Executive Summary

Improving Transitions of Care

A Quality Improvement Collaborative to Benefit Frail Elders

April 2007 through October 2008

Supported by the Community Health Foundation of Western and Central New York, thirteen teams from Western and Central New York worked together for about eighteen months in a Collaborative focused on improving transitions of care for frail elders in their communities. The teams included both the sending and receiving care provider in the target transition.

The purpose of this project was to stimulate change in practice and care delivery systems to improve transitions for frail elders as they move from one care setting to another. Better management of these transitions improves continuity, reduce error and delay, and increase patient control of health decisions.

Transitions of Care Defined:

Transitions of Care refers to the movement of patients from one health care practitioner or setting to another as their condition and care needs change. This may include transitions from hospitals to nursing homes or home care after an acute illness, transitions from nursing homes to home care or home without care, or transitions from one physician to another. The locations and care practitioners involved in care transitions are many. As a result, information shared with patients and their caregivers is often confusing, contradictory, or missing critical information. Appropriate transitions of care include understanding the needs of chronically ill patients, understanding health goals and wishes, making appropriate logistical arrangements, educating patients and families about expectations and next steps, and coordinating between health care practitioners at both settings.

Most of the focus on medical error is on patients in institutional settings; however the seriousness of the problems that exist between settings is significant and often overlooked. Most health care practitioners only practice in one setting and understand little about the requirements of other settings. In addition, health care practitioners do not follow the patient to the next level of care thereby increasing the risk for error and for problems with continuity of care.

Opportunity for Improvement: Dr. Coleman's research, under a grant from the John A. Hartford Foundation, developed interventions that support patients and caregivers during care transitions. He demonstrated patient re-hospitalization could be reduced by half through the use of simple tools and coaching. In

another study looking at a representative sample of Medicare patients, Dr Coleman found that 12-25% of poorly managed care transitions required a return to a higher intensity of care setting. His three-item Care Transitions Measure (CTM) was endorsed for public reporting by National Quality Forum in May 2006 and is considered the national standard for assessing transition effectiveness.

His qualitative studies have shown that patients and their caregivers are unprepared for their role in the next care setting, they do not understand essential steps to manage their condition, and they can not contact appropriate health care practitioners for additional guidance. Many patients and their caregivers are frustrated to have to perform tasks that were left undone by health care practitioners in the transition of care.
For more information, see www.caretransitions.org

The Collaborative Experience: The participating teams worked on specific projects to change practice and improve care during transitions. To help them make these changes, the Collaborative included three two-day residential learning sessions, coach training sessions, periodic reporting and coaching, site visits, and team leader meetings. Between each meeting teams worked independently following a plan, do, study, act structure to focus their work. In this way each team benefited from the collective wisdom of all of the teams as well as the expert faculty. They were able to achieve measurable and sustainable improvements in practice. The model for the Collaborative was developed from the work of the Institute for Healthcare Improvement (IHI) in Boston.

Foundation Support: The Community Health Foundation funded all consultation, coaching, education, management and coordination including travel, lodging and meal costs for three people from each team to participate in the learning sessions. In addition, each team received grants of up to $30,000 to support the team's work and the measurement of the project's progress.

The expert consultant team was led by Dr. Eric Coleman, from the University of Colorado, a nationally known expert in transitions. He and his team were trainers at the learning sessions and coach training and provided telephone and in-person assistance to individual teams. The project coaching and management was provided by Christine Klotz, Program Advisor, CHFWCNY.

Foundation Contact: For further details on this Collaborative, contact Christine Klotz, CHFWCNY Program Advisor at cklotz@chfwcny.org, or the foundation office at info@chfwcny.org.

The following table provides highlights about the work of each team. For more information, the Collaborative CD includes a copy of each team's final report with selected run charts, as well as digital copies of assessments, forms, and protocols developed by the teams.

Transitions of Care Quality Improvement Collaborative – Team Highlights

Teams from Central New York

Team – Lead organization in bold	Goal(s)	Project Focus	Highlights of Project
Beechtree Care Center and TC Adult and LTC Services (Ithaca)	By October 2008 we will double the number of residents who are successfully discharged from Beechtree Care Center to the Community (successfully discharged – not readmitted to institutional care within 30 days)	Implemented the transition coach role to support the transition of short-term nursing home patients returning to home. Reduced medication discrepancies at discharge.	• A medication discrepancy check resulted in new procedures. Through the transition coach project, there was near elimination of post-discharge medication discrepancies. • Only 1 of 19 clients were re-admitted within 30 days following coach support
Crouse Hospital and St. Joseph's Home Care Services (Syracuse)	Implement the transition coach role to: • Reduce avoidable ED visits and hospital readmissions for congestive heart patients and atrial fibrillation patients • Improve patient satisfaction • Improve perceived quality of life • Reduce medication incidents	Implemented the transition coach role to support patients with congestive heart failure in their transition from hospital to home care. Expanded project to include atrial fibrillation patients.	• The transition coach has become the standard of care for CHF and atrial fibrillation patients. • Reduced hospital readmissions below target of 9.7% to 3.3% • For those readmitted, reduced length of stay and intensity of care to improve hospital margin • Changed post-hospital medical follow-up procedures • Developed a red-flag tool for patient self-management
Hospice and Palliative Care of Tompkins County and Oncology-Hematology Services at Ithaca Medical Group Tompkins)	1. To improve the quality of life for patients undergoing chemotherapy treatment for advanced cancer by use of a Transition Coach. 2. To ease the transition from aggressive treatment to hospice if that becomes appropriate.	Implemented the transition coach role to create a link between a physician practice and hospice for patients with less than two years life expectancy.	• Even though patients had advanced cancer, the quality of life measure showed small improvements in scores following support from the transition coach. • Emergency calls and visits to the office were reduced for patients with support of the coach.

Teams from Western New York

Team – Lead organization in bold	Goal	Project Focus	Highlights of Success
Alzheimer's Assoc of WNY and Millard Fillmore Hospital (Buffalo)	To improve the transition from acute care hospital to home (with or without post acute rehab stays) for people with dementia and their caregivers.	Implemented the transition coach role to support patients with dementia or Alzheimer's, and their caregivers, transition from hospital to home.	• Improved identification of hospital patients with dementia and memory loss • Finding ways to support family caregivers through transitions with 90% of caregivers reporting improved understanding of triggers for hospitalization • Care Transitions Measure increased following implementation of coach role
Center for Hospice and Palliative Care and Aspire of WNY (Buffalo)	1. Raise awareness of end of life care options, anticipation of changing health needs and person centered advance care planning for the developmentally disabled consumer 2. Reduce unnecessary transfers from the home into alternate care settings.	Used a set of protocols (stop light tools) with staff of residences for the developmental disabled to reduce preventable transitions to ED and acute care for older residents with developmental disabilities.	• Implemented a set of five stop light tools in 11 residential settings • Developing a DVD about the benefits of hospice in work with aging adults with mental retardation and developmental disabilities • Transitions to ER were lower in residences using tool. After the tool was implemented transitions to ER dropped for every target condition and for all other conditions
Community Concern of WNY and TLC Health Network (S Erie and Chautauqua Counties)	To increase self-responsibility and understanding of their health care issues for patients over 60 years of age discharged to the 5 towns.	Implement the transition coach role to link older patients being discharged from the hospital link with community-based services.	• Transition coaching reduced hospital readmissions by 50% • Readmitted patients who received coaching stayed out of the hospital twice as long (69.2 days) compared to patients who declined coaching (38.7 days) • Patient activation scores showed most patients had better understanding of medications and were more prepared to follow up with their primary physician

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Kaleida -- Degraff Hospital and Nursing Home (Erie)	1. Ensure hospital patients have enough information about nursing homes to decrease their anxiety prior to admission and to enable them to work with NH staff in planning for and managing their own care after admission to a nursing home. 2. Collaborate with the pt/resident and hospital/NH staff to manage pain effectively prior to and upon admission to NH. 3. Coaches will ask hospitalized pts about advance care planning 4. Ensure that the status of each NH resident's advanced directive is addressed within 72 hrs following admission.	Implement the transition coach role as part of the LTC screener role to ease the transition of patients from the hospital to the nursing home setting,	• Changed discharge procedures for final pain medication to reduce pain on admission • Through lessons-learned established a collaboration with the Sharing Your Wishes coalition
Council on Aging/ HANCI, Niagara Office for the Aging and Our Lady of Peace (Niagara)	Initiate a self-management support system for well seniors, frail elders and caregivers, as part of a county point-of-entry system to reduce hospitalizations and maintain well-being.	Implement a self-management effort to support hospital and short-term nursing home patients prepare for discharge to home through link with community-based services. Teach well elders to assume more self- responsibility in their care planning.	• Developed a self-management tool focused on four pillars and integrated into a larger program • Following the program: o Use by seniors of a medication management system increased from 71% to 93%; o Taking a medication list to physician appointments increased from 85 to 95%; o Keeping a personal health record increased from 35% to 54%, and o Knowledge of red flags increased from 78% to 97%

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HomeCare and Hospice, Olean General Hospital and The Bogoni Center (Allegany, Cattaraugus, Genesee, Wyoming)	To increase the ability of COPD/CHF patients over 65 yrs. to self manage healthcare and reduce avoidable hospital and ER admissions.	Implement the transition coach role to support the transition of CHF and COPD patients from hospital to home care	• Developed self management tools for CHF and COPD • Only 17.5% of patients with coach support were readmitted within 30 days, 10% within 60 days • Most patients reported goals achieved and showed improved patient activation scores.
Hospice Buffalo, Lifetime Health Medical Group, and Uniform Data Systems of UB	To improve timely access to Hospice for chronically ill frail elders from a primary care practice.	Working with a primary care practice, implement a screening tool to identify appropriate hospice patients earlier and ease their transitions from hospital to home and to hospice services.	• Tested a new tool to identify practice patients who may be appropriate for transition to end-of-life care • Increase hospice length of stay by 33% for COPD patients, 90% for cardiac patients and 74% for cancer patients compared to average hospice LOS. • Use of tool determined care burden and gave practice new information to help discuss end-of-life care options. • Implemented personal health records for older adults in the medical practice
Hospice Chautauqua and WILLCARE Home Health (Chautauqua)	To reduce transfer error and/or delay of treatment for patients over the age of 65 w/ dx of CHF and/or COPD.	Implement the transition coach role to support patients with CHF or COPD as they move between hospital, home care and hospice services.	• Hospital re-admissions for those with transition coach dropped to less than 10 % compared to close to 50% for other patients • CHF and COPD patient length of stay in hospice increased from about 100days to 185 for CHF compared to 80-100 for all patients • Implementing tele-health support to reduce 911 calls

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Hospice Niagara and Niagara Rehabilitation Center (Niagara)	To develop, implement, and test an electronic gateway for clinicians to ascertain a resident/patient's potential for admission into hospice facilitating/prompting either a referral or an opportunity for the delivery of hospice informational materials. This overall goal will benefit patients and families by a) Reduce confusing information regarding appropriateness for hospice care b) Provide hospice information for patients and caregivers to advocate for their health care goals.	Implement an electronic tool to ease the transition of appropriate patients from long-term care and home care to hospice care.	• Developed and implemented an electronic gateway for hospice referrals • Predictable tools for eligibility and admission was over 77% • Gateway implementation led to increased referrals and admissions. Hospice days (in the target facility) increased from 12 in the month prior to the tool to 213 in May.
Parish Nurse Institute, Stall Geriatrics, Niagara University Nursing Program (Erie and Niagara)	1. To assess the efficacy of Parish Nurses acting as transition coaches in maintaining frail elderly in their homes following an acute hospital stay 2. Demonstrate the benefit to the individual faith communities (e.g. # of active faith community members to work on committees and pay dues) and community at large (health care $'s saved through reducing rehospitalizations and emergency room visits)	Integrate the role of transition coach into the role of parish nurses to support the transition of older hospitalized parishioners back home	• Incorporated coach role into parish nurse role, gained national attention for this work with a presentation at the Westberg Parish Nurse Symposium • Quality of Life measures improved in 60% of cases and maintained in others • Care Transition Measures improved in 58% of cases and remained constant in all others • Patient Activation measures improved in 62.5% of cases and remained constant in the others