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Care Transitions Resources

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CONTENTS

| | Page |
|----------------------------------|-------------|
| Care Transitions Resources | 1 |
| Peer-Reviewed Literature | 1 |
| Other Resources | 11 |

Care Transitions Resources

The movement of patients from one health care provider or setting to another as their health care condition and needs change is termed a care transition. Research has shown that during care transitions, patients, especially those at higher risk for rehospitalization such as people with dementia, can be subject to inadequate communication between providers in various settings, poor continuity of care, and limited access to services which can contribute to poor outcomes and less than optimal care. A growing body of research on care transitions and work in the field aims to improve these care transitions. The list below includes peer-reviewed literature and other resources related to various aspects of care transitions for people with dementia.

Peer-Reviewed Literature

(Note: Where free access to articles is available, electronic links are included.)

Aminzadeh, F., Dalziel, W., Molnar, F., & Garcia, L. (2009). Symbolic meaning of relocation to a residential care facility for persons with dementia. *Aging & Mental Health, 13*(3), 487–496. doi:10.1080/13607860802607314

Abstract:

Objectives: This study explored the perspectives of persons with dementia (PWD) on the meanings and experiences associated with relocation to a residential care facility (RCF).

Methods: A qualitative design was employed, which involved in-depth interviews with 16 PWD at their homes within two months prior to relocation. The work of Strauss and Corbin guided the analysis process.

Results: Participants viewed relocation to an RCF as a major residential change and life transition requiring significant adaptive efforts. The experience clearly had a profound personal meaning for the participating PWD, shaped by their unique personal identities, psycho-environmental histories and current living circumstances. However, despite individual variations, four major themes captured the common perspectives and experiences in the sample. Relocation to an RCF: (a) symbolized the end of an era and a long-established way of life; (b) signaled the inevitable downward trajectory of old age; (c) meant living a more protected, dependent, structured and communal lifestyle in a place that is associated with ‘hospitality’ and ‘rest’; and (d) presented a life course challenge that could be dealt with by drawing on one’s sense of identity as a ‘survivor’.

Conclusion: The findings raise awareness of the subjective meanings of residential transitions in the experience of aging with dementia, and inform supportive interventions to optimize housing decisions for PWD in order to promote successful adaptation to their new living environments.

Aminzadeh, F., Molnar, F., Dalziel, W., & Garcia, L. (2013). An exploration of adjustment needs and efforts of persons with dementia after relocation to a residential care facility. *Journal of Housing for the Elderly*, 27(1-2), 221–240. doi:10.1080/02763893.2012.754824

Abstract:

This study examined the adjustment needs and efforts of individuals with dementia after relocation to a residential care facility. This was a qualitative prospective study that involved in-depth face-to-face interviews with 16 individuals with dementia and their family caregivers at 2 and 6 months post-relocation. In their efforts to recreate a sense of home, individuals with dementia had to meet three major highly interrelated and overlapping categories of needs to settle in, fit in, and find meaning in this transition. The satisfactory fulfillment of these adjustment needs resulted in a sense of comfort, connection, and continuity associated with feeling at home. Participants' efforts to place themselves in their new living environments created a simultaneous need to integrate relocation into their overall sense of self. The results support earlier research indicating that place making is a critical process in the overall psychosocial adjustment to old age. The findings inform supportive interventions to assist individuals with dementia to reconstruct home in a residential care environment.

Bauer, M., Fitzgerald, L., & Koch, S. (2011). Hospital discharge as experienced by family carers of people with dementia: A case for quality improvement. *Journal for Healthcare Quality*, 33(6), 9–16. doi:10.1111/j.1945-1474.2011.00122.x

Abstract:

To explore whether hospital discharge practices meets the needs of the family carer of a person with dementia. Qualitative methodology utilizing semistructured interviews with the primary family carer of a person with dementia after hospital discharge. Purposive sampling methods were used to recruit family carers within 2 months of discharge from hospitals in the state of Victoria, Australia. Twenty-five family carers were interviewed. Key issues that families found problematic include: coordination of discharge planning, the ability of the staff to address family members' needs, poor engagement with family, and perceived lapses in care delivery. Findings suggest that a number of changes to hospital processes and health professionals' practices are needed in order to better meet the transitional needs of family carers of people with dementia. Considerations for practice to improve the quality of hospital discharge preparation for family carers of people with dementia are provided. © 2011 National Association for Healthcare Quality.

Bauer, M., Fitzgerald, L., Koch, S., & King, S. (2011). How family carers view hospital discharge planning for the older person with a dementia. *Dementia*, 10(3), 317–323. doi:10.1177/1471301211407790

Abstract:

This study reports on the experiences of 25 family carers of the hospital discharge planning process for their family member with a dementia. Analysis of the data indicates that the needs of family carers were not always addressed in the hospital discharge process and that discharge planning and execution is in need of improvement.

Bradway, C., Trotta, R., Bixby, M. B., McPartland, E., Wollman, M. C., Kapustka, H., McCauley, K., & Naylor, M. D. (2012). A qualitative analysis of an advanced practice nurse-directed transitional care model intervention. *Gerontologist*, 52(3), 394–407. doi:10.1093/geront/gnr078. Epub 2011 Sep 9.

Abstract:

Purpose: The purpose of this study was to describe barriers and facilitators to implementing a transitional care intervention for cognitively impaired older adults and their caregivers lead by advanced practice nurses (APNs). **DESIGN AND METHODS:** APNs implemented an evidence-based protocol to optimize transitions from hospital to home. An exploratory, qualitative directed content analysis examined 15 narrative case summaries written by APNs and fieldnotes from biweekly case conferences.

Results: Three central themes emerged: patients and caregivers having the necessary information and knowledge, care coordination, and the caregiver experience. An additional category was also identified, APNs going above and beyond.

Implications: APNs implemented individualized approaches and provided care that exceeds the type of care typically staffed and reimbursed in the American health care system by applying a Transitional Care Model, advanced clinical judgment, and doing whatever was necessary to prevent negative outcomes. Reimbursement reform as well as more formalized support systems and resources are necessary for APNs to consistently provide such care to patients and their caregivers during this vulnerable time of transition.

Free full-text: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC21908805/>

Chenoweth, L., Kable, A., & Pond, D. (2015). Research in hospital discharge procedures addresses gaps in care continuity in the community, but leaves gaping holes for people with dementia: a review of the literature. *Australasian Journal on Ageing*, 34(1), 9-14. doi: 10.1111/ajag.12205

Abstract:

Aim: To examine the literature on the impact of the discharge experience of patients with dementia and their continuity of care.

Methods: Peer-reviewed and grey literature published in the English language between 1995 and 2014 were systematically searched using Medline, CINAHL, PubMed, PsycINFO and Cochrane library databases, using a combination of the search terms Dementia, Caregivers, Integrated Health Care Systems, Managed Care, Patient Discharge. Also reviewed were Department of Health and Ageing and Alzheimer's Australia research reports between 2000 and 2014.

Results: The review found a wide range of studies that raise concerns in relation to the quality of care provided to people with dementia during hospital discharge and in transitional care.

Conclusion: Discharge planning and transitional care for patients with dementia are not adequate and are likely to lead to readmission and other poor health outcomes.

Daiello, L., Gardner, R., Epstein-Lubow, G., Butterfield, K., & Gravenstein, S. (2014). Association of dementia with early rehospitalization among Medicare beneficiaries. *Archives of Gerontology and Geriatrics*, 59(1), 162–168. doi:10.1016/j.archger.2014.02.010

Abstract:

Preventable hospital readmissions have been recognized as indicators of hospital quality, a source of increased healthcare expenditures, and a burden for patients, families, and caregivers. Despite growth of initiatives targeting risk factors associated with potentially avoidable hospital readmissions, the impact of dementia on the likelihood of rehospitalization is poorly characterized. Therefore, the primary objective of this retrospective cohort study was to investigate whether dementia was an independent predictor of 30-day readmissions. Administrative claims data for all admissions to Rhode Island hospitals in 2009 was utilized to identify hospitalizations of Medicare fee-for-service beneficiaries with a diagnosis of Alzheimer's Disease or other dementias. Demographics, measures of comorbid disease burden, and other potential confounders were extracted from the data and the odds of 30-day readmission to any United States hospital was calculated from conditional logistic regression models. From a sample of 25,839 hospitalizations, there were 3908 index admissions of Medicare beneficiaries who fulfilled the study criteria for a dementia diagnosis. Nearly 20% of admissions (n=5133) were followed by a readmission within thirty days. Hospitalizations of beneficiaries with a dementia diagnosis were more likely to be followed by a readmission within thirty days (adjusted odds ratio (AOR) 1.18; 95% CI, 1.08, 1.29), compared to hospitalizations of those of without dementia. Controlling for discharge site of care did not attenuate the association (AOR 1.21; 95% CI, 1.10, 1.33). Copyright © 2014. Published by Elsevier Ireland Ltd.

Digby, R., Moss, C., & Bloomer, M. (2011). Transferring from an acute hospital and settling into a subacute facility: The experience of patients with dementia. *International Journal of Older People Nursing*, 7(1), 57–64. doi:10.1111/j.1748-3743.2011.00282.x

Abstract:

Background: In a Melbourne metropolitan health network, patients with dementia can have difficulty settling into a subacute rehabilitation facility after transfer from the acute hospital.

Aims and Objectives: To understand how older patients with mild to moderate dementia experienced the transfer from acute to subacute care and settling-in period.

Design: A descriptive design was used. Eight patients with mild to moderate dementia were recruited, one to 5 days after transfer.

Method: A qualitative method using in-depth interviews was used. The data were analyzed using content analysis.

Results: Four main themes were identified: ‘Settling into a new environment’, ‘staff attitudes to people with dementia’, ‘loss of control’ and ‘family support’.

Conclusions: Person-centered care that comes from the perspective of respect for the individual transcends all these issues. People with dementia require more support to settle after transfer. Family involvement can assist in facilitating a smooth transition.

Implications for Practice: Nurses who understand the specific needs of patients with dementia can develop ways of working with patients to ensure person-centered care. More conversations with people with dementia are needed to investigate how this can be achieved. Orientation procedures should ensure that support for people with dementia is optimized during the settling-in phase. ©2011 Blackwell Publishing Ltd.

Epstein-Lubow, G., & Fulton, A. (2012). Post-hospital transitions for individuals with moderate to severe cognitive impairment. *Annals of Long-Term Care*, 20(3), 18–24.

Abstract:

The post-hospital transition is a target for quality improvement in the care of individuals with cognitive impairment. Effective interventions have been shown to reduce the rate of rehospitalization for medical patients without dementia. Similar interventions are being developed to reduce the rate of rehospitalization in the context of cognitive impairment. While awaiting evidence and the subsequent administrative, services, and policy changes that will allow for better quality transitions, there are efforts that clinicians and family members can embrace immediately. The authors provide a review of several of these efforts. Ultimately, the long-term goals are to improve aftercare service matching for individuals with cognitive impairment and prevent unnecessary hospitalizations and undue suffering by patients and family caregivers.

Epstein-Lubow, G., Fulton, A., Gardner, R., Gravenstein, S., & Miller, I. (2010). Post-hospital transitions: Special considerations for individuals with dementia. *Medicine and Health, Rhode Island*, 93(4), 125–127.

Abstract:

Several post-hospital transition programs have demonstrated reductions in rehospitalization and lower costs for medical patients. However, these studies have often excluded those with cognitive impairment even though this population has a heightened need for coordinated care after a hospital stay. Improving transitional care may be more difficult for people with cognitive impairment and special considerations may be necessary. These considerations include identifying the caregiver and their understanding of discharge instructions, planning for follow-up appointments related to mental and physical health, and paying particular attention to safety issues.

Fitzgerald, L., Bauer, M., Koch, S., & King, S. (2011). Hospital discharge: recommendations for performance improvement for family carers of people with dementia. *Australian Health Review*, 35(3), 364. doi:10.1071/ah09811

Abstract:

Background: It is acknowledged that discharge planning benefits both consumers and hospitals. What is not widely understood is the experience that the family carer of a person with a dementia has and whether the hospitals meet their in-hospital and post-hospital needs.

Objective: To explore whether metropolitan and rural hospital discharge practices meet the needs of the family carer of a person with dementia.

Results: Although this and other research indicates that a continuum of care model is beneficial to family caregivers, no evidence has been identified that family carers currently experience this type of quality planning. Family carers were often unaware of the existence of a hospital discharge plan and were rarely engaged in communication about the care of their family member with a dementia or prepared for discharge.

Conclusion and Recommendations: Discharge planning processes for family carers of people with dementia could be substantially improved. It is recommended that hospitals develop policy, process and procedures that take into account the family carer's needs, develop key performance indicators and adopt best practice standards that direct discharge planning activities and early engagement of the family carer in healthcare decisions. It is recommended that health professionals be educated on communication, consultation and needs of family carers.

Fortinsky, R., & Downs, M. (2014). Optimizing person-centered transitions in the dementia journey: A comparison of national dementia strategies. *Health Affairs*, 33(4), 566–573. doi:10.1377/hlthaff.2013.1304

Abstract:

The journey for people with Alzheimer's disease or another dementia involves the need for increasing levels of support, with transitions across care settings. Although transitional care has received increasing attention in the health care arena, no widely accepted transitions typology exists for the dementia journey. At the same time, national dementia strategies are proliferating. We developed a typology containing six transitions that cover the dementia journey from symptom recognition to end-of-life care. We then critically evaluated whether and how the national dementia strategies of Australia, England, France, the Netherlands, Norway, Scotland, and the United States addressed each transition. Adopting a person-centered perspective, we found that most or all of the national strategies adequately address earlier transitions in the journey, but fewer strategies address the later transitions. We recommend that next-generation national dementia strategies focus on later transitions, specify how care coordination and workforce training should make transitions more person centered, and use person-

centered outcomes in evaluating the success of the strategies' implementation and dissemination.

Heid-Grubman, J. (2013). Dementia, care transitions, and communication: Sharing information is key to patient-care. *Generations*, 37(3), 97–99.

Abstract:

Transitions from one level of care to another or from one service provider to another can be difficult regardless of one's age or circumstances. For individuals with dementia, however, transitions are fraught with potential for negative outcomes, including increased confusion, falls, and incontinence. This article explores three specific goals for providing a person-centered approach to care transitions, including the following: avoiding unnecessary transitions whenever possible, enhancing communication flow, and developing a care-delivery system across the continuum of care.

McCauley, K., Bradway, C., Hirschman, K. B., & Naylor, M. D. (2014). Studying nursing interventions in acutely ill, cognitively impaired older adults. *American Journal of Nursing*, 114(10), 44–52. doi:10.1097/01.NAJ.0000454851.22018.5d

Abstract:

Overview: Although it increases the risk of poor outcomes and raises the costs of care, cognitive impairment in hospitalized older adults is often neither accurately identified nor well managed. In conducting a two-phase, comparative-effectiveness clinical trial of the effects of three nursing interventions-augmented standard care, resource nurse care, and the transitional care model-on hospitalized older adults with cognitive deficits, a team of researchers encountered several challenges. For example, in assessing potential subjects for the study, they found that nearly half of those assessed had cognitive impairment, yet many family caregivers could not be identified or had no interest in participating in the study. One lesson the researchers learned was that research involving cognitively impaired older adults must actively engage clinicians, patients, and family caregivers, as well as address the complex process of managing postdischarge care.

Naylor, M., Hirschman, K., Hanlon, A., Bowles, K., Bradway, C., McCauley, K., & Pauly, M. (2014). Comparison of evidence-based interventions on outcomes of hospitalized, cognitively impaired older adults. *Journal of Comparative Effectiveness Research*, 3(3), 245–257. doi:10.2217/cer.14.14

Abstract:

Aim: This article reports the effects of three evidence-based interventions of varying intensity, each designed to improve outcomes of hospitalized cognitively impaired older adults.

Materials & Methods: In this comparative effectiveness study, 202 older adults with cognitive impairment (assessed within 24 h of index hospitalization) were enrolled at one of three hospitals within an academic health system. Each hospital was randomly assigned one of the following interventions: Augmented Standard Care (ASC; lower

dose: n = 65), Resource Nurse Care (RNC; medium dose: n = 71) or the Transitional Care Model (TCM; higher dose: n = 66). Since randomization at the patient level was not feasible due to potential contamination, generalized boosted modeling that estimated multigroup propensity score weights was used to balance baseline patient characteristics between groups. Analyses compared the three groups on time with first rehospitalization or death, the number and days of all-cause rehospitalizations per patient and functional status through 6-month postindex hospitalization.

Results: In total, 25% of the ASC group were rehospitalized or died by day 33 compared with day 58 for the RNC group versus day 83 for the TCM group. The largest differences between the three groups on time to rehospitalization or death were observed early in the Kaplan-Meier curve (at 30 days: ASC = 22% vs RNC = 19% vs TCM = 9%). The TCM group also demonstrated lower mean rehospitalization rates per patient compared with the RNC ($p < 0.001$) and ASC groups ($p = 0.06$) at 30 days. At 90-day postindex hospitalization, the TCM group continued to demonstrate lower mean rehospitalization rates per patient only when compared with the ASC group ($p = 0.02$). No significant group differences in functional status were observed.

Conclusion: Findings suggest that the TCM intervention, compared with interventions of lower intensity, has the potential to decrease costly resource use outcomes in the immediate postindex hospitalization period among cognitively impaired older adults.

Free full-text: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4171127/>

Naylor, M., Stephens, C., Bowles, K., & Bixby, M. (2005). Cognitively impaired older adults: From hospital to home. *AJN, American Journal of Nursing, 105*(2), 52–61.
doi:10.1097/00000446-200502000-00028

Abstract:

Overview: Although it's known that cognitive impairment in older adults can adversely affect outcomes of care during and after hospitalization, it often goes unrecognized or is poorly managed. Few clinicians understand these patients' needs or those of their caregivers (a spouse, partner, friend, or family member). For these reasons, we conducted an exploratory study, the primary purposes of which were the following: to determine the rates of cognitive impairment among older adults hospitalized for acute medical or surgical events; to identify the needs of these older adults and caregivers throughout an episode of acute illness; to examine patients' and caregivers' needs at specific times during and immediately after hospitalization.

Free full-text:

http://journals.lww.com/ajnonline/Fulltext/2005/02000/Cognitively_Impaired_Older_Adults_From_Hospital.28.aspx

Parry, C., Coleman, E., Smith, J., Frank, J., & Kramer, A. (2003). The care transitions intervention: A patient-centered approach to ensuring effective transfers between sites of geriatric care. *Home Health Care Services Quarterly*, 22(3), 1–17. doi:10.1300/j027v22n03_01

Abstract:

During an episode of illness, older patients may receive care in multiple settings; often resulting in fragmented care and poorly-executed care transitions. The negative consequences of fragmented care include duplication of services; inappropriate or conflicting care recommendations, medication errors, patient/caregiver distress, and higher costs of care. Despite the critical need to reduce fragmented care in this population, few interventions have been developed to assist older patients and their family members in making smooth transitions. This article introduces a patient-centered interdisciplinary team intervention designed to improve transitions across sites of geriatric care.

Shankar, K. N., Hirschman, K. B., Hanlon, A. L., & Naylor, M. D. (2014). Burden in caregivers of cognitively impaired elderly adults at time of hospitalization: A cross-sectional analysis. *Journal of the American Geriatrics Society*. 62(2):276–84. doi:10.1111/jgs.12657. Epub 2014 Feb 6.

Abstract:

Objectives: To describe the factors associated with burden that caregivers of cognitively impaired older adults (dementia, delirium, or both) at the time of hospitalization experienced.

Design: Cross-sectional data analyses.

Setting: Three hospitals-one academic tertiary hospital and two associated community hospitals.

Participants: Caregivers (N = 495) of cognitively impaired older adults at the time of hospital admission.

Measurements: Multivariable linear regression was performed to analyze the effect of the independent variables (caregiver: demographic characteristics, depressive symptoms, self-efficacy; older adult: neuropsychiatric symptoms, delirium, functional deficits) on caregiver burden. *Results:* Higher burden was associated with younger caregiver age (P = .02), being a spouse (P = .03), depressive symptoms (P < .001), caregivers' lower perceived self-efficacy in managing care recipient symptoms (P = .002), and limited finances at the end of the month (P = .01). Caregiver burden was also strongly associated with the care recipient factors distressing neuropsychiatric symptoms (P = .001), delirium (P = .001), and greater functional deficits in basic activities of daily living (P = .001).

Conclusion: These findings suggest that caregivers of older adults who were cognitively impaired at hospital admission experience burden. Understanding the factors that contribute to burden at the time of hospitalization for caregivers of persons with cognitive impairment can inform the development of interventions targeted throughout the

hospitalization that have the potential to decrease burden. © 2014, Copyright the Authors
Journal compilation © 2014, The American Geriatrics Society.

Free full-text: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3945647/>

Tew Jr, J. (2012). Care transitions and the dementia patient: A model intervention builds communication, trust-and better care. *Generations*, 36(4), 109–112.

Abstract:

For patients with dementia, the transition from hospital to the community can trigger a recurrence of challenging behaviors, creating frustration among caregivers. Enhanced communication during transition and support for caregivers awaiting patients' transfer home is critical in this population. This article reviews a transitional care intervention designed and implemented in a gero-psychiatric hospital where a transitional care nurse provides enhanced bidirectional communication, nursing home outreach, training, and post-discharge follow-up for area facilities receiving patients from the forty-two-bed geriatrics unit at Pittsburgh's Western Psychiatric Institute & Clinic.

Villars, H., Dupuy, C., Soler, P., Gardette, V., Soto, M., & Gillette, S. et al. (2013). A follow-up intervention in severely demented patients after discharge from a special Alzheimer acute care unit: Impact on early emergency room re-hospitalization rate. *International Journal of Geriatric Psychiatry*, 28(11), 1131–40. doi:10.1002/gps.3932

Abstract:

Background: Emergency room (ER) re-hospitalizations are prevalent in severe Alzheimer's disease affected older patients.

Design: Quasi-experimental before and after study.

Setting: Discharge of severely demented patients from a Special Alzheimer Acute Care Unit.

Participants: A total of 390 patients hospitalized in the unit from 2007 through 2009, with at least one of the following characteristics: severe disruptive behavioral and psychological symptoms of dementia (BPSD) (agitation, aggressiveness, and psychotic symptoms), change of living arrangement related to BPSD, exhaustion of the principal caregiver, and discharge of a subject with anosognosia living alone in the community.

Intervention: The intervention consisted of an individualized care plan, targeting the problems observed during the hospital stay, implemented by the means of regular telephone contacts (in the first week after discharge, before the end of the first month, and then at 3 and 6 months) between a geriatric team and the patient's caregiver. Information was gathered on functional decline, BPSD, change of living arrangement and treatment. The calls were followed by a telephone intervention providing advice, support, and information to the caregiver. When required, these calls were followed by a consultation with a physician or psychologist, or by a consultation in the patient's home.

Measurements: The primary outcome measure was the ER re-hospitalization rate, defined as occurring within 31 days of discharge. *Results:* The early ER re-hospitalization rate was 8.39% in 2007 versus 8.02% in 2008 ($p = 0.818$) and 7.47% in 2009 ($p = 0.563$). Vocal disruptive behavior are more prevalent in re-hospitalized patients (9.64% versus 3.97%, $p = 0.05$) than in non re-hospitalized patients.

Conclusion: We found a nonsignificant decrease of early ER re-hospitalization rate at 1 month after discharge. Interventions addressing severe dementia affected patients with BPSD are needed, as this is a major issue in the organization of health care systems.

Other Resources

(Note: Contact your National Alzheimer's and Dementia Resource Center staff person for materials in this section.)

Alzheimer's Association, California Southland Chapter. (2014). *Care transitions notebook: Caring for someone with Alzheimer's or related dementia after a hospitalization*. Los Angeles: Alzheimer's Association.

Description: This care transitions notebook is broken into 15 sections to help caregivers identify possible issues they may face in the 30 days after a person with dementia leaves the hospital and comes back home. During this time, it is important that the person with dementia's needs are coordinated so his or her health and social needs are met. This care transitions notebook focuses on people in the middle stage of the disease.

Georgia Department of Human Services. *Hospital care transitions cost calculator*.

Description: This is a cost calculator designed for Area Agencies on Aging in Georgia. The calculator includes items that are commonly used during care transitions. Users of the calculator can input costs for individual items and determine a total cost for certain services.

Georgia Department of Human Services. *Hospital transitions: Manual to engage Georgia Aging Network*.

Description: This manual includes information on care transitions including an overview of evidence-based interventions related to care transitions, information on how to access and implement the programs, steps that can be taken to demonstrate to hospitals that working with the Aging Network is valuable, and how to market support services offered to older adults in the community.

Northeast Iowa Area on Aging. (2014). *Care transitions grant #1306: Final report*. Care Transitions Model. Transitioning Care from Hospital—Linking Home and Community Based Services.

Description: This report details the Northeast Iowa Area on Aging's efforts within its grant program to provide patients with in-home services to aid their recovery with needed services to reduce readmission to the hospital. Case management was offered to assist with coordination and monitoring of services once they were discharged home. Caregiver

support for the co-learner was offered to alleviate stress or burnout while caring for their family member.

Hirschman, K. *Transitional care model: Working with cognitively impaired patients and their family caregivers*. Presentation to Care Transitions Learning Collaborative on April 8, 2015.

Description: Dr. Hirschman is a member of a research team funded by the NIH to study care transitions for cognitively impaired older adults. Dr. Hirschman prepared this slide deck to use as a reference for a call sponsored by the National Alzheimer's and Dementia Resource Center. Below are resources Dr. Hirschman mentioned in her presentation:

Transitional Care Model website: <http://transitionalcare.info/>

Transitional Care Model publications: <http://transitionalcare.info/publications>

Transitional Care Model Materials related to low and medium dose interventions:
<http://transitionalcare.info/expanding-tcm-cognitively-impaired-older-adults-and-their-family-caregivers>