Authors:

1. Alice Bonner, PhD, RN
2. Margaret A. Mahoney, PhD, RN
3. Adam Burrows, MD
4. Randi Berkowitz, MD
5. Akash Shah
6. Aaron Nathan, BS

Abstract: The Program of All-inclusive Care for the Elderly (PACE) is an innovative health care model that provides high-quality care to nursing home eligible seniors with chronic care needs within their own communities. Numerous studies have documented the impact of fragmentation in care during transitions, resulting in higher than expected hospitalization rates and negatively influencing patient outcomes. PACE strives to improve care transitions and reduce avoidable readmissions and fragmented care through enhanced care coordination and care integration. This study explores methods to enhance the engagement of seniors and family members and improve self-management during transitions from hospital to home. With input from participants, families and staff, we will test the usability of recommendations for a new transitions coaching toolkit for self-care/self-management at Upham’s Corner Health Center PACE Centers in Boston. We will conduct focus groups and key informant interviews of participants, staff and caregivers in order to explore experiences around care transitions, including facilitators and barriers to effective care. We will also examine health care utilization based on rates of hospitalizations, ED transfers, SNF transfers, and time to nursing home placement. Information gathered will be analyzed using qualitative methods and will form the basis for recommendations related to how these PACE centers can enhance care transitions, information exchange and the use of technology in self-care/self-management of complex, dually eligible individuals. Our main goal is to provide recommendations for future quantitative methods and more extensive program evaluation building on these findings.