

**Aging and Disability Resource Centers  
Implementing the Affordable Care Act:  
Making it Easier for Individuals to Navigate Their Health and Long-Term Care through  
Person-Centered Systems of Information, Counseling and Access  
Evidence Based Care Transition Program**

**State Agency:** WA State Department of Social and Health Services

**Name of ADRC and Healthcare Partners:**

Northwest Regional Council (ADRC), Yakima County ADRC, Qualis Health (QIO), St. Joseph Hospital, Skagit Valley Hospital, Yakima Memorial Hospital, and Yakima Regional Hospital

**Project Period:** September 30, 2010 to September 30, 2012

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**Evidence Based Care Transitions Model:** Care Transitions Intervention<sup>SM</sup>

**Project Summary:**

Washington State Department of Social and Health Services-Aging and Disability Services Administration (DSHS-ADSA), supports this two year Aging and Disability Resource Center (ADRC) Evidence-Based Care Transition project in collaboration with one regional Quality Improvement Organization (QIO), the Care Transitions Intervention<sup>SM</sup>, two Area Agencies on Aging (AAAs), Insignia, and four hospitals.

**Goal/Objectives:**

The goal of the project is to establish an ADRC Care Transitions Intervention<sup>SM</sup> Model in Washington State for eventual Statewide Expansion. The approach is to build on the current CMS-funded Care Transitions Intervention<sup>SM</sup> (CTI) Model in Whatcom County to formalize the ADRC role, increase ADRC capacity to facilitate care transitions; and to develop a template for building additional care transition partnerships in Washington State. The objectives are to: (1) Formalize the ADRC role in the current Whatcom County CTI model; (2) Expand use of the ADRC CTI model within the same service area; (3) Provide training and implement lessons learned to an additional ADRC; (4) Apply continuous quality improvement and evaluation; and (5) disseminate project information.

**Anticipated Outcomes/Results:**

The expected outcomes of this ADRC Care Transition project are: (1) Increased ADRC capacity and reach with hospitals in the identified counties; (2) Improved re-hospitalization rates for participating hospitals; (3) Improved health, chronic conditions self management, by CTI participants; and (4) Evidence of improved efficiencies and/or cost savings by end of project. The products from this project will be: state care transitions data collection requirements; an ADRC CTI evaluation plan; an ADRC CTI implementation toolkit; semi-annual reports; and a final report.