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Care Transitions: Empowering Older Adults with Post-Hospital Interventions

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Case Study

Care Transitions: Empowering Older Adults with Post-Hospital Interventions

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Educational Objectives

1. Understand how Care Transitions Interventions® (CTI®) can decrease hospital readmission rates among older adults, ages 60 and over.
2. Recognize how CTI® services assist older adults to stay in their homes after hospitalization for 30 days or more without unnecessary readmissions.
3. Appreciate examples of ways Senior Connections, The Capital Area Agency on Aging, collaborates with community partners.
4. Identify how Senior Connections refers older adults and caregivers to community resources for effective utilization and outcomes.

Background

Older adults may have necessary hospital stays due to chronic conditions and look forward to returning home. Yet, many end up going back to the hospital because of complications, confusion, or because they or their caregivers were not prepared to manage their care. The Centers for Medicare and Medicaid Services estimates that nearly one in five Medicare beneficiaries readmits to the hospital within 30 days of discharge. (Centers for Medicare and Medicaid Services, 2019) It is crucial for those recovering to have adequate and safe housing, good nutrition, available transportation for medical appointments, and, especially, an understanding of what to do to after hospitalization.

When patients are about to be discharged from the hospital, a medical provider reviews specific instructions with them and any caregivers present. All may be focused on leaving the hospital itself rather than absorbing this important information. There are several other reasons why there may be unsuccessful information sharing at the time of discharge, including changes in care settings; providers who fail to communicate well; confusion over which medications to take upon returning home, resulting in errors and complications; and discharge instructions that are confusing or that conflict with information received from other providers.

Older adults discharging from the hospital can experience successful recoveries when empowered with knowledge on how to manage their health. Knowing

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what to expect and having a plan on what to do in the event of health setbacks can help prevent unnecessary hospital readmissions. The ability to visualize a desired lifestyle after recovery is equally important.

Coleman Care Transitions Intervention®

Eric Coleman, MD, MPH, a nationally recognized expert on hospital-to-home care transitions, has developed an evidence-based model to reduce high readmissions rates. To address the problems of uncoordinated and fragmented care during the period of hospitalization and transition back to home, the John A. Hartford Foundation awarded the University of Colorado Health Sciences Center, Denver, a five-year grant in 2000 to develop the Care Transitions Intervention® focusing on the critical first 30 days after discharge. Dr. Coleman, a Robert Wood Johnson Clinical Scholar and a Beeson Scholar, served as principal investigator of this project.

During the 30-day Care Transitions program, patients with complex care needs and family caregivers work with a Care Transitions Health Coach and learn self-management skills that will assist in easing their transition from hospital to home.

The 30-day Care Transitions Intervention® (CTI®) begins with a visit by the Health Coach to the patient in the hospital, at which time the Health Coach introduces the CTI® program to the patient and/or caregiver at the bedside. The Health Coach gives the patient a Personal Health Record, a pamphlet to be used as a tool to record his or her individualized health information and instructions following discharge. Subsequently, this tool is reviewed in detail during the Health Coach's home visit with the patient, which is ideally scheduled to take place within the first three days following the patient's discharge from the hospital. After the home visit, the Health Coach makes three weekly phone calls to follow up with the patient's progress. After the third phone call, at 30 days following discharge, the case is closed.

The Coleman Care Transitions Intervention® Model focuses on The Four Pillars®:

1. Medication self-management
2. The Personal Health Record
3. Timely primary care/specialty care follow up
4. Knowledge of red flags that indicate a worsening in their condition and how to respond

At the CTI® home visit, the Health Coach coordinates with the patient to have him/her reconcile medications, comparing the previous medicines taken by the patient to those ordered at discharge. Many hospital readmissions are caused by mistakes or confusion regarding which medications to take following discharge, and in what dosages. The Health Coach makes certain that the patient or caregiver knows the name of each medication, its purpose, and the proper dosage. The Health Coach assists the patient with calling the pharmacist or primary care physician, if any clarification is needed.

The CTI® Personal Health Record previously given to the patient at the hospital visit is brought out at the home visit, and the Health Coach assists in guiding the patient in recording individual information in the pamphlet. The patient lists medications being taken and any questions to ask of the primary care physician and/or pharmacist. The Health Coach also asks the patient to visualize and record details of an activity that he or she might reasonably resume 30 days from the time of the home visit. Some patients look forward to attending an important social or family event, while others may simply desire to return to gardening in their yard.

Every patient discharged from the hospital is instructed to have a follow-up appointment with his or her primary care physician within a week of discharge. Often, this appointment is scheduled for the patient prior to discharge, and the information is included in the discharge documents. The Health Coach can remind the patient of the appointment and assist in arranging for transportation to and from the appointment. This primary care physician appointment is essential for transferring the first point of contact from the hospital to the primary care physician.

Recovery from a hospital stay often has its setbacks. The Health Coach discusses the patient's condition and reviews potential symptoms that may require additional medical attention. These "red flags" are addressed individually and the Health Coach assists the patient in devising a plan of action to adopt in the

event they should occur. When at all possible, the Health Coach encourages the patient to notify the primary care physician or specialist, rather than making the hospital emergency department the first resource.

After the home visit, the Health Coach makes three weekly phone calls to the patient or caregiver. They discuss the outcome of the follow-up appointment with the primary care physician, whether the patient has experienced any red flag symptoms, and how the patient is progressing toward personal goals.

Senior Connections' Care Transitions Program
To address repeat hospitalizations among older adults with chronic illnesses, and to improve quality of care by reducing unnecessary readmissions, Virginia's Area Agencies on Aging have individually and collectively joined with community partners to provide patients with successful care transitions from hospital to home. Senior Connections, The Capital Area Agency on Aging, began its Care Transitions Program in 2014 as part of the Community-based Care Transitions Program (CCTP). Created by Section 3026 of the Affordable Care Act, the CCTP tested models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.

Three full-time and one part-time Health Coaches completed the Care Transitions Intervention Coach Training Program® in multi-day sessions in Richmond, Virginia and Denver, Colorado. Training consisted of lectures by Dr. Coleman and staff, observation and discussion of video CTI® examples, and role playing. Each Coach was certified in CTI® before Senior Connections began its program.

Senior Connections established partnerships with area hospitals in working to reduce hospital readmissions among older adults, under the CCTP, starting in 2014. Hospital case managers forwarded referrals for patients meeting the following criteria: 60 years old, or older; a primary diagnosis of: COPD, pneumonia, sepsis, congestive heart failure (CHF), acute myocardial infarction (AMI), diabetes, stroke, renal failure, or atrial fibrillation; and residing in Senior Connections' Planning District of the counties Hanover, Henrico, Charles City, Chesterfield, Goochland, New Kent, Powhatan, or Richmond City.

The Health Coaches followed the Coleman Model in Care Transitions Interventions® for each participating patient. In addition, the Coaches observed the patient's home environment during the home visit, and listened to the patient and/or caregiver for indications of needs.

Connections to Resources

Health Coaches can make direct referrals to resources within Senior Connections which benefit the patient and improve the probability of a good recovery, such as home delivered meals, respite care, and transportation. Patients requiring multiple resources were referred to Senior Connections' Care Coordination Program for individual follow-up and assistance. Patients who are homebound may not have a dependable food resource. Of course, good nutrition is essential for life and for a healing body. If the Senior Connections' Care Transitions (CT) Health Coaches learn of a nutritional need during the home visit, they will refer a patient who qualifies to the Home Delivered Meals Program. Patients qualify if they are unable to leave home unassisted and have no one to help regularly with meal preparation.

Home delivered meals recipients receive hot meals consisting of meat or other protein food, vegetables, fruit, bread, milk or other dairy food, and dessert. Those requiring special diets such as diabetic, renal, and vegetarian receive meals prepared accordingly. Foods may be chopped or pureed, if needed. Daily social contact from the delivering Meals on Wheels volunteer offers a means for regular check-in. Senior Connections provides an annual reassessment with each meals recipient for eligibility and other needs.

Older adults and their families may encounter increasing needs, yet be at a loss to know how to obtain assistance. CT Health Coaches may recognize a need that the discharged patient has for personal services to assist with activities of daily living. They would then make referrals to Senior Connections to apply for respite services. The Senior Connections Care Coordinator would then complete personal assessments during a home visit and may also coordinate additional resources beneficial to the patient. Senior Connections contracts with community-based service agencies to provide services like homemaker or

personal care services.

The follow-up primary care physician appointment, scheduled within seven days after discharge from the hospital, is a key element in proceeding toward a good recovery. The CT Health Coach asked each patient if he or she had transportation arrangements in place for the appointment. If needed, the Coach could make an internal referral for the patient to Senior Connections' Ride Connection resource, a mobility management program, helping older adults and persons with disabilities to access transportation so they might remain safely at home and live a healthy, connected life. For those who meet eligibility requirements, Ride Connection provides a limited number of round-trip rides to medical appointments for persons living in the City of Richmond and surrounding counties. Ride Counselors offer transportation education, travel training, and referrals to local transportation providers, as well as discounted GRTC fixed route bus and CareVan tickets, and Chesterfield Access vouchers on a limited basis.

Social determinants of health can affect not only health care access, but also health care outcomes. Senior Connections provides opportunities throughout the region for older adults to pair socialization with sustenance through its Friendship Cafés. These are neighborhood gathering places for older adults where a nutritious midday meal is served; they are in 20 churches and community centers in Richmond and surrounding counties. Meeting up with good friends and participating in diverse activities helps to assure that participants remain active and connected to the community, while meeting their nutritional needs.

Case Study #1

Mary G. was in the hospital, diagnosed with pneumonia. The hospital Case Manager referred her for Care Transitions services. Mary is 74 years old and lives with her husband, Ed, in North Chesterfield. Her daughter, Cynthia, was at the hospital bedside when the Senior Connections Health Coach introduced the CTI Program. Mary was scheduled to be discharged later that day, and a home visit was scheduled for the following day. At the home visit, the Health Coach met with Mary and Ed. The Health Coach reviewed the Four Pillars of the CTI and found that the patient's goal was to go back to church. Mary's follow-up appointment with her primary care provider (PCP) was scheduled in five days and her daughter would take her there. Mary had her hospital discharge summary listing her medications and instructions for taking them. The Health Coach reviewed each and made certain that Mary and Ed understood what each was and the purpose for taking the medicine. Together, they reviewed "red flags" associated with Mary's condition and she and her husband agreed they would call the PCP if any occurred, rather than taking a chance on waiting and having a more serious condition develop. When Ed indicated that he and Mary are unable to see friends as much as they used to, the Health Coach gave them information on Senior Connections' Friendship Cafes and found one near their home. Once Mary recovers, she and Ed can participate together in social activities and enjoy lunch there on weekdays. They both expressed gratitude for the attention, support, and confidence gained as Mary recovers.

Case Study #2

A hospital Case Manager introduced a Senior Connections Health Coach to Barbara, a 68 year old woman in the hospital's ICU. She was receiving care for complications due to diabetes. Barbara was to be discharged that day, and a Care Transitions home visit was scheduled for the following day. Barbara lives alone in a small, neat apartment across the street from the hospital. She stated she often goes to the hospital cafeteria for lunch. At the home visit, she and the Health Coach reviewed the Personal Health Record, in which Barbara recorded each of her medications. Some medications were new, prescribed while in the hospital. Barbara had a question regarding the proper dosage for one of them and was unsure about who to call and the right questions to ask. Instead of calling on the patient's behalf, the Health Coach helped Barbara clarify what her question was and role played how the phone call to the pharmacy might go. Barbara made the phone call during the home visit and obtained the answer to her dosage question. The Health Coach also coached Barbara as she rescheduled a follow-up doctor appointment which conflicted with another medical appointment that had already been set. Barbara stated that she receives medical transportation assistance from friends at her church.

Barbara and the Health Coach reviewed potential red flags regarding her condition and what to do in case they occurred. Barbara agreed it would be best to call her primary care physician when symptoms first arise. They also discussed her plans for the upcoming holiday. The Health Coach followed up with Barbara by phone over the following three weeks. Barbara continued to recover and remained out of the hospital during that time.

Case Study #3

A Senior Connections Health Coach was referred by a hospital case manager to make a home visit with a patient who had been discharged earlier that day. Magda is a 79 year-old woman who had been hospitalized with COPD. A former smoker, she is on oxygen and struggles to reach her bedroom on the second floor of her home. She lives with her daughter, Betty, in a townhouse in Richmond's Oregon Hill neighborhood. Betty is her mother's primary caregiver and provides transportation to doctor appointments. Magda reported being alone at home a great deal, as Betty works full-time. She finds moving around her home to be strenuous due to having difficulty breathing. The Health Coach reviewed the Personal Health Record and the other three Pillars of the Coleman CTI Model with Magda and Betty. Betty had many questions about her mother's medications, and the Health Coach reviewed each one in detail. Magda does not get out of the house often, and the Health Coach told her about Senior Connections' TeleBridges telephone reassurance program. Magda could receive phone calls from volunteers who would check in two to five times each week to listen to and encourage her. The Health Coach made three coach calls to Magda over the next three weeks and learned Betty had inquired about TeleBridges on Magda's behalf. Magda reported she had been writing down questions ahead of doctor appointments in her Personal Health Record so that she would be reminded to ask them during the visits. She indicated she is feeling more confident about managing her health, and is optimistic about the future. She did not have a hospital readmission during the following month.

No Wrong Door and Care Transitions

Senior Connections is part of Virginia's No Wrong Door Network (NWD), enabling CT Health Coaches to enter data on hospital and home visits along with the weekly coach calls. NWD also allows Coaches to make electronic referrals to resources both within Senior Connections and outside to other agencies that use the system. As the NWD website explains:

"The No Wrong Door System allows providers, who are serving the same individual, to securely share personal-level data between partners, eliminating the need to collect the same information over and over again. The cornerstone of No Wrong Door is an electronic tool called CRIA (pronounced "cree-yah," which stands for Communication, Referral, Information and Assistance). Using CRIA, NWD partners can make electronic referrals to each other with the click of a button. With consent, the referral includes all the information needed for the "receiving partner" to begin working with the individual immediately. Just imagine how much time it could save if the information that you normally collect during intake or enrollment, is already at your fingertips. Imagine how much more personal your first meeting could be if you have access to an individual's background and situation, prior to meeting them. Imagine if you could see a snapshot of the status of all of your referrals at any given time. All of this is possible within No Wrong Door."

Outcomes

Senior Connections' Care Transitions Program using the Coleman CTI® Model dramatically reduced 30-day hospital readmissions among older adults in the Richmond region.

Senior Connections is a member of the RVA Care Transitions Coalition (RVACTC), a group that works with Health Quality Innovators (HQI), the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Virginia and Maryland. As a participant in the Care Transitions Project, the RVACTC received quarterly, aggregate, community data reports from HQI reflecting hospital readmissions among Medicare Fee-For-Service beneficiaries. In the third quarter (June-September) of 2015, 18.38% of Richmond-area Medicare beneficiaries were readmitted to the hospital within 30 days of discharge. The most recent available data

(January-March 2019) shows a readmission rate of 17.18%.

Senior Connections began tracking its CTI® program's data in the fall of 2015. Between then and May 2019, 1216 people completed the CTI. The first year (October 2015-September 2016) showed an overall 30-day readmission rate of 12.0% for patients completing the CTI® Program. During the following year, (October 2016-September 2017) the 30-day readmission rate was 5.4% for patients completing the 30-day CTI® Program. Subsequent years showed continuation of these reduced rates: 7.9% for October 2017 to September 2018 and currently 6.9% (October 2018 through May 2019).

Conclusion

Senior Connections' Care Transitions interventions have resulted in greatly reduced 30-day readmissions rates for those older adults served. The CTI® model provides a short-term period of support to educate and empower older adults and their caregivers in managing health outcomes. Through successful Care Transitions Interventions®, older adults learn about their illnesses, what to expect during recovery, and how to be proactive regarding their own care.

Senior Connections has been able to arrange for additional services such as home delivered meals, transportation, and socialization opportunities to those needing assistance to remain in their own homes during recovery and beyond. Our success has resulted in our being recognized with a 2019 Best Practice Award from the Commonwealth Council on Aging. The program's success, funding partners, and recognition combine to establish Senior Connections' Care Transitions program as consistent with the agency mission: *Empowering seniors to live with dignity and choice.*

Study Questions

1. What advantages do caregivers have in applying care transitions skills to support older adult patients in their recoveries?
2. Hospitals and senior services providers have established partnerships in encouraging successful recoveries for older adult patients. What other partnerships might be beneficial in this effort?
3. How can Care Transitions practices be expanded in the community?

Resources

Centers for Medicare and Medicaid Services, Community Based Care Transitions Program. Retrieved August 16, 2019 from https://innovation.cms.gov/initiatives/CCTP/

Care Transitions Program, https://caretransitions.org/ (for more information on Care Transitions Intervention, Dr. Eric Coleman)

John A. Hartford Foundation, Care Transitions Model www.johnahartford.org/ar2007/pdf/Hart07_CARE_TRANSITIONS_MODEL.pdf

Medicare Part A Claims, April 2013 through January 2019. Data provided to HQI as Medicare QIN-QIO.

No Wrong Door Virginia, www.nowrongdoorvirginia.org/providers.htm

Pooler, J., Srinivasan, M. (2018). Issue Brief: Social Determinants of Health and the Aging Population www.impaqint.com/sites/default/files/issue-briefs/Issue%20Brief_SDOHandAgingPopulation_0.pdf

Ride Connection, https://seniorconnections-va.org/services/support-to-stay-home/ride-connections/

Senior Connections, The Capital Area Agency on Aging, https://seniorconnections-va.org/

About the Author

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