

The Community Supports Navigator Program

Sponsoring Agency: Community Caregivers

Initial Problem to be Addressed: Preventable hospital readmissions – Data demonstrate that older adults have high rates of readmission after they have been discharged from the hospital (15% within 30 days and 30% within 90 days). The Centers for Medicare and Medicaid Services (CMS) are supporting efforts in New York and around the country to reduce the number and rate of unplanned or preventable hospital readmissions and to improve health outcomes for patients.

Brief Program Description: The Community Caregiver's Community Supports Navigator (CSN) initiative adapts traditional care transition models by using highly trained volunteers to serve as caring partners/coaches to provide support and advocacy for older adults (and their primary caregivers) as they transition from a hospital in-patient stay back to the community. Volunteer Navigators would help by coaching the consumer to manage their non-medical post-discharge tasks by assisting with post-discharge follow up, medication supports, and transportation, all of which have been shown to be necessary for an older adult to return and remain safely in his/her home.

This program is currently being implemented in Albany and Tompkins Counties as part of a 2009 Administration on Aging grant to empower individuals to navigate their health and long-term-care options. In Albany County, Community Caregivers is collaborating with Albany County-NY Connects and the Eddy Visiting Nurse Association to match trained volunteers (provided by Community Caregivers) with a Care Transitions Intervention (CTI)-trained nurse to provide non-medical coaching to older adults at-risk of hospital readmission.

How does the Program Help/Why do you like the program? The CSN program extends the continuum of care after discharge for patients most at-risk of unplanned hospital readmissions. The volunteer provides coaching designed to maximize the success of that continuum, which occurs from a patient's hospitalization through their most vulnerable period post-discharge. The reduction in preventable readmissions will lead to a significant cost savings for the health care system. The use of volunteers to provide coaching support to consumers will further act as a cost-saving measure that supports civic engagement.

Total Program Cost and Major Income Sources: The program is supported by a 2009 Administration on Aging grant. Community Caregivers will act as the host agency to supply the volunteers for this program. Since the program is able to utilize volunteers, a majority of the program costs will be administrative.

Special Issues/Characteristics: The Community Supports Navigator program models the Care Transitions Intervention developed by Dr. Eric Coleman. However, the program expands upon Coleman's CTI program in that it pairs the CTI-trained coach (provided by the Eddy VNA) with a trained volunteer. This is an extremely innovative pilot program, as it is one of the few care transitions programs across the country that uses volunteers as "coaches." It also coincides with the Affordable Care Act initiatives in that it supports the provision of high quality and efficient care leading to a reduction in unplanned hospital readmissions.

For Further Information Contact: Christine Damon, Acting Executive Director, Community Caregivers, 518-456-2898 or Erin Stachewicz, Albany County-NY Connects Coordinator, 518-447-7469.