Coastal Care Transitions Program (CCTP) partners with a local hospital, Southeast Georgia Health System (SGHS), to provide care transitions to patients discharging from hospital to home. Working with SGHS allows the hospital to learn more about the AAA programs and services and the aging network; and it also allows the AAA to help assess the needs of the hospital in regards to transitional care for its patients. With a shared interest in increasing patient education and empowerment and reducing hospital readmissions, this partnership allows for both agencies to better serve vulnerable older adults transitioning from the hospital setting.

CCTP utilizes the Bridge Model of care transitions to deliver services to patients. Bridge is a 30-day evidence model of care transitions and is a social work based transitional care model designed for older adults discharged home from an inpatient hospital stay. Bridge helps older adults to safely transition back to the community through intensive care coordination that starts in the hospital and continues after discharge. Emphasis is placed on addressing the client's medical and psychosocial needs, and the importance of linking care providers across existing networks. In order to facilitate this linkage, the Bridge Model frequently makes use of the Aging Network, in this case, the Area Agency on Aging.

Guided by Bridge, the CCTP utilizes pre-discharge and post discharge processes. The pre-discharge process includes identifying patients eligible for care transitions, a meeting between the Bridge Care Coordinator (BCC), Discharge Planner and patient, and initiating referrals to community resources and services. The post-discharge process is designed to help identify needs and barriers that may impact the patient's ability to remain at home and improve their health. Essential components of the program include education, coaching, review of hospital discharge instructions and linkage to community resources. As necessary, patients receive other support services such as home delivered meals, in-home services, and material aid These are critical pieces of the intervention, as they encourage empowerment and increase patient activation.

Patients' participation is based on pre-determined eligibility criteria, including target diagnostic related groups, and a geographical service area. Identified targeted diagnostic related groups (DRGs) include patients with Acute Myocardial Infarction, Pneumonia, Congestive Heart Failure, and Renal Failure.

Proven outcomes for CCTP include: reducing hospital readmissions, increasing patient activation, providing education / coaching, increasing compliance with discharge instructions, providing patient and home safety evaluations, linking patients to community resources and increasing collaboration between community service agencies and hospital systems.