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Tim Landrin: Good afternoon. This is the short person session. As Naomi said, my name is Tim Landrin and I work the Southwestern Pennsylvania Area Agency on Aging, a three county section, surprisingly enough in the southwestern corner of Pennsylvania. Also, Ray DuCoeur who is the executive director of Westmoreland County Area Agency on Aging is here too. We are the two AAAs who provide the coaching in this project.

And we see it as an extension of our mission. You know, the mission of an Area Agency on Aging and also the AoA is to provide, to develop and to provide services to people to keep them in their home and to help them maintain their health and independence in the community. So, anyway, what I want to do is take you deep into the practical side of this. We are at the grassroots level.

We are an Area Agency on Aging. We work with people in the community. We work with our local hospitals there. We work with one hospital in our agency. Ray's organization works with three hospitals in his county. So we want to talk about – what I really want to talk about is how we got started and moving on in this endeavor and as coaching.

First of all, we first met, as Naomi said, we talked with Dr. David Wenner, who's a Medical Director of Quality Insights of Pennsylvania, the QIO in Pennsylvania. And we had also then had numerous and he talked to us about it and helped us understand how this could be a part of our mission and how this is part of our natural process as providing services to older people in the community.

There were numerous meetings with hospital, with the QIO, face to face, emails, phone calls, and those continue, of course. We developed a workflow process. We developed responsibilities, posters, handouts, the PHR, the personal health record, things of that nature. Whenever we identified staff, and these are part-time staff. These are folks who are already working full-time with our agency. So these are part-time staff performing these coaching duties. But we looked at – well, two of them are nurses. Two of them are nurses. There are 10 altogether between our two agencies, registered nurses.

The others are human services workers. And we look for a very above average knowledge of medical conditions obviously. They need to be flexible and they had to have good organizational skills. The roles, whenever we looked at roles both with us and with the hospital and this was very important. We wanted to do respect the policies and the limitations of each organization. We needed to be open each other's comments and suggestions. We needed to compromise. There was a lot of compromise as Naomi said.

We did run into some problems, but that's OK. We worked things out. And we were honest with each other as far as working through the issues, the concerns, and those types of things. We did attend, as Naomi said, Dr. Coleman's training. I attended as an administrator. Ray also attended along with our coaches, so that was done. And we felt that was important from the standpoint of, the administrative

standpoint that we have that strong administration support and involvement.

OK, the implementation process, and a lot of you have heard this already, but just to go through it one more time, we were following the same criteria. We began coaching actually in July of 2009. So, we were one year, this QIO was one year into the project. The target population is the Medicare Fee-For-Service beneficiaries. We identified folks who were alert oriented or a caregiver who met that criteria, who was alert oriented. People who were able to understand the concepts of the program. They could follow direction and have a potential to take control of their medical situation. The diagnoses we looked at were congestive heart failure, COPD, and a few other diagnoses such as diabetes. We also transitioned the coaching, or excuse me, we coached folks who were part of the ZIP codes. So there were target ZIP codes as mentioned before in the project so that was the other selection criteria.

Some lessons learned. The QIO role was vital. They were able to, with their project coordinators, work with us with Naomi's help and just vital in helping us understand and the communication between us and the hospital, also understand the whole concept of the model and what we were working with. We had worked with a hospital for many years. Both of us had. Both of our agencies had done that. However we were able to better understand what the hospital staff was going through, understanding their major concerns, their relationships with patients. We also, the coaches were, as we moved through this, the coaches became part of the hospital family. They were accepted into that. So, they go there and I'll tell you in a second exactly how we worked this, but it was a part of that and what bears it out as Naomi mentioned, the questionnaire that was done, there was improved involvement and there was value in that collaboration with the hospital.

The value of the onsite hospital visits. What we do, the coaches go there one day a week for a few hours to meet the patient. These are referrals coming from that hospital. The coaches then make contact, make that initial contact with the patient, possibly the family is there too. They develop a rapport. There's very consistent follow up. Whenever we are on the phone, we are making that home visit, there is a lot of, you know, there is a rapport. They know us. They know who we are. The AAA is known in the community. We walk in, our coaches walk in and say "I'm from the Area Agency on Aging‖ and they say, "Oh yeah, I know who you are. Thank you for being here.‖ And so we have a recognition in that area. Moving on.

Limitations. Resources. We are very committed to this project. Both of our Area Agencies on Aging. However, our AAA, neither one of our AAAs receive any type of additional funding to provide this coaching. We feel that due to those funding constrictions, that only 8 percent, well, we know that only 8 percent of discharge patients were coached. However, hopefully with increased funding, we feel that we could, would hire more coaches that could be trained and thus, we could lower the visits, or excuse me, the risk of rehospitalizations

back into the community.

Couple of success stories. And just very quickly, because I know I'm running late. Quite honestly, as I said, this is part of our mission. So, not only were we coaching, we were also receiving referrals. A lot of these people were already known to us. So a lot of the people who we saw we may already know and may already be providing services to them. People that may not be known to us we were able to very smoothly transition into the provision of services. Monitoring them, keeping them and providing other services. Taking referrals. Couple simple examples, and I think the doctor from San Francisco mentioned this this morning... about transportation. That's happened a lot. Where a patient says, well I'm not sure how I can get home from the hospital. That's a very simple barrier that we, well that's a barrier that we can simply resolve within our agency. But, anyway, those were parts of the… a couple of stories. We've had a number of stories. One of them being with a person with anemia who was in there.

They were able to identify their medication. They knew they had to go to the doctor. However the doctor, she had not called the doctor yet. The coach was able to convince her and help her, coach her to call the doctor. The coach also identified an over-the-counter medication that was – that she was taking that her physician wanted her to discontinue. So we were able to do that.

Just simple things like that, but very important things like that. Things that we were able to do become second nature to us. And we learned from coaching also. And the training was excellent. The training was excellent so. So that's pretty much what we're doing. And I know as we have questions and answers, we may be able to provide you with some more information. Thank you.