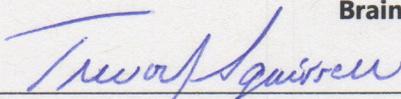
Signature of Authorized Agent

Sarah Launderville

Printed Name

07/29/13

Date



Brain Injury Association of Vermont

Signature of Authorized Agent

TREVOR SQUIRREL

Printed Name

7/31/13

Date