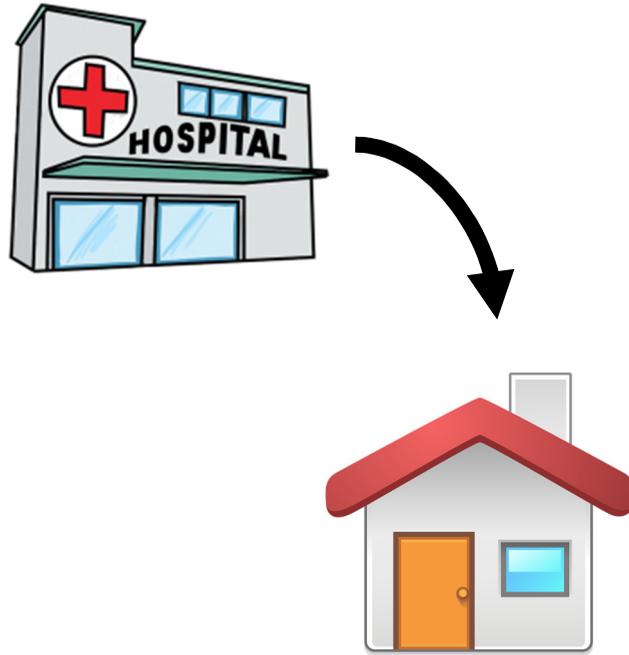




Care Transitions

Department of Aging and Youth



Promoting independence, dignity, health, and quality of life

Tel: 315-946-5624



Department of Aging and Youth

1519 Nye Road
Suite 300
Lyons, NY 14489

Phone: 315-946-5624
Fax: 315-946-5649
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nyconnects@co.wayne.ny.us

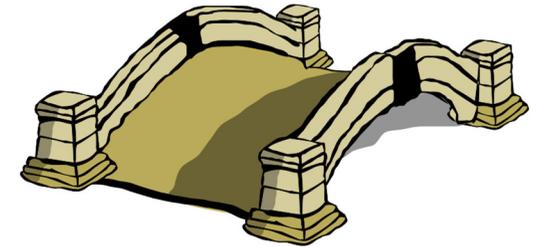
Program Description

The **Care Transitions Program** seeks to assist seniors and people with disabilities to transition from hospital to home successfully. The program, in conjunction with the hospitals and doctors' offices, will target individuals at high risk of hospital/ED re-admission to provide assistance and supports that will reduce the readmission rate and increase the rate of compliance with hospital discharge instructions (including follow-up visits).

The Care Transitions Coordinator will work with patients and families by:

- * Educating them on available Long Term Services and Supports
- * Coordinating with their existing medical and other service providers
- * Assisting with completing applications for benefits and with understanding discharge instructions

- * Linking patients with needed services and resources in the community
- * Advocating for appropriate care, benefits, and services for patients.
- * Supporting patients and their families until more permanent, long-term services can be put in place.



The Care Transitions Program can help bridge the gap between discharge and long term services starting

How the program works:



Target Population:

1. Seniors without Medicaid insurance
2. Disabled Individuals without Medicaid
3. People with Medicaid who could benefit from a care manager
4. Other high risk individuals



Referrals:

- nyconnects@co.wayne.ny.us
- 315-946-5624—ask for NY Connects
- Name, contact person and #, referring person's name and #, admission and projected discharge date, summary of issues to be aware of
- Referrals can come from hospital, doctor's office, family members, patients

Program CAN:

- ⇒ Meet with people at the hospital or in their homes
- ⇒ Discuss Long-Term Services and Supports
- ⇒ Help with screening and applying for benefits
- ⇒ Compare old and new meds lists with people to highlight changes, call doctors or pharmacies with questions
- ⇒ Assist in setting up follow-up doctor appointments or tests, arranging transportation, attending appointments with patients as needed
- ⇒ Check in on person until long term services are in place

Program CANNOT:

- ⇒ Always meet with people immediately, although we try
- ⇒ Provide services directly or arrange for emergency services
- ⇒ Process or speed up applications
- ⇒ Set up medi-sets, give medical advice, administer or oversee meds, spot interactions, or discuss what meds are for
- ⇒ Make people go to appointments or tests, give medical advice or act as a representative or health care proxy or other decision maker
- ⇒ Provide Long-Term case management services

Personnel:

Jenn Juby—Care Transitions Coordinator (she will be the one directly working with the patients)

Kendra Payne—Program Supervisor (she supervises Jenn, does the training and reporting, will be tracking referrals, etc.)

Amy Haskins—Aging Services Coordinator (she supervises Kendra, communicates with the state and director about local programs)

Penny Shockley—Agency Director

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