

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

Aging Concerns Unite Us

June, 2010

*Supported by: Community Health Foundation of Western and
Central New York*

What is a transition?

- A move from one care setting to another
 - Hospital to rehab
 - Rehab to home
 - Rehab to hospital
 - Opening and closing a home care agency case
- Transition is more than an admission or discharge
- Transition not completed until patient is safely under the care of another prepared provider, who may be a family caregiver

Effective Transitions of Care

- Effective transitions require
 - A prepared practice team with coordination between the sending and receiving care teams

AND

 - Informed, activated patients and caregivers

Your experience?

- Have you or anyone in your family experienced a care transition in the last year?
 - How did it go? Did everything go well? And, did you know your responsibilities along the way?
- How about your experience with your clients?
 - How often do transitions work the way they are planned?

The Community Health Foundation of Western and Central New York

- One of three areas of funding focuses on deferring the consequences of frailty among elders and on helping elders function successfully in the community with effective health care and supports
- Improving transitions of care, reducing falls risks, and supporting medication management are key areas of interest
- Support for Collaboratives focused on Improving Care Transitions

Care Transitions Intervention

Dr Eric Coleman, University of
Colorado Health Science Center

Evidence of Serious Problems with Care Transitions – Dr. Coleman

- Adverse events after discharge
 - 1 out of 5 patients had an adverse event after discharge – most were preventable
 - 2/3 were related to medications
- Medication errors
 - Almost half of hospitalized patients had medication changes without explanation
 - Transfers from nursing home to hospital led to an average of 3 med changes; 1 on 5 led to adverse event

Evidence of Serious Problems with Care Transitions, cont.

- Information transfer
 - Information doesn't go from one setting to the next
 - Often illegible
- Higher costs
 - Higher use of emergency care and hospital care
 - Duplication of tests and services



*Listen to Your Patients and
Families:
They Are Telling You How
to Improve Care Transitions*



Listen to Your Patients and Families: They Are Telling You How to Improve Care Transitions

- Inadequately prepared for next setting
- Conflicting advice for illness management
- Inability to reach the right practitioner
- Repeatedly completing tasks left undone

Information Transfer

“They overmedicated me like you wouldn’t believe [in the NH]. All they had to do was make one call to my primary care doctor”

- Sites of care operating independently
- Poor inter-professional and inter-institutional communication

Findings from Dr Coleman’s focus groups with patients

Preparation

“The doctor did not know that there was no way my wife could take care of me”

- Desire to receive information ahead of time
- Family and caregiver needs often overlooked or expectations for care provision unrealistic

Findings from Dr Coleman’s focus groups with patients

Self-Management

“A lot of times the questions don’t come until you get home”

- Often did not know the questions to ask or the person to direct them to
- Not being able to get through on phone to obtain answers needed to manage condition

Findings from Dr Coleman’s
focus groups with patients

Empowerment

“You know, we’re responsible for our own healthcare and its our fault if we fall through the cracks”

- Contribution to care plan not taken seriously
- Need for an advocate
- SNF staff’s lack of empowerment a barrier

Findings from Dr Coleman’s focus groups with patients

Challenges to Improving Quality

Patient Level



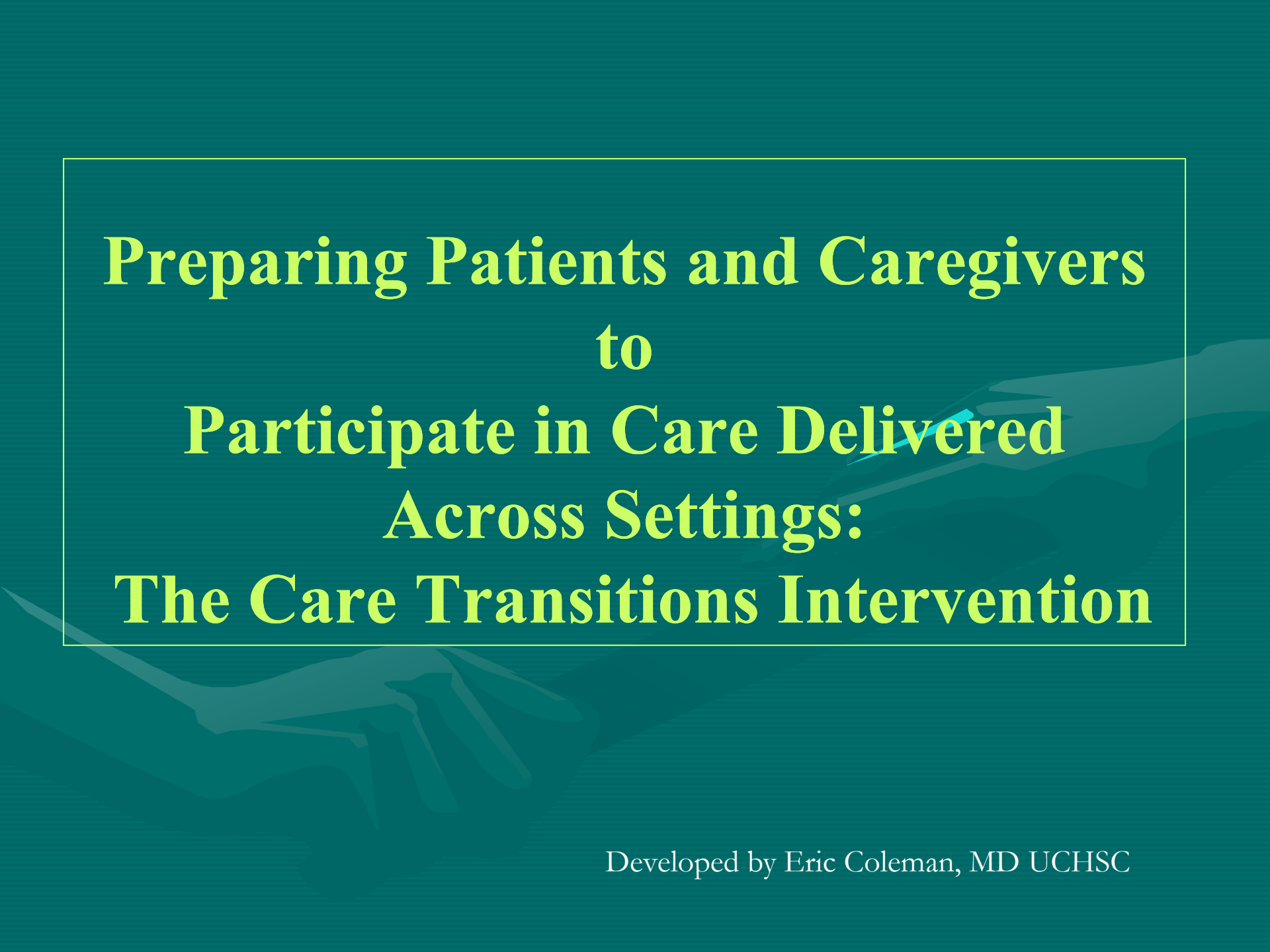
- Institutions fosters dependency and complacency
- This changes abruptly on transfer when expected to assume major role in self-care
- Rising prevalence of cognitive impairment intensifies this challenge

Practitioner Level

- Rare for one clinician to orchestrate care across multiple settings
- Many practitioners have never practiced in settings to which they transfer patients
- Many practitioners don't understand what happens at other sites of care or the importance of including families in decisions

System Problems

- Half of the patients re-admitted within 30 days had not seen a physician
- Health information does not connect between facilities
 - Inter-operability seldom works
- Payments for services have little or no incentive to coordinate care
 - No incentives or penalties for poor transitions



**Preparing Patients and Caregivers
to
Participate in Care Delivered
Across Settings:
The Care Transitions Intervention**

Developed by Eric Coleman, MD UCHSC

Key Elements of Intervention

- “Transition Coach” (Nurse or Nurse Practitioner)
 - Prepares patient for what to expect and to speak up
 - Provides tools (Personal Health Record)
- Follows patient to nursing facility or to the home
 - Reconcile pre- and post-hospital medications
 - Practice or “role-play” next encounter or visit
- Phone calls 2, 7 and 14 days after discharge
 - Single point of contact; reinforce, ensure follow up

Four Pillars

- Medication self-management
- Patient-centered record (PHR)
- Follow-up with PCP/Specialist
- Knowledge of “Red Flags” or warning signs/symptoms and how to respond

Improving Transitions of Care

Through Effective Family Caregiver Partnership: A Collaborative to Benefit Frail Elders

- Fourteen Teams are participating in a Collaborative working on improving transitions of care
 - Hospital to home
 - Transitions in and out of hospice
 - Long term care and home care agencies
 - Community agencies working with older adults and caregivers not related to a direct transition

Self-Care Support for the “Silent” Care Coordinators

- Patients/family caregivers perform a significant amount of their own care coordination
- Employing the Care Transitions Intervention can transfer a core set of transition-specific self-care skills to help patients/family caregivers ensure that their needs are met
- We looked for something more, something that would help family caregivers and turned to United Hospital Fund

