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: Illinois Department on Aging

Name of ADRC and Healthcare Partners:
Suburban Cook County ADRC and Adventist La Grange Memorial Hospital, MacNeal Hospital, and Rush University Medical Center

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

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Evidence Based Care Transitions Model: Bridge Program

Project Summary:
The Illinois Department on Aging (IDOA), in partnership with the suburban Cook County ADRC, Illinois Department of Health and Family Services (IDHFS), and the Illinois Department of Human Services Division of Rehabilitation Services (IDRS), will oversee local implementation of the Bridge Program (Bridge). Bridge was based on a randomized control trial care transition program: Enhanced Discharge Planning Program (EDPP) at Rush University Medical Center (RUMC), and a rigorously evaluated program - the Aging Resource Center (ARC), a program of Aging Care Connections (ACC). AgeOptions, the Area Agency on Aging/ADRC for suburban Cook County and the Progress Center for Independent Living (PCIL) are the coordinating entities for this Suburban Cook County region. AgeOptions and PCIL will train Bridge Care Coordinators regarding community services for seniors and those with disabilities in order to improve hospital care transitions.

Goal/Objectives:
The primary goals of this grant are 1) to expand existing ADRC transitional care services to 600 disabled individuals under age 60 and vulnerable adults age 60+ at imminent risk of nursing home placement who are discharged from Adventist La Grange Memorial Hospital (ALMH), RUMC, and MacNeal Hospital, 2) to implement EDPP protocols to coordinate the connection to PCIL, 3) to facilitate a smooth transition back to the community and 4) to replicate the Bridge at MacNeal Hospital through another ADRC partner, Solutions for Care (SFC).

Anticipated Outcomes/Results:
ADRC program enhancements will reduce re-hospitalizations, promote quality care, enhance communication between health care providers and consumers, improve consumer safety, reduce caregiver stress and start time for community services, divert consumers from unwanted nursing home admission, and reduce emergency department visits.