



## **Improving Transitions of Care** **Through Effective Family Caregiver Partnership:** **A Collaborative to Benefit Frail Elders**

### **Overview**

When frail elders transition from one care setting to another, their moves are often fraught with errors, delays, miscommunication, and a decrease in the patient's and caregivers' control over health decisions. As part of a commitment to enhancing caretaking transitions, the Community Health Foundation of Western and Central New York (CHFVCNY) awarded grants to form a collaborative of fourteen project teams from nine Western and Central New York counties.

A "transition 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.

This work represents the third collaborative supported by the Foundation focused on improving care transitions and deferring frailty in older adults. This collaborative sought to expand on previous learnings by integrating the use of the Care Transitions Intervention (CTI) developed by Dr. Eric Coleman of the University of Colorado Health Sciences Center with the newly developed *Next Step in Care: Family Caregivers and Health Care Professional Working Together*. *Next Step in Care* was developed by the United Hospital Fund, a respected leader in the effort to improve partnerships with family caregivers. In addition, teams were expected to work with their local Sharing Your Wishes coalition for the advance care planning component.

### **The Collaborative Experience**

The fourteen participating teams each worked on identified projects and priorities with the support of advisors. The collaborative process provides a structure for teams to have an immediate impact on care and practice. The collective wisdom of participants and faculty are combined with the resources of committed care-provider organizations to achieve change, quality improvement and measurable results for older adults and family caregivers'. The collaborative model is based on the Quality Improvement Collaborative model developed by the Institute for Healthcare Improvement (IHI) in Boston. Periodic learning sessions, coaching and technical support helped the teams achieve measurable and sustainable results.

In defining their work teams focused on better management of care transitions to improve continuity, reduce error and delay, and increase patient and caregiver control of health decisions. Teams focused their efforts on:

- Improving provider understanding of family caregivers' roles in care transitions. Along with improving family caregivers' abilities to manage and coordinate care during transition.
- Changing practice and systems of care to support the coaching model to increase involvement and transfer knowledge so that patients and their caregivers can better manage care.

The table below contains detailed information regarding the specific project goals of each of the fourteen teams. Some of the key lessons learned by teams include:

1. Often caregivers do not identify themselves as caregivers, making the identification of a family caregiver increasingly difficult.
2. Programs and interventions focused on caregivers must be done in a manner that is flexible and meaningful to them, it cannot feel like a burden or an extra duty.
3. The Care Transitions Intervention (CTI) is a flexible model that easily adapts to a variety of care settings and types of patients.
4. The use of the CTI requires an effective coach who is willing to remove themselves from the “doer” role and works closely with patients and caregivers to transfer knowledge effectively.

## **Outcomes**

By focusing on measurement, teams have tracked what is working and how to sustain or expand on success. Each team identified and tracked key indicators to measure what is done during the collaborative, how well it was done, and the impact of the project on older adults and caregivers. Below is a sampling of the measures of all fourteen teams, further detail can be found in the below chart and in the final summary reports for each team.

### **1. What did The Collaborative do?**

- 862 older adults coached
- 710 caregivers coached and/or educated
- 46 staff trained in the Care Transitions Intervention
- 53 organizations involved, either directly or indirectly in the collaborative work

### **2. How well did The Collaborative do the work?**

- Caregivers reported that staff helped them to better understand their role in care transitions.
- Patients and families have noted that the “*Next Step in Care*” material has been helpful in understanding what to expect when transitions occur, keeping track of medication changes, increasing their knowledge of symptoms and having a central location for information
- Coached patients reported feeling more prepared for care transitions because of the intervention with a coach.

### 3. Is Anyone Better off?

- Teams utilizing the Patient Activation Assessment (PAA), a measure of patients progress in attaining competency in the CTI's four pillars of care, saw an average improvement in score of **56%** compared before the intervention and following the coaching intervention.
- Team utilizing the Patient Activation Measure (PAM), a measure of a patient's level of activation in their own health and health care, saw an average improvement of **25%** in the raw score compared before the intervention and following the intervention.
- Teams measuring re-hospitalization rates indicate that on average coached patients were **24%** less likely to be readmitted to the hospital following the coaching intervention.
- Teams measuring improvement in caregiver confidence report an average improvement of **36%** following the intervention

#### **Foundation Support:**

The Community Health Foundation of Western and Central New York (CHFWCNY) funded all consultation, coaching, education, management and coordination including meeting related expenses. In addition, each team received a grant of \$30,000.

CHFWCNY is an independent private foundation. The mission of CHFWCNY is to improve the health and healthcare of the people and communities of western and central New York. The Foundation has selected two of the most vulnerable and underserved populations in western and central New York to be its priority: *Frail Elders and Young Children in Communities of Poverty*. In 2009, CHFWCNY refined its commitment to elders to defer decline and to help elders function successfully in the community with effective health care, and to children to primarily invest in resources that will benefit children ages birth through five.

## Transitions of Care Quality Improvement Collaborative - Team Highlights

<b>Team – Lead organization in bold</b>	<b>Team Goal(s)</b>	<b>Highlights/Outcomes</b>	<b>Sustainability Plan</b>
<b>Alzheimer’s Association of WNY</b> (Buffalo)	To increase caregivers levels of confidence in managing transition of care.	<ul style="list-style-type: none"> <li>• On average caregivers improved their confidence 28% through a “<i>Next Step in Care</i>” class</li> <li>• Caregivers stated that after attending the class they felt empowered and felt they now know where to turn for help</li> </ul>	The “ <i>Next Step In Care</i> ” material has been incorporated into the materials used when working with family caregivers. There is now a class specific to this material offered regularly at the Alzheimer’s Association Office.
<b>Community Concern of WNY</b> (S Erie and Chautauqua)	To better manage care transitions and to stimulate change in practice that will improve transitions for frail elders, to reduce hospital admission rates and to improve continuity of care for the client.	<ul style="list-style-type: none"> <li>• 64% have remained healthy, 20% were hospitalized after coaching, 9% died, and 7% were placed.</li> <li>• Average Patient Activation Assessment (PAA) scores improved by 22% at post assessment.</li> <li>• Nine out of ten caregivers found the “<i>Next Step in Care</i>” materials to be helpful</li> </ul>	Community Concern of WNY has incorporated the Care Transitions model into normal case management practices. Erie County Senior Services has approved the addition of this service therefore allowing Community Concern to continue coaching older adults.
<b>Cortland Regional Medical Center</b>	To develop a transitions coaching program for the purpose of improving the transition of care from the hospital to home, from rehab to home and from homecare to discharge without services, demonstrated by a reduction in readmissions and increased patient satisfaction.	<ul style="list-style-type: none"> <li>• Prior to coaching 59% of readmitted patients were admitted within 30 days. Following coaching only 22% of these patients were readmitted within 30 days.</li> <li>• On Average patients improved their PAM Raw Score by 27% during the coaching intervention</li> </ul>	The hospital has allotted “per-diem” hours specifically for a transitions coach role. The Hospital will also pursue continued grant funding in hopes of expanding the transition coach role.

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<b>Council for Older Adults (COA)</b> in Niagara County	To improve the family caregiver’s ability to manage and coordinate care during and after care transitions.	<ul style="list-style-type: none"> <li>• Average PAA scores improved by 80% at post assessment</li> <li>• Average Caregiver confidence and knowledge improved by 50% over 30 days</li> <li>• Many of the caregivers and patients stated that they feel less stressed knowing that they can call if they have questions</li> </ul>	The Care Transitions Intervention and the <i>Next Step in Care</i> information have been incorporated into the regular work and activities of the organization.
<b>Crouse Hospital</b> (Syracuse)	To enhance the continuum of care for medically complex community dwelling adults and older adults by improving transitions between levels of care through activation of self care and self management for individuals and caregivers.	<ul style="list-style-type: none"> <li>• Average PAM scores improved from 35.73 (Stage I) at admission to 40.65(Stage III) at discharge</li> <li>• At least 75% of patients involved in the program maintained or improved their functional (ADL) ability as measured by the KATZ</li> <li>• Those physicians surveyed rated this effort 3.5 out of 4.0 indicating they were highly satisfied with the program</li> </ul>	Crouse Hospital selected this project as one of the main foci of quality improvement efforts for 2010-2011. The interdisciplinary process and transitional care will continue to be provided to medical-surgical patients
<b>Hospice Buffalo</b>	To integrate the <i>Transition Coach Model</i> and <i>Next Step in Care Bundle</i> into the current Tele-Connections Program with the goal of improving transition from hospice care to traditional (or no) services to create a catch net for those who are discharged from hospice that will eliminate unwanted ER visits and/or hospitalizations.	<ul style="list-style-type: none"> <li>• 71% of patients have either a HCP, DNR or both and the nurse has had a discussion about the benefits of Advance Directives with 100% of current patients</li> <li>• 83% of current Teleconnections patients say that they are using their personal health record.</li> <li>• Among the current 41 patients there have only been 2 ER/hospitalizations</li> </ul>	Hospice Buffalo has included this program in the 2011 operating budget and the program will continue as currently implemented

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<b>Hospice Chautauqua</b> and WILLCARE Home Health	To identify patients with a life-limiting illness, experiencing a recent decline in condition and who have a primary caregiver daily to be supported throughout the transition from formal home care services to informal support services with hospital admissions, ED visits and skilled nursing facility placements decreased.	<ul style="list-style-type: none"> <li>• Patients were less likely to require an ED visit and/or facility admission if they received transition coach services and their caregivers received ongoing support and education</li> <li>• On average caregivers assessed with the CAM improved their scores by 37%</li> </ul>	The team will continue to collect data to support the use of a transitional services team with those patients who are referred to hospice but unable to be immediately admitted. This data will be used to demonstrate the cost-effectiveness of continuing to use former transition coaches in new liaison roles in the absence of grant funding.
<b>Hospice and Palliative Care of Tompkins County</b> (Ithaca)	<ol style="list-style-type: none"> <li>1. To improve the quality of life in terminally ill hospice patients/caregivers by creating and distributing a “HospiCare Guide”.</li> <li>2. To activate caregivers and patients of new hospice admissions in proactive symptom management and care giving with home visit and telephone follow-up from Transitions Coaches</li> <li>3. To institute a “Discharge Packet” and formal process utilizing the Transition Coach to improve the quality of life of patients discharged from hospice.</li> </ol>	<ul style="list-style-type: none"> <li>• Average percent decline in emergent visits was 18%, indicating an improvement in patients and caregivers ability to manage their symptoms</li> <li>• Average monthly cost for emergent visits declined by 50%</li> <li>• Average percent increase in on-call phone calls was 32.35% <ul style="list-style-type: none"> <li>○ This indicates coached patients knew when to call for assistance rather than allowing their conditions to escalate leading to emergent visits or hospitalization.</li> </ul> </li> <li>• Total cost savings over ten months due to reduced emergent on call visits is \$17,450</li> </ul>	Sustainability has been the goal from the onset of this project. Transition coaching is performed by the Admissions Nurse at onset of service. There are no additional staffing costs associated with the CTI. The sustainability of this work is undeniably clear and is supported by the clinical team, executive staff and board members. The CTI developed by the team has evolved from a project to an integrated part of the organizations comprehensive services.

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<b>Jones Memorial Hospital</b> Allegheny/Western Steuben Rural Health Network and County Office for the Aging	To achieve a sustainable practice change that develops a partnership with family caregivers and improves the outcomes of transitions for frail elders as they move from one care setting to another.	<ul style="list-style-type: none"> <li>• The readmission rate for the project was 6%. (3 patients out of 38)</li> <li>• A 39% decline in re-hospitalizations for coached patients</li> <li>• The project identified a system level medication error rate of 19% leading to key organizational changes to reduce errors.</li> </ul>	The coaching concepts will continued to be utilized with hospitalized patients. As time permits the Case Managers who are coaches will conduct home visits as was done during this intervention.
<b>Loretto</b> (Syracuse)	To use the coaching model to improve transitions to Loretto Housing sites and to St. Joseph's Home Care by having the resident actively engaged in their health management and living environment.	<ul style="list-style-type: none"> <li>• 31% of coached patients improved by one stage level on the Patient Activation Measure (PAM).</li> <li>• 54% of coached patients remained a level 3 or 4 on the PAM</li> <li>• Un-coached patients were 44% more likely to be readmitted to the hospital following their stay in short term rehab.</li> <li>• 69 % of coached patients began following a new medication regime</li> <li>• 94% of coached patients went to their primary care doctor appointment</li> </ul>	The Senior Vice President is currently in conversation with local organizations regarding the grant findings. The organization is exploring other funding options that could possibly be used to continue the coaching model. Also, the Team Leader and Transition coach are exploring ways to integrate the coaching philosophy into the existing role of the Social Work/Discharge Planner and RN roles.
<b>Meals on Wheels of WNY</b> and Stall Geriatrics	To address the nutritional component for clients/caregivers who have a diagnosis of Diabetes and to educate them as to the importance of the nutrition provided by Meals on Wheels for WNY.	<ul style="list-style-type: none"> <li>• 83% of clients reported their stress level was lower as a result of this intervention</li> <li>• 76% of clients reported the information was very helpful in their understanding of diabetes</li> <li>• 39% of clients reported that their blood sugar was lower after receiving the intervention</li> </ul>	Because of the positive feedback from program recipients involved in the grant, the organization has approved its continuation. Coaching will be offered to an expanded group of recipients beyond diabetics to support those older adults in the most need of coaching.

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<b>Orleans County Office for the Aging</b> Medina Memorial Health	To identify patients prior to diagnosis with dementia or those who have dementia like symptoms that flow through local hospitals or other agencies that serve Orleans County residents. Offer coaching services to these patients and their families.	<ul style="list-style-type: none"> <li>• 85% of coached caregivers indicated the education and assistance provided by the transitions coach was “very helpful”</li> <li>• 100% of caregivers surveyed indicated they feel more confident as a caregiver because of the support received by the transitions coach</li> </ul>	The “ <i>Next Step in Care</i> ” resources have been incorporated into the work of the Office for the Aging staff. Coaching will continue under another program offered by the office. The organization plans to continue to work with local health facilities to improve referrals.
<b>Salvation Army,</b> VNS CNY (Syracuse)	To utilizing “ <i>Next Step in Care</i> ” the Salvation Army will develop an education plan and interventions useful to the senior social adult day center participants to impact positive outcomes when they transition to various levels of care and independence.	<ul style="list-style-type: none"> <li>• Of the individuals at the adult day center who attended the workshops, only 3 needed to be hospitalized for more than one overnight stay. <ul style="list-style-type: none"> <li>○ 2 of the 3 indicated feel much more empowered during the hospitalization as a result of the workshops.</li> </ul> </li> </ul>	The Salvation Army will provide care transitions training for Expanded In-home Services for the Elderly Program,(EISEP) case managers and Neighborhood Advisors The VNA is investigating a collaborative effort for transition coaching in cooperation with Crouse Irving utilizing a master’s level candidate in nursing care



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<b>United Memorial Medical Center</b> (Batavia)	<ol style="list-style-type: none"> <li>1. To improve provider understanding of family caregivers' role in care transitions and communicate with them more effectively</li> <li>2. To improve systems and support to increase involvement by patients and their caregivers to better manage their chronic condition</li> <li>3. To reduce inpatient readmissions for CHF by 25% for approximately 200 patients per year</li> </ol>	<ul style="list-style-type: none"> <li>• The rate of re-admits remains about the same. However, the time from discharge to re-admit has increased indicating improvement in symptom management.</li> <li>• The length of stay for re-admitted patients has decreased from an average of 7.6 days to an average of 4.2 days</li> <li>• The cost per patient for services is decreasing yielding an associated increase in net revenue per patient. <ul style="list-style-type: none"> <li>○ Average cost per patient decreased from \$5,717 at program initiation to \$4,870 in August 2010.</li> </ul> </li> </ul>	<p>The Team has meet with Senior Leaders of the organization. It was determined the program can sustain itself, as it has shown the ability to decrease LOS and acuity of readmissions. The team reached out to the Primary Care Providers to educate their patients and their care givers prior to becoming hospitalized, hence increasing understanding of their health and wellness, as well as increasing their understanding of CHF.</p>