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Guest Editor's Message

By Cathy Jo Cress, MSW

An estimated 90% of hospital readmissions take place within 30 days of discharge and are unintended. These readmissions, often avertable, cost Medicare \$17.4 billion in 2004. The financial toll of avoidable readmissions is only one harmful effect on the U.S. health care system, now in the process of a major reinvention. The human cost of repeated disease can be equally damaging in terms of the corrosion in function, reduced symptom-free days, and loss of faith in a health care system previously trusted to preserve or improve health. Health care errors and adverse events often associated with transitions in care only swell national discontent and growing very public distrust in our poorly performing system.

Health care reform, exemplified by the Affordable Care Act of 2010 (ACA), propels the topic of chronic care into the forefront and speaks for the need to mandate care coordina-

tion. The hunt for ways to improve health care for older persons with chronic illnesses put the spotlight on areas where care is deficient and costly. Transitions of care (TOC) are one such segment of the health care experience.

For years GCMs have provided services to their clients during transitions of care. Routinely moving clients from home to hospital to rehabilitation and back home, or to alternative living arrangements, GCMs have advocated for their clients. By transmitting and reconciling medications and other information from one provider to another; counseling and educating clients and their families about health conditions; navigating warped systems and coordinating services to meet changing client need, GCMs are experts in spotting the gaps and filling them.

Geriatric care managers can help the long-term care system, doctors,

and hospitals by becoming a part of the LTC and transition in care system and the hospital-to-home team. They can do this providing the necessary coaching and support to patients and their families so that older clients are not readmitted, and stay in the community, thereby reducing health care system expenses.

This issue of the Winter Geriatric Care Management Journal contains articles that show recent studies and research on transitions in care and demonstrates how geriatric care managers can be part of that home team and actually prevent hospital admission while doing their regular job. That job is using the continuum of care to keep older clients at the safest level of care.

I want to thank the following authors for creating a new dimension to the dialogue and call for action for GCMs: Robin Jones, Marisa Scala-Foley, Michelle Washko, Caroline Ryan, Abigail Morgan, M. Brian Bixby, Deborah Newquist, and Rona Bartelstone.



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Bridging the Gap: The Role of Geriatric Care Managers in Reducing Avoidable Hospital Readmissions

*By Marisa Scala-Foley, MGS, Michelle M. Washko, PhD,
Caroline Ryan, MA, Abigail Morgan, MSS, MLSP*

Summary

Avoidable hospital readmissions have received scrutiny due to their link with poor quality health outcomes and high care costs. Two provisions of the Patient Protection and Affordable Care Act specifically target avoidable hospital readmissions, one of which focuses on care transitions -- the movement of patients between health care practitioners and settings as their condition and care needs change during an illness. Proper planning offers a proven way to prevent rehospitalizations and improve outcomes for patients. This article discusses the role of geriatric care managers within care transition teams and strategies implemented by care transitions programs to reduce avoidable hospital readmissions.

Introduction

Viewed as an indicator of poor quality and high cost, the problem of avoidable hospital readmissions has received increasing scrutiny in recent years, with policymakers, payers, health systems, health and long-term supports and services providers, and community-based organizations alike working toward reducing rehospitalizations (MedPAC, 2007; MedPAC, 2008). Nearly one in five Medicare beneficiaries discharged from the hospital are readmitted within 30 days, and about one-third within

Nearly one in five Medicare beneficiaries discharged from the hospital are readmitted within 30 days, and about one-third within 90 days, and up to 76 percent of these readmissions may be preventable (MedPAC, 2007).

90 days, and up to 76 percent of these readmissions may be preventable (MedPAC, 2007). Such unwanted hospital readmissions have high costs – both financially, for health care payment systems, as well as physically and emotionally for people with Medicare and their families. In 2004, Medicare spent \$17.4 billion in hospital payments on unplanned readmissions (Jencks, 2009).

The 2010 Patient Protection and Affordable Care Act (ACA) has a three-part aim of better care for individuals, improved population health, and lower costs. While numerous provisions of the ACA seek to foster improved care coordination for Medicare and Medicaid beneficiaries, two provisions specifically target avoidable hospital readmissions, albeit in different ways. Section 3025 authorizes the Secretary of Health and Human Services to reduce Medicare payments to hospitals with higher-than-expected readmission rates, and Section 3026

establishes the Community-based Care Transition Program, which provides funding to community-based organizations and hospitals that “furnish improved care transition services to high-risk Medicare beneficiaries” (H.R. 3590, 2010). The Community-based Care Transition Program is part of a companion effort undertaken by the U.S.

Department of Health and Human Services called the Partnership for Patients. One of the two major goals of the Partnership is to “help patients heal without complication,” aiming for a 20 percent reduction in hospital readmissions by the end of 2013 (U.S. Department of Health & Human Services, 2011).

Readmissions and Care Transitions

Care transitions are defined as “the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness” (University of Colorado Denver, 2011). Such transitions might include going from a hospital or skilled nursing facility to home, from a hospital to a skilled nursing facility, from one level of care to another (e.g., from a surgical unit to an intensive care unit within a hospital), or even from one form of

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payment to another (e.g., from private pay to a Medicaid waiver).

Poor care transitions can result in medication errors, gaps in follow-up care, miscommunication, unnecessary rehospitalizations, and nursing home admissions (Jencks et al, 2009; American Geriatrics Society Health Care Systems Committee, 2007). A 2009 AARP survey of persons with chronic conditions found that 21 percent of those surveyed felt that their health care providers did not communicate well with each other – with 20 percent believing that this had had a negative impact on their health. Nearly 20 percent also cited a lack of coordination in their care transitions (AARP, 2009).

In addition to the medical factors associated with poor transitions, unmet needs in the community can impact the success of care transitions. Some studies have found that between 40 and 50 percent of readmissions may be due to social factors and a lack of access to community resources (Proctor et al, 2000). In a recent study evaluating the home food environment of hospital-discharged older adults, one-third of participants reported being unable to both shop and prepare meals after discharge (Anyanqu et al., 2011). Medicaid waiver program research also demonstrates that greater volume of attendant care, homemaking services, and home-delivered meals are associated with lower risk of hospital admissions (Xu et al, 2009).

Supporting care transitions needs to be a collaborative, community-based process that brings together professionals from all health-care related fields – including geriatric care management – to facilitate smooth transitions and prevent readmissions (Ventura et al, 2010). This article will discuss the role of geriatric care managers within care transition teams and common strategies implemented by care transitions programs to reduce avoidable hospital readmissions.

Care Transitions—Addressing the Problem

Transitional Care – defined by the American Geriatrics Society as “a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location” – is designed to prevent unnecessary rehospitalizations and improve outcomes for older people (American Geriatrics Society Health Care Systems Committee, 2007). Evidence-based care transition models -- including the Care Transitions Intervention (University of Colorado Denver, 2011), the Transitional Care Model (University of Pennsylvania School of Nursing, 2011), Better Outcomes for Older Adults through Safe Transitions, or BOOST (Society of Hospital Medicine, 2011), Guided Care (Johns Hopkins University, 2011), Geriatric Resources for Assessment and Care of Elders, or GRACE (Counsell et al, 2006), the Bridge Program (Illinois Transitional Care Consortium, 2011), Project Re-Engineered Discharge, or RED (Boston University Medical Center, 2011), Interventions to Reduce Acute Care Transfers, or INTERACT (Florida Atlantic University, 2011), and more -- have been developed to provide support to individuals and caregivers during and after the transition across hospital, skilled nursing facility, and community settings.

While the models may differ in terms of staffing, duration, and target setting, in most care transitions programs, individuals and caregivers at risk for poor transitions and hospital readmissions are identified and connected with designated care transition staff prior to discharge. Interdisciplinary communication and coordination as well as patient activation ensures that individuals and their caregivers understand post-discharge instructions regarding their medications and self-care, connect with outpatient physicians and other community services and supports post-discharge, and recognize and know how to respond to symptoms that may indicate potential complications.

Care Transitions and the Aging Network

In 1965, Congress enacted the Older Americans Act (OAA) to provide a broad range of coordinated services to older Americans which would enable them to maintain maximum independence as they increase in age. These services include nutrition programs, health promotion activities, ombudsman services in Long-Term Care settings, home- and community-based services, and caregiver support, to name a few. This legislation also created the AoA and the “Aging Network” — a national system with entities at the federal, state and territorial, tribal, and local levels. It includes 56 State Units on Aging, 629 Area Agencies on Aging (AAAs), 246 tribal organizations, some 20,000 local community service organizations, hundreds of thousands of volunteers, and a wide variety of national organizations, all of which work together to provide social services to older adults. State Units on Aging, which are state and territorial government agencies, administer, manage, design, and advocate for benefits, programs, and services.

More locally, Area Agencies on Aging provide a range of services that help individuals remain in their homes and communities for as long as possible. The Aging Network serves large numbers of older people and individuals with disabilities, including diverse populations and those with low incomes. Through this network, AoA reaches approximately 11 million individuals each year. The Aging Network receives not only the majority of AoA’s federal appropriation, but also funding from a variety of other sources (including the Centers for Medicare & Medicaid Services, or CMS, and the Department of Veterans Affairs, or VA) to deliver long-term services and supports. AoA is the only federal-level agency solely devoted to serving the social service needs of Americans aged 60 and over by means of programmatic activity. The Aging Network specifically targets services to the most vulnerable and frail elderly, and participants in Older Americans Act (OAA) services are more likely to be in poor health, need support

for multiple Activities of Daily Living (ADLs) and more likely to be managing multiple chronic conditions (Kleinman and Foster, 2011; Altshuler and Schimmel, 2010). It is this target population that is most likely to be at risk for multiple hospital readmissions and can benefit from support during transitions across settings.

Supporting transitions across care settings has been an Aging Network activity for many years, and AoA and CMS have funded several initiatives related to improving the coordination of care transitions. Since AoA and CMS first began supporting the development of Aging and Disability Resource Centers (ADRC) in 2003, ADRCs have been working to assist individuals in “critical pathways,” defined as the times or places when people make important decisions about long-term supports and services. This work included several innovative community interventions to facilitate the hospital discharge process and help nursing facility residents return to the community. In 2009, AoA and CMS named “person-centered hospital discharge planning” as a key operational component of an ADRC and in 2010, 16 states were awarded funding to significantly strengthen the role of ADRCs in implementing evidence-based care transition programs (Administration on Aging, 2011).

Many care transition programs within the Aging Network are able to capitalize on existing infrastructure to implement evidence-based care transition strategies and provide increased access to critical long-term services and supports post-discharge. For example, community care transition staff from an ADRC or AAA not only provide options and access to transportation and remove barriers for attending physician appointments, but also empower and educate individuals on how to make the most of the appointment. Connection to community-based programs and services are especially important for individuals who need support

beyond the short-term care transition program period which may also have the potential to impact frequency of readmissions (Proctor, 2000).

Care Transitions and the Current Role of Professional Geriatric Care Managers

Professional Geriatric Care Managers are important partners within local Aging Network initiatives and these community partnerships play a critical role within interdisciplinary care transitions teams. As members of care transition teams, it is helpful for professional Geriatric Care Managers (GCM) to understand effective care transition strategies and how these strategies fit within their current professional roles and responsibilities.

Many care transition programs within the Aging Network are able to capitalize on existing infrastructure to implement evidence-based care transition strategies and provide increased access to critical long-term services and supports post-discharge.

Often the first transition that individuals experience within the health care system is the transition from the community to the hospital, and can provide important information to the hospital about the resources and supports that the individual and caregiver accessed prior to hospitalization. Community transition partners, including GCMs, have the unique ability to move across settings with the individual and caregiver, and the community is also frequently the last “receiver” post-discharge from healthcare settings. GCMs and community-based care transitions staff, such as AAA/ADRC staff, serve an important role in preparing the individual and caregiver for the next care setting through medication reconciliation, patient activation, an

introduction to warning signs and symptoms, and development of a post-discharge follow up plan (Parry et al, 2003). Finally, successful transitions across care settings depend upon effective communication, incorporating multi-disciplinary team perspectives with sharing important client information and building a sense of shared accountability as individuals transition from one setting to another (Parry et al, 2003).

In terms of the current roles of GCMs, NAGCM standards of practice relate well to the common elements of successful care transitions. Of particular note are the standards relating to the client relationship and professionalism of practice: (1) identifying the client, (2) promoting self-determination, (3) right to privacy, (4) definition of the role to other professionals, and (5) development of care plans (National Association of Professional Geriatric Care Managers, 2011).

- Identifying the client. GCMs serve as client advocates and liaisons between various members of the client’s system, including family members, in-home aides, physicians and others (Kelsey & Laditka, 2007). This standard reinforces the concept of patient activation,

where self-management of health and health decisions must include both the patient and family as part of the core health care team (Bodenheimer et al., 2002). This standard also relates to the theme of shared accountability and collaboration between providers in order to support a care transition. A GCM has the ability to examine the client system across care settings and collaborate with community partners to provide important insight to health care professionals whose perspective and influence may be limited to a particular setting.

- Promoting self-determination. Core to this standard is the GCM

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identifying and articulating clients' values and preferences in their care plans, regardless of the physical, mental or emotional capacity of the client (National Association of Professional Geriatric Care Managers, 2011). This standard can be most closely tied with the care transition theme of patient activation. Patient activation describes an individual's ability to self-manage their own health, and personally engage in option development and decision-making processes (Hibbard et al, 2004). Rather than responding to presented care options, clients and family members should be full collaborators and developers of their own health goals to the maximum extent possible.

- Right to privacy. The right to privacy needs to be maintained to the maximum extent possible, while fully disclosing the limits to confidentiality upfront to the client. Previous qualitative studies indicate that GCMs continue frequent contact with clients across various hospital, nursing home and home settings, and often act as patient advocates (Dobrish, 1987, Kelsey & Laditka, 2007). As such, GCMs can be integral members of an interdisciplinary care transitions team. Such a role may require additional considerations for disclosing patient or client information. Client populations that are at high risk of multiple readmissions will require upfront discussions and preparation of appropriate agreements (informed consent, release of information, etc.) for the GCM should they be hospitalized. Considerations can include:
 - o How will a GCM be notified of a hospitalization
 - o What role does the client wish the GCM to play during the hospitalization, and how will

information about this role be conveyed to other members of the care transitions team, such as hospital, rehabilitation, or nursing facility staff.

- o Whether GCM will need business affiliate agreements with hospitals under HIPAA -- or will hospital case management department consider a GCM a member of the core care team, therefore bypassing HIPAA requirements (Yang & Kombaracaran, 2006).
- Definition of the role to other professionals. GCMs should clearly define their role and scope in terms of a client's wishes and the GCM's professional capacity (National Association of Professional Geriatric Care Managers, 2011). This standard most closely aligns with the critical theme of supporting multidisciplinary communication and shared accountability during a transition across the continuum of care. GCMs can serve as the bridge between actively engaged patient and family members and the professional health care team. In addition to providing perspective of clients across the continuum of care, GCMs bring an underrepresented expertise through their geriatric perspective and training to multidisciplinary teams in settings where trained gerontologists may be in short supply (Counsell et al, 2007). Yet involvement in a truly collaborative and interdisciplinary team process remains a difficult concept to incorporate into everyday practice (Netting & Williams, 1996). Geriatric care managers' commitment to identifying the client and total client system provides an advantage in being able to view the sum of all parts at play, but can also put GCMs at odds with a sense of shared accountability as GCMs may see themselves as more accountable to clients than to a team of loosely connected health care professionals.
- Development of plans of care. In terms of supporting a successful

care transition, this standard closely relates to supporting follow-up care and medication management post-discharge, as well as developing care plans that support patient/client activation. After a discharge from a hospital, care plans often require adjustments. GCMs are well suited to inform the discharge process of clients' existing care plans as well as community resources available to address new supportive service needs. GCMs also frequently accompany clients to physician appointments and help their clients make sure that important questions are addressed. GCMs can help identify poly-pharmacy issues, activate clients to address their medication questions with their follow-up primary care physicians, or make referrals to pharmacists for medication therapy management. However, specialized training and collaboration with other healthcare professionals is needed to fully address important medication reconciliation processes post-discharge (Rust and Davis, 2011).

Discussion

Transitioning from one care setting to another can be potentially harmful for individuals with serious or complex illnesses, in part because the care transition process is prone to errors resulting from poor communication and coordination, inadequate care management or follow-up care, etc. In addition, poor care transitions are costly. Almost one in five Medicare patients (approximately 2.6 million older adults) are readmitted to the hospital within 30 days of their original discharge. This extrapolates to a cost of over \$26 billion per year (U.S. Department of Health & Human Services, 2011). Successful and cost-effective care transitions require better connections between medical providers and community services providers. While there are roles for many different professionals to play in this process, geriatric care managers can clearly be part of a community-based solution.

Investing in geriatric care managers for care transitions.

Given the new emphasis on care transitions in the Affordable Care Act and the rapid aging of our population, the need for an increased number of professionals well-versed and trained in care transition planning is more crucial than ever. Geriatric care managers are perfectly positioned in the Aging Network to fulfill this role, and many already do. Geriatric care managers can provide initial assessments, access to community services, care coordination, counseling, and family members support for clients who may not qualify for increasingly stringent income requirements for public services (Dobrish, 1987, Kelsey & Laditka, 2007). However, according to a 2010 survey of Area Agencies on Aging Directors, only about 12.6 percent of AAAs employ certified geriatric care managers. Yet, in preparation for the current population age wave, AAAs foresee the need to invest within the next five years in additional case managers and expand staff qualifications to include certified geriatric care management within their case management units (Morgan, et al, 2010).

Geriatric care managers can play different roles in care transition planning within the Aging Network. First, they can be and are employed as transitional care staff. They can also be utilized as members of the interdisciplinary care transitions teams. Finally, they can serve as “community conveners,” pulling together all the appropriate medical and social service providers who relate to care transitions. This in turn improves connections for the patient and their family to the long-term services and supports system.

However, if geriatric care managers are to properly meet these kinds of job duties, it must be made sure that they receive

appropriate skills training to help them meet the demands that will be asked of them. For example, geriatric care managers should consider how care transition strategies align with their existing professional roles and responsibilities, including patient activation, which requires empowering their patients/clients, as opposed to “doing” for them, and engaging in teach-back methods where the patient/client learns to advocate and act on their own behalf. Additionally, professional

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education programs for future care managers should specifically address breakdowns in the interdisciplinary team/collaborative processes. The soft skills of conflict resolution and problem-solving can help keep the lines of communication open, and if geriatric care managers are part of the bridge between the medical and community, these can help to keep the relationship functional and the care transition planning process moving. Finally, given the importance of medication reconciliation to the care transition process, additional training about this critical issue may be needed for GCMs – particularly who do not have a nursing background.

The problem of poor transitions has serious outcomes for patients, their families, and our health care system – one that needs collaborative, multidisciplinary, community-based solutions in order to provide high quality, more cost-effective care. The Aging Network and geriatric care managers can and will continue to play a critical role in reaching these aims.

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Do Geriatric Care Management Interventions Make a Difference? Prove It.

By Deborah Newquist, PhD, MSW, CMC

The environment within which geriatric care managers (GCMs) provide their services is undergoing a sea of change. Health care reform, embodied in the Affordable Care Act of 2010 (ACA), has catapulted the topic of chronic care into the forefront. Along with the cresting wave comes recognition of the need for and importance of care coordination. Explicit mention of care coordination services is found throughout the ACA (U.S. Department of Health and Human Services, 2011). The search for ways to improve health care for older persons with chronic illnesses has shed light on many areas where care is deficient and unnecessarily costly. Transitions of care (TOC) is one such segment of the health care experience.

For years GCMs have provided TOC services to their clients as part of their care management approach. GCMs have been involved in shepherding clients from home to hospital to rehabilitation and back home, or to alternative living as circumstances demanded. They have advocated for clients in the different care levels; transmitted and reconciled medications and other information from one provider to another; counseled and educated clients and their families about health conditions; navigated twisted systems with mind bending options; coordinated services to meet changing client needs; and they have seen to it that gaps were identified and filled. In fact, GCMs have bridged the medical and social arenas regularly with a holistic focus on each client's needs and goals.

GCMs have practiced the GCM Model of Care, which includes TOC

services, for decades. The GCM Model is person-centered, face-to-face, and uses the same qualified care manager throughout the spectrum of care. It is assessment driven and includes a comprehensive care plan and ongoing evaluation. It also includes education, advocacy and patient empowerment where appropriate. Strikingly, it is these very features of the GCM Model that are now being recognized (but sadly not credited to GCMs) and promoted by case managers, disease management specialists, transition of care specialists, patient advocates, and others in the medical arena, many of whom heretofore focused primarily on managing diseases or health care utilization alone (Brown, 2009; Parry, Coleman, Smith, et al, 2003; Social Work Leadership Institute, 2008; The Transitional Care Model, 2011). Another important feature of the GCM Model is also that it can adapt its approach to encompass persons whose self-management requires tailored supports, such as for early dementia patients who live alone.

Now is a critical time for GCMs to showcase their model to the larger society, and particularly to those shaping the future of health care delivery. GCMs need to demonstrate their worth and expertise in managing the chronic care of older persons in order to help shape future trends, and to preserve their ongoing practice opportunities. GCMs are experts in maximizing the health, functioning, independence, and quality of life of older persons with chronic illnesses and disabilities. Demonstration and dissemination of the methods and outcomes of GCM services are needed now more than ever before. We need

studies to document the who, what, how, and so what of GCM services.

Models of Research on Care Coordination

Numerous types of studies, articles, and reports have been produced in recent years examining care coordination in general, and including transitions of care in particular, in an attempt to identify program models that produce improved patient quality of care and cost-effective outcomes. A wide range of research types can be found and are instructive for GCMs to consider. These include collections of case studies describing particular programs or models around the country (Cooley, Feeney, & Krakauer, 2010; Kanaan, 2009). A variation on that approach would be case studies of "hot spot" patients (those heavy users of services) tracing their experiences to identify factors and methods for bringing order to medical chaos (Gawande, 2011). Population studies of particular groups of clients or patients, such as reports of patients from particular settings or with particular diagnoses, have also been done (Naylor, 2005-2008; Windham, Bennett, & Gottlieb, 2003). Convenience samples have also been used, for example utilizing only members of a particular HMO. Studies which have aggregated data from multiple sources are another approach, such as a study of all Medicare patients' readmission rates in all hospitals within a specified hospital service delivery area (Robinson & Stansbury, 2010). Qualitative studies of patient experiences have been conducted to aid in the development and refinement of program models (Parry, Kramer, & Coleman, 2006).

Meta-analyses of multiple studies have also been conducted to distill key models (Boult, et al, 2009; Brown, 2009).

“Evidence-based outcomes” is the new vogue of research and practice. To determine whether an intervention makes a difference in effecting an outcome, studies attempt to compare outcomes to a specified standard and measure comparative differences. So, for example, if the national average for hospital readmissions for a particular patient group is X, a study of one hospital’s population might deploy TOC services to that patient group and then compare their outcome to the national average or benchmark (Cooley, Feeney & Krakauer, 2010). Or they might use a pre and post-test model, comparing readmission rates after the TOC services were provided with readmission rates from before (Robinson & Stansbury, 2010).

The gold standard, according to many, is the randomized, controlled trial. An example of this approach would be to randomly separate all Medicare patients discharged from a given hospital into two like groups (matched for age or number of diseases, or admission diagnosis, etc.—controlling the intervening variables), with one group to receive the TOC service intervention and the other control group to not receive the TOC services, and then to measure and compare the readmission rates of the two groups to see if the TOC services made a difference (Coleman, et al, 2006; Naylor, et al, 2004).

Studies are always assessed by the research community as to their reliability, validity, generalizability, and limitations. In addition, policy-makers looking for solutions also seek to know if proposed models are cost-effective. They also want to know if a model is scalable, meaning can the model serve larger numbers of persons and still maintain its operational integrity and effectiveness.

Research on a particular program might commence with a case study, followed later by a more in-depth population study, leading still later

to a controlled trial. Although some believe that nothing short of a randomized controlled trial is worthwhile, the literature shows that information gained through various research efforts, both qualitative and quantitative, adds to our understanding. Also, starting small and moving toward a more sophisticated methodology has value over not doing anything at all if a program cannot do a clinical trial initially.

Groundwork for Research on the GCM Model

Some issues that GCMs can confront in undertaking or participating in research on the GCM Model involve the need for standardized clinical approaches. GCM processes are not uniformly standardized within practices and across practices. Thus, the kinds of data collected may vary. GCMs need to balance standardization against the priority of client-centeredness. In other words, do you force a client to answer all the questions on a particular form, even if some of them are not relevant to his or her circumstance, just so your data are uniform and your processes strictly standardized? Another issue is: how do you measure GCM clinical skills and judgments; do they fit into a reductionistic research model that attempts to quantify all variables?

The GCM Model follows a step-wise process of care coordination guided by a plan of care which is based on a multi-dimensional assessment and ongoing monitoring and evaluation. This is a standardized clinical approach with flexibility to customize when and where appropriate from the model, similar to the one described by Naylor. She refers to it as “individualized care guided by evidence-based protocols” (The Transitional Care Model, 2011). While the assessment instruments and data management systems used by GCMs vary, basic information about each client’s physical and mental health, and functional, social, spiritual, legal, financial, and environmental status, and each client’s goals, are central to a standard GCM assessment

(Cress, 2012). So too is the step-wise process of assessment, care planning, then care coordination.

Other issues involve data storage, retrievability, and availability. How are GCMs storing their client data, and are those data easily retrievable for research purposes? Client confidentiality and releases are also of paramount importance. Additionally, would GCMs be willing to collaborate and share information about their programs, or would proprietary concerns preclude that?

Conclusion

We are moving into a new era where managing chronic diseases and preventing or forestalling disabilities associated with age are in the forefront. Improving transitions of care is one aspect of this effort.

Where do geriatric care managers fit into this new paradigm? Traditionally, this is our domain. Many new players are moving into this space however. If we cannot document our approaches and demonstrate their effectiveness, we run the risk that our clients of the future will be cared for in other spheres. ACOs, transition coaches, patient advocates, medical homes, and others will siphon off clients and GCMs will suffer.

GCMs and the national association need to embark on a research program. Information about who we are, what we do, and why it matters will aid in our public relations efforts and in our public policy activities. Sole practitioners and larger practices will be better able to assess how they are doing if they have industry standards to compare themselves against. The national profile of the organization and its members will rise as reports and publications emerge.

I call on GCMs to:

- Participate in research studies about GCMs when asked.

As an example NAPGCM has established a new research development committee. The first meeting will soon create strategies

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for GCM research, including how GCMs can prevent hospital readmission. So, if you are asked to participate in a NAPGCM research study, this would be your opportunity to help the association prove that statistically GCMs can avert hospital readmission.

- Conduct your own research in-house.

As an example, SeniorBridge, a national geriatric care management agency collects their own data see (Bartelstone, 2011; Bartelstone, GCM Journal Fall, 2011, Volume 21, Issue 2, "Transitioning Care to the Home: Reducing Rehospitalization Among Frail Elders").

- Collect and store data in a manner that makes it available for retrieval and analysis.

As an example, SeniorBridge is able to retrieve and analyze their own data to show that geriatric care management can prevent hospital readmission (Bartelstone, 2011; Bartelstone, GCM Journal Fall, 2011, Volume 21, Issue 2, "Transitioning Care to the Home: Reducing Rehospitalization Among Frail Elders").

- Be willing to share data.

As an example, if the new NAPGCM research committee asks you to share data, please consider doing so, to help the entire association.

- Support the development of standardized protocols.

The new NAPGCM research committee will be developing these standardized protocols, so your support of the committee and its eventual findings will be of benefit to the entire association and its members.

The national association is currently exploring how to move forward on a research initiative. It will require all of us working together.

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Transitioning Care to the Home: Reducing Rehospitalization Among Frail Elders

Rona S. Bartelstone, LCSW, BCD, CMC, C-ASWCM

There have been numerous studies in recent years that document the relatively high risk of rehospitalization among recently discharged, complex care Medicare beneficiaries.

According to the 2009 Jencks article in the New England Journal of Medicine, one in five seniors are rehospitalized within 30 days of being discharged from a hospital, fueling the reality that Medicare beneficiaries account for 15 percent of the US population but more than two-thirds (37 percent) of hospitalizations and almost half (47 percent) of total hospital costs. Furthermore, more than 56 percent are rehospitalized within a year. Alarming, only half of discharged beneficiaries recall receiving self-care instruction or seeing a doctor after discharge, suggesting that a substantial number of hospitalizations could be prevented. Finally Peikes reported in 2009 that patients with multiple complex chronic illnesses are likely to be hospitalized 1.3 times per year.

Emergency room visits and hospital admissions are failures of the healthcare system to provide timely, effective care. The problem stems from our healthcare system's focus on disease management and a lack of attention to the reality that activity limitation is an independent risk factor for increased healthcare costs.

In fact, according to a LewinGroup analysis of Medical Expenditures published in 2010,

Emergency room visits and hospital admissions are failures of the healthcare system to provide timely, effective care. The problem stems from our healthcare system's focus on disease management and a lack of attention to the reality that activity limitation is an independent risk factor for increased healthcare costs.

seniors with multiple chronic conditions who received help with instrumental activities of daily living (IADL) and activities of daily living (ADL) were seven times more likely to be among the top five percent of patients most expensive to treat -- more than twice the rate of those with multiple chronic conditions alone.

Chan et al. reported in the Archives of Physical Medicine and Rehabilitation in 2002 that these increases in cost are attributed to an increase in the frequency of all events (e.g., hospital admissions, outpatient visits) rather than an increase in the intensity or cost of those events.

These startling facts make it imperative to seriously consider alternative methods of providing long-term care to Medicare beneficiaries and especially to those with multiple complicating diagnoses that make care in the community most challenging. While this phenomenon is not new, it is being newly examined due to concerns about the growing cost of health care and the emerging provisions under the Patient Protection and Affordable Care

Act (PPACA) to positively impact this challenge. There is also recognition that the baby boom generations will exponentially impact the cost of long-term care with increasing longevity and incidents of complex chronic care needs. It is now recognized that when patients with complicated medical, functional, and cognitive conditions receive care coordination in the

home by specially trained geriatric care managers, hospitalizations and emergency room admissions are substantially reduced. In fact, SeniorBridge's data show 90 percent fewer emergency room admissions, 80 percent fewer hospitalizations, and 70 percent fewer rehospitalizations within 30 days in older adults receiving care management in the home.

This article discusses a care management model of service delivery that reduces hospitalizations, 30-day hospital readmissions, and ER visits by focusing on the functional challenges of care recipients in the community, in addition to health care diagnoses. The integrated approach of addressing the medical, psychosocial, and environmental challenges of frail seniors in the community enables the focus of care to shift from the acute care setting to the home care setting.

As healthcare companies innovate to create sustainable solutions to this growing challenge, SeniorBridge has created a model that facilitates good social policy without investment of

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public funds and is therefore poised to inform social policy and create models for replication and continuity. As the largest care management company in the country, SeniorBridge provides a role model for how other care management practices can also begin to impact positive health outcomes for Medicare beneficiaries throughout the country.

SeniorBridge's integrated approach addresses the reality that disease management is only part of the problem -- and that until we address patients' functional needs, we cannot provide these patients the care they deserve.

Background

SeniorBridge is a national care management company with an 11-year heritage of managing the care of people with complex chronic conditions in their homes. The

company's interdisciplinary approach utilizes an integrated care management team of nurses and social workers to address functional, environmental, behavioral, and medical needs. This person-centered approach facilitates the creation of partnerships that build on the strengths of care recipients in a manner tailored to their needs and preferences.

SeniorBridge's proprietary web-based electronic health record allows for documentation of health information from multiple physicians and care manager assessments including information about the living environment, the social support system, the behavioral health issues, and legal and financial status in addition to the traditional medical diagnoses, medications, treatments, and hospitalizations. The breadth of this health record enables our care managers to monitor and address the full array of issues as they relate to the medical concerns that impact chronic care needs. Furthermore, the electronic health record facilitates real-time communication between care managers and health care

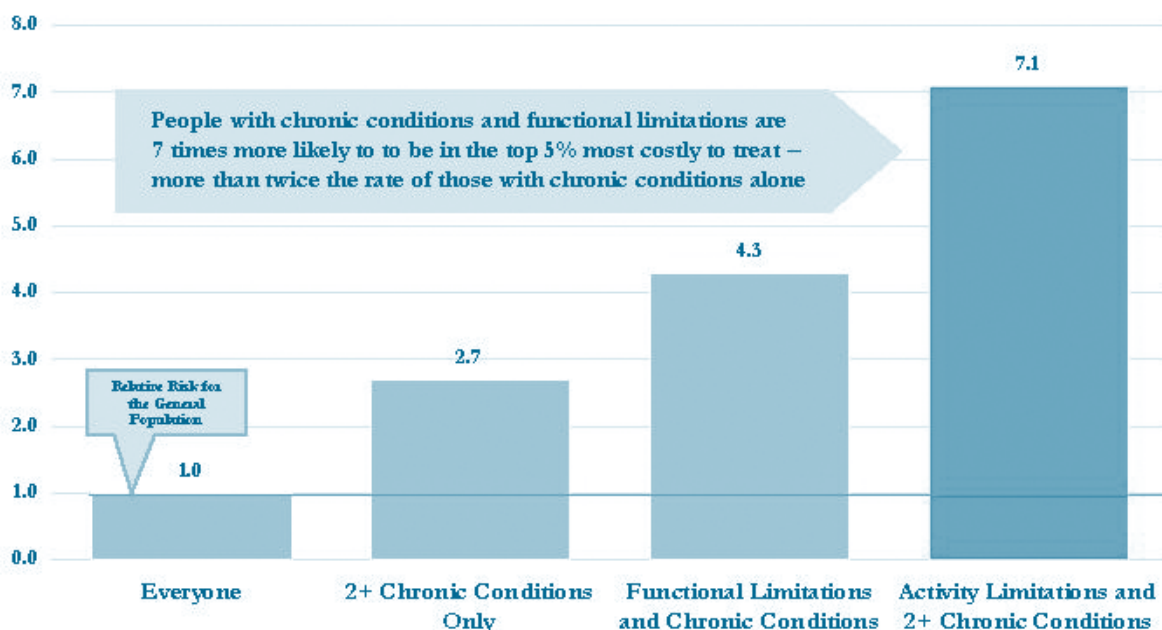
providers to assure that the services in the home are consistent with the physician-driven plan of care. In this manner, the care manager becomes the physician extender into the home setting, while assuring maximum use of primary care to forestall preventable use of emergency room visits and hospitalizations.

The Problem: Addressing Function Among Vulnerable Populations:

The Robert Wood Johnson Foundation analysis of the 2006 Medical Expenditures Panel Survey shows that three-fourths of people 65 years of age and older have two or more chronic conditions. And according to the LewinGroup's analysis of the same 2006 Medical Expenditures Panel Survey, people with multiple chronic conditions and instrumental Activity of Daily living and/or Activity of Daily Living limitations are seven times more likely to be among the top five percent most costly to treat.

Chan et al. reported in the Archives of Physical Medicine and

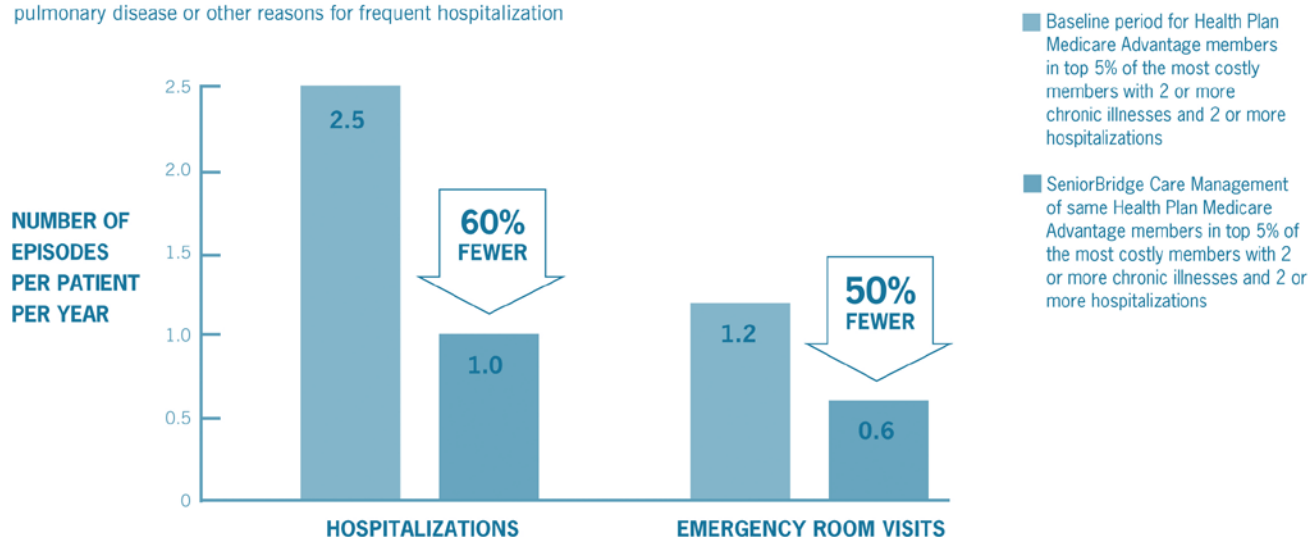
Relative Risk of Being a High Cost Patient



Source: LewinGroup analysis of 2006 Medical Expenditures Panel Survey, 2010

SeniorBridge Results with High Risk Patients Reduced Hospitalization and Emergency Room Visits Among Top 5% Most Costly Medicare beneficiaries, 2010–2011

With multiple chronic conditions, such as congestive heart failure, chronic obstructive pulmonary disease or other reasons for frequent hospitalization



Rehabilitation in 2002 that these increases in cost are attributed to an increase in the frequency of hospital admissions, outpatient visits, and other events rather than an increase in the intensity or cost of those events. Repeated hospitalizations arise from issues such as medication management errors, inability to access follow-up care with physicians, inability to comply with nutrition and hydration regimens, falls related to environmental hazards, and/or a social support system that lacks the presence, knowledge, and/or information to assure proper care.

Furthermore in 2008, Arbaje, et al. showed that, “PDE (post discharge environment) and SES (socioeconomic status) were related to an increased likelihood of early readmission (to the hospital). Unmet functional needs may be associated with limited availability of assistance, which presents challenges to implementing a post discharge regimen, complicates the care transition, and increases the risk of early readmission,” according to their study. Arbaje et al. go on to state that, “having any ADL or IADL need may be significant for affecting health care utilization. Providing for

unmet functional needs (a modifiable characteristic) may affect the occurrence of early readmission in community-dwelling older adults.”

Regardless of socio-economic status, older adults often have low health literacy, live with multiple Activity of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) deficits and lack social support and resources necessary to comply with plans of treatment – all of which are likely to be the most prominent determinants of early readmission.

SeniorBridge has a tradition of care management teams that have served individual older adult clients with multiple complex chronic health and functional needs and their families. Attempts to coordinate the complexity of needs and their inability to successfully manage all aspects of the plan of care, these individuals and families increasingly look to private care managers to help with care giving activities. As a private Care Management Company, the population that we serve is often as complex in their care needs as those of the most complex and expensive Medicare beneficiaries.

Clients on service for a year or longer have 82 percent fewer hospitalizations and 91 percent fewer emergency room visits than the typical Medicare beneficiary – and our clients are among the most complex beneficiaries. A typical client is older than 80 and has multiple chronic co-morbidities, often including congestive heart failure, COPD, stroke, pneumonia, and cognitive changes such as Alzheimer’s or a related dementia. According to Anderson, et al. the general Medicare population has an annual average 1.2 hospitalizations and 1.1 emergency room visits respectively per year. The ability to significantly reduce in-hospital and emergency room usage leads to improved patient satisfaction, improved quality of life, and reductions of costs for both the healthcare system and the individual.

The Solution: In-home Integrated Care Management

As already stated, SeniorBridge has demonstrated significant improvements in the delivery of healthcare services by working with

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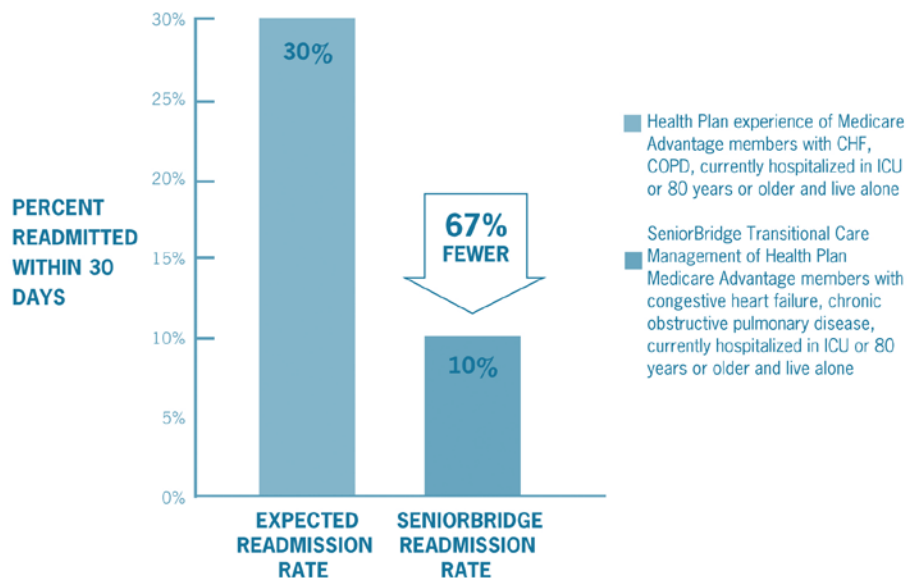
clients in their home and across settings when necessary. The Care Management Team focuses on assuring or compensating for the IADLs and ADLs that are significant contributing factors to the incidence of rehospitalization. This is done in partnerships with organizations that share the concern for lowering both hospital and emergency room usage for the purposes of improving quality of life, preserving scarce resources, and moving care from the acute care setting to the home and community setting.

The Care Management tasks that enable SeniorBridge to successfully intervene with complex client needs include the following key components.

1. Partnering with the entire formal and informal support system of the client. This includes: family members; involved friends; physicians; hospitals; social services; legal and financial advisors; paid caregivers; other service personnel; the Medicare home healthcare provider; DME provider; transportation; dietitian; rehab professionals; pets; and other invested individuals or organizations.
2. Engagement and communication with the involved team in a manner that respects the expertise and leadership of each component of care. This may include the use of mediation techniques to help assure that each member of the team is committed to the agreed upon plan of care. This can be a sensitive area, especially when there may be conflicting organizational, personal, or value-based goals among team members. Continuous communication, including the necessity of in-person team meetings is critical to the coordination and consistency of care, especially as circumstances change over time for the care recipient. Engagement and communication are especially important at points of transition to assure that there are no gaps in service when moving from one level of care to another or when moving from one provider of care to another.
3. A commitment to a consumer-centered perspective toward the provision of services. This means that the lifestyle, preferences, and faith traditions of the care recipient have to become the springboard from which all care emanates. This, of necessity, includes the available financial resources to meet the needs of the care recipient and his or her family situation. This also requires a commitment to the strengths and dignity of the care recipient to avoid excess disability through the creation of unnecessary dependence.
4. Improving the health literacy of the consumer and the entire support system is crucial to successful coping in the community. Both the care recipient and his/her support system need to understand the diagnoses, treatments, and options for care in each disease process. It is especially important to help care givers (both family and paid) know what signs and symptoms might mean in terms of a specific diagnoses and when to call the Care Manager should they have a concern about the health status of the care recipient. Creating health literacy is a continuous process based upon the changing needs and changing complexion of the care recipient's biopsychosocial status, their ability, and readiness to learn.
5. Continual adjustment of the plan

SeniorBridge Results with High Risk Patients Reduced Rehospitalizations Among High-Risk Medicare beneficiaries, 2010–2011

With high-risk, chronic conditions such as congestive heart failure, chronic obstructive pulmonary disease or other reasons for frequent rehospitalization



of care based upon the daily needs of the client over time. The individualization of the care plan means that the Care Manager is expected to modify the plan of care to meet variations in need throughout the course of our engagement with the client system. Some clients start off with intensive services because they are coming from an acute episode from which rehabilitation is expected. Just as likely is that others will start with limited care and need increasing support as their health status declines over time.

6. Manipulation of the environment to meet the needs of the care recipient situation. This can relate to any number of structural or concrete tasks that help the care recipient to function in an environment that is safe and conducive to their needs. This can include such complex tasks as:
 - a. Medication management. Especially for those individuals who may have medical conditions that are frequently in flux and cause the necessity of careful management of medication dosing.
 - b. Environmental modification. These might be relatively common modifications such as grab bars or more complex needs such as reconfiguration of the home itself.
 - c. Nutritional/dietary supports. To assure an appropriate diet consistent with their medical needs, cultural background, and faith traditions. Since eating is also a social activity, it may be important to identify opportunities for socialization within the home or the community to enhance the ability to participate in healthy nutritional habits.
 - d. Transportation needs. This is important for maintaining the delivery of both medical and social needs.
 - e. Psychosocial supports. To prevent isolation and the potential for depression and cognitive decline that often accompanies the lack of human interaction. This might also

include therapeutic interventions to help the individual cope with their health challenges, losses, and uncertainty brought about by the disease process, including chronic grief.

- f. Exercise, as tolerable and appropriate. To prevent further physical decline that may lead to preventable disability.
- g. Opportunities for enjoyment. Whether or not the person is able to continue to enjoy former hobbies, interests, or activities, it is important that the care recipient have activities or interactions to anticipate with joy. The ability to engage in activities that enhance our lives, relationships, well-being, or sense of productivity can be key to successful coping.

Naturally, all of the tasks described above are done in a manner that is consistent with the primary functional domains of the care management process, namely:

- Intake/engagement
- Assessment
- Care Planning
- Care Implementation
- Care Monitoring and Adjustment
- Quality Assurance/Patient Satisfaction
- Termination

For each client this professional team develops, in concert with the person's physician, an individual care plan tailored to the functional, medical, and emotional needs of the care recipient. Home safety assessments and evaluations of medical, functional, and psychosocial status identify basic factors that leave older patients vulnerable to falls, while monitoring for more critical issues such as cognitive decline that may not be readily apparent in a doctor's office or over the phone. Other services available in the home include tele-health care monitoring and on-call care management support 24 hours per day, seven days per week

To ensure collaboration between

health professionals treating each patient and to improve quality of care, an electronic health record is created for each participant to manage and organize ongoing assessments, medical and professional notes, clinical and medical analyses, as well as care plans. This unique electronic record is created through SeniorBridge's proprietary information system. This system also makes it possible for SeniorBridge to aggregate client information for the purposes of understanding from a more objective perspective the nature of client needs based upon service usage, length of service engagement and the constellation of services used, and the overall health outcomes. A critical component of our health record is its ability to track a 360-degree view of clients' hospitalizations including when they occur, the facility at which the client is treated, length of stay, reason for admission, and the discharge plan.

This system allows the care managers to identify patients with functional limitations who are at risk of a rehospitalization and implement an evidence-based approach to supporting them. The system goes beyond medical needs and explores physical and cognitive functional limitations that put them at risk for adverse events and rehospitalizations. Does the patient have food in the refrigerator to ensure adequate nutrition and hydration? Is the patient taking medications or vitamins you don't know about? Are their support limitations preventing them from complying with a discharge plan?

As can be seen in the screen shot below, the ability to input comprehensive data about each client, is a hallmark of the success that our care managers are able to achieve. The system allows for the accumulation and aggregation of client information that facilitates the tracking of trends. Some of the most critical trends include: information about referral sources, client demographics and health status, length of stay, and

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Transitioning Care to the Home: Reducing Rehospitalization Among Frail Elders

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service usage. Furthermore, data is accumulated in real time, which allows for more accurate tracking of client needs and predictions about the business pipeline.

The Outcomes & Lessons Learned

As previously stated, SeniorBridge is able to demonstrate improved health outcomes, reduced use of emergency room visits, and decrease in the hospitalization and rehospitalization rate of its clients. This is attributable to the following lessons that have been learned over time and that can provide a roadmap for other care teams that are able to bridge the gap between locations of service and focus care on the most appropriate and least restrictive locales, namely the home and the office of the primary care physician. In addressing the care at home, it will be imperative to focus on building upon client strengths and compensating for functional deficits.

Lessons Learned

- 1) Providing an integrated team of health and social services professionals in the community setting facilitates improved continuity of care. Addressing the comprehensive needs of patients empowers the individual and social support to maintain a health regimen in the home. The team of physician, nurse, and social worker allows for environmental safety, more efficient use of community resources, emotional support for improved coping, and health education to create care partnerships and health maintenance.
- 2) Education of healthcare consumers is crucial to positive outcomes. Approximately 50 percent of the time that care managers spend with clients is in health education and counseling to cope with their complex care needs. Improved outcomes result from behavioral changes that are accomplished over time, in the home, when the patient and support system are not in crisis and therefore more available emotionally and intellectually for learning.
- 3) Real time communication with the entire team facilitates team building and efficient use of resources. The use of an electronic health record that is available in real time has enabled communication between the community-based care managers and the physician to assure that adjustments to the plan of treatment are made in the home and at the primary level of care. Notes from the care managers' interventions assure that the team is informed and become part of the physicians' chart in the primary care setting. Use of community resources and education is thereby reinforced by all members of the team, supporting education and compliance by the care recipient and his/her support system.
- 4) Maintenance of a relationship with the entire team provides the patient with a virtual "safety net" that they can immediately access when changes occur in health status or function. When the client and his/her support system have an on-going trusted relationship with a team of providers, they are more readily able to identify appropriate supports for help when there are changes in status. This assures



S **Clients Professionals Help**

Clients > Assessment > Create Assessment

Branch	Demo 1 ▾	Client	Client, Jack ▾
Filter by Status		<input checked="" type="checkbox"/> Active <input type="checkbox"/> Discharged <input type="checkbox"/> Processed <input type="checkbox"/> Closed	
Filter by Services		<input checked="" type="checkbox"/> Schedulable for Caregiver <input checked="" type="checkbox"/> Not schedulable for Caregiver	

Main Info		Info Sheet				
Clinical History	Contacts	Environment	Functional	Physiological	Med Admin	Med Profile
Background	Psychosocial	Financial/ Legal	Service Goals	Care Plan	Print	Status

clients that they can receive care in their home setting and experience fewer barriers to accessing health and social services. This also assures that care is provided at the appropriate level of services rather than waiting for the crisis to occur, which in turn results in care being provided at the most expensive and sometimes excessive level of care.

- 5) The integration of technology with consistent interpersonal support facilitates service delivery. It is the combination of “high-tech” with “high-touch” services that enables the integration of care across the professional team, across settings and with the client. The electronic health record, along with tele-monitoring devices and other software systems to track clinical interventions are enhanced when the healthcare professional can teach the consumer to make the best use of standards of care in the home over time. The educational process and counseling for emotional coping improve when the consumer feels that they are a partner in the process of their own care.
- 6) Care in the community setting that addresses function of patients can reduce hospitalizations and improve patient satisfaction. The positive health outcomes reported above demonstrate that it makes good business sense and good social policy to encourage increased use of care in the community for those Medicare beneficiaries who have complex care needs. In addition to improved health outcomes, patient satisfaction with their care and their functional status demonstrates the success of community-based care teams.

National health care reform, changing reimbursement systems, the recognition of the need to partner with patients (rather than just treat them), and changes in the workforce and in the economy all are incentives for pioneering new approaches to health care delivery. The provision of quality, coordinated care in the

community with a focus on improving function and empowering client systems may be one of the most effective means of meeting these increasing challenges.

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Evidence-Based Transitional Care for Chronically Ill Older Adults and Their Caregivers

M. Brian Bixby, MSN, CRNP

Summary

The Community-Based Care Transitions Program (CCTP) authorized by Section 3026 of the Affordable Care Act of 2010 aims to reduce hospital readmissions, test sustainable funding streams for care transition services, maintain or improve quality of care, and document measurable savings. A multidisciplinary research team developed the Transitional Care Model (TCM) to address the needs of very high-risk chronically ill older adults transitioning from hospital to home post-acute illness. Three completed National Institute for Health-funded randomized controlled trials testing TCM have consistently demonstrated results compatible with CCTP goals and indicating utility of TCM in successfully addressing each of the aims.

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An estimated 90% of hospital readmissions occurring within 30 days of discharge are unplanned. These readmissions, most often preventable, cost Medicare \$17.4 billion in 2004 (Jencks, Williams & Coleman, 2009). The financial toll of preventable

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readmissions is only one negative effect of a health care system in need of realignment. The human cost of repeated disease exacerbations can be equally costly in terms of deterioration in function, reduced symptom-free days, and loss of faith or satisfaction with the health care system previously trusted to maintain or improve health. Health care errors and adverse events often associated with transitions in spite of care only increase dissatisfaction and distrust of a poorly performing system.

Transitional Care, defined as a range of time-limited services and environments that complement primary care and are designed to ensure health care continuity and avoid preventable poor outcomes among at-risk populations as they move from one level of care to another, among multiple providers and across settings, has been identified as one solution with strong evidence of effectiveness in avoiding preventable negative outcomes, including readmissions, in the most at-

risk populations. Transitional care programs focus on maintaining continuity, fostering communication, and educating patients so that health care is effectively managed across levels of care access while identifying and addressing reasons for adverse outcomes (Naylor, Aiken, Kurtzman, Olds & Hirschman, 2011).

Nationally there are four main approaches that address transitions of care: Project Re-Engineering Discharge (RED), the Care Transitions Program (CTP), Better Outcomes for Older Adults through Safe Transitions (Project BOOST), and the Transitional Care Model (TCM). RED is a research group based at Boston University Medical Center developing and testing strategies to improve the hospital discharge process to promote patient safety and reduce readmission rates. CTP addresses the needs of patients and caregivers while also encouraging the adoption of technology to increase communication between providers and settings. Project BOOST is a hybrid developed by the Society of Hospital Medicine. BOOST addresses physician training and mentoring to improve patient outcomes at discharge. BOOST toolkits are utilized during hospitalization to identify post-discharge care needs and augment standard discharge planning and is used as a complement to the more intensive transitional care programs CTP and TCM.

While each program has its unique approach to addressing the transition between hospital and home, all of these transitional programs focus on intensive inpatient education that targets the admitting diagnosis, symptom identification and management, scheduling needed follow-up care, and medication knowledge and reconciliation. These programs focus on addressing problem medications and streamlining the plan of care based on current practice guidelines. All transitional care models provide telephone support after hospitalization to reinforce the discharge plan. CTP and TCM provide post-discharge in-home follow-up of varying intensity that aids in reinforcing the plan of care, in addition to telephone support. The TCM will be discussed in depth as a model to address the mandate of the CCTP initiative.

The TCM was originally developed in the 1980s by Dr. Dorothy Brooten. The success of the model in achieving

positive outcomes clinically, financially, and most importantly, satisfying patients and caregivers, led to the testing of this approach to address the transitional needs of other populations of Philadelphia to address the needs of very low birth weight infants and their caregivers making the transition from hospital services to home with the support of a discharge team led by a Clinical Nurse Specialist. The success of the model in achieving positive outcomes clinically, financially, and most importantly, satisfying patients and caregivers, led to the testing of this approach to address the transitional needs of other populations. Since the early 1990s, a multidisciplinary research team also based at the University of Pennsylvania and led by Dr. Mary Naylor developed and has been refining and demonstrating the effectiveness of the TCM in meeting the needs of chronically ill older adults. Findings of three completed National Institute of Nursing Research funded randomized control trials (RCTs) and a National Institute of Aging study have demonstrated that TCM improves health outcomes, decreases and delays readmissions, and reduces overall health care costs when compared with usual care. This body of research has resulted in collaborations with insurers, health systems, providers, consumers, and other concerned stakeholders to translate the model into practice (Naylor, Brooten, Campbell, Jacobsen, et al., 1999, Naylor, Brooten, Campbell, Maislin, et al., 2004, Naylor, Brooten, Jones, et al., 1994). These RCTs document the TCM's ability to: increase time to first readmission or death, improve physical function, improve quality of life, increase patient satisfaction, decrease total all-cause readmissions, and decrease total health care costs.

The TCM is an advanced Practice Nurse (APN)-led model utilizing a holistic person and family care centered approach. A tested and refined protocol guides and streamlines care with the APN acting as the single "point person" across

the episode of care. Utilizing the "point person" facilitates information exchange and assures timely communication that spans settings. Unique features of the TCM are that care is provided by APNs specializing in the care of high risk elders and their caregivers. Follow up occurs across hospital and home settings by the same APN who individualizes the plan of care. With the exception of a few critical junctures that are described below, the TCM guidelines allow for flexibility to let the APNs use their clinical judgment to determine frequency, intensity, and nature of contact – in-person or telephone. APNs are expected to visit the patient within 24 hours of identification, daily during hospitalization, and within 24 hours of discharge to prevent any potential adverse clinical events associated with the transition.

Through the completed RCTs the Penn team has identified and refined a high-risk profile of patients characteristically in increased need and identified those most likely to benefit from the intervention (Bixby & Naylor, 2009). These high-risk criteria have been augmented by findings from reviewing the clinical literature. Attaining the age of 80 or being older combined with other criteria may increase risk of poor transitions. Moderate to severe functional deficits and the inability to manage daily tasks or complete self-care will complicate discharge planning and require short- or long-term problem solving to address the deficit and any subsequent continued decline. Functional status can be measured by the Hospital Admission Risk Profile (HARP), Katz Index of Independence in Activities of Daily Living (ADL), or The Lawton Instrumental Activities of Daily Living (IADL) Scale. Pilot work has been completed using the TCM to meet the needs of patients with active behavioral or psychiatric health issues. Large scale testing of the TCM's efficacy in meeting the needs of this population is currently being completed. For our work we screen for documented depression and only exclude those with severe depression receiving treatment as their primary or secondary reason for hospitalization.

The Geriatric Depression Scale – Short Form (GDS) is a useful tool to assess depressive symptoms in the past weeks. Four or more active coexisting health conditions or treatment with six or more prescribed standing medications have been found through our RCTs and literature review to increase risk of rehospitalization. Two or more hospitalizations within past six months or a hospitalization within the past 30 days increases the all-cause risk of readmission. This risk is significantly increased for those hospitalized having baseline dementia or treated for delirium (or both). Lack of formal or informal family caregiver support has ramifications for short- and long-term outcomes especially in areas of treatment adherence and completion of needed follow-up care. Low health literacy is often described as a variable affecting outcomes, especially nonadherence to the therapeutic regimen. It is important in assessing your patient to not take reports of other clinicians at face value unless well documented. Willful nonadherence is rare. Often the nonadherent patient has valid reasons for skipping or missing medications, therapies, and appointments. These causes need to be carefully assessed in a non-judgmental manner to address and attempt to disrupt nonproductive behaviors. In our clients we find social issues that need to be addressed around costs of medications, access to food, and the ability to physically obtain medication. Solutions can be mutually worked as part of the TCM follow up.

If two or more of the above findings are present, further investigation is warranted and formal collaborative assessment of discharge planning—transitional care needs should be initiated if not already completed. As noted above, cognitive impairment significantly impacts – and complicates – discharge planning and assessment of transitional needs and heightens risk for all-cause risk for readmission and is often overlooked or unknown. In our pilot work of 145 patients who completed the screening, 65% (n = 94) had no evidence of cognitive impairment and 35% (n

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= 51) had evidence of cognitive impairment; in 65% (n = 33) of the latter group, cognitive impairment was identified only by using the screening instruments (Naylor, Stephens, Bowles, & Bixby, 2005). A useful tool to quickly assess patient cognitive status is the Mental Status Assessment of Older Adults (Mini-Cog). This tool (along with those recommended earlier) is available from the John A. Hartford Institute for Geriatric Nursing (<http://consultgerim.org>) and is in the scope of practice for nursing to administer. As with any tool, the Mini-Cog represents a point in time and indicates current status and not a diagnosis. It does, however, direct the clinical team towards a needed work-up. Any suspected or documented cognitive impairment with or without the above screening criteria should independently trigger post-discharge intervention to assure appropriate information transfer and follow-up after discharge to home or other care setting. It is imperative that either a well-informed caregiver be actively involved during the discharge process or a referral for visiting nurse services is made (with preference for both being involved).

The TCM protocol schedule is very straightforward. There are a few minimal expectations but no rigid guidelines. The APNs are not held to productivity standards, but rather are given the time to address the complex needs of this most at high risk group and to address their needs amenable to intervention and long-term patient benefit. While 30-day rehospitalization rates need to be radically addressed we also look to make changes that affect the long-term outcomes of not only the primary diagnosis but also of co-morbid conditions. The APNs are instructed to use their clinical judgment to determine the frequency (number) and intensity (length) of patient and caregiver visits and telephone contacts. The minimal

expectations are that a patient will be visited at the hospital within 24 hours of study enrollment; daily throughout the hospitalization; within 24 hours of discharge to home; at least weekly during the first month; and at least semi-monthly through the duration of the intervention. The APNs are strongly encouraged to attend the first discharge physician follow-up appointment if a transition in provider (hospital-to-home) is occurring. In addition to in-person visits the APNs monitor their patients via telephone. The APNs are available via telephone daily Monday-Friday and on an on-call basis on weekends to answer physician, patient, and caregiver questions. APNs initiate telephone contact with a patient during any week that a patient is not visited at home. The purposes of these calls will range from monitoring patient's health status to reinforcing skill acquisition.

Patients are visited in the acute inpatient setting within 24 hours of enrollment in the TCM program. Ideally they will have also been enrolled within 25-36 hours of admission. The APN conducts a comprehensive assessment of the patient's health status. This assessment continues, completed, and amended after discharge to reflect hospital and home findings. Priority needs and services are defined with the input of the patient and caregiver(s) throughout the patient's stay. Goals inform the emerging plan of care. The APN collaborates with provider and other members of the health care team to streamline the plan of care. Home visits should begin within 24 hours of discharge from the hospital. This is a critical time to assess understanding and patient implementation of the plan of care. Any delay in visiting is clearly documented and outcomes tracked. After the initial visit, a minimum of one home visit per week is made during the first month. Bimonthly visits continue until discharge from the program. Telephone contact is made with the patient, as needed, and in each week an in-person visit is not scheduled. An explicit, personalized plan for emergency care is developed during hospitalization and the initial

visit. This plan addresses what to do during those hours when the APN is unavailable; it also lays the groundwork for longer term understanding of symptoms, early identification, and intervention. The APN relies on their clinical judgment and each patient's unique circumstances to determine the actual number and nature of contacts.

It is informative for the APN to accompany the patient on their first post-discharge visit with their provider. During the visit, the APN helps the patient and caregiver(s) to achieve their visit goals by coaching the patient to develop a list of questions and triage it prior to the visit so the most important issues are addressed. The APN will also provide the patient with copies of their hospital discharge and any tests for their providers review. The APN may act as an advocate for the patient and importantly assists the patient in understanding the provider's instructions and need for additional follow up.

Per the standard definition, transitional care is time limited and from the initial assessment the APN should be continually assessing discharge readiness and ability for self-management. Probable reasons for readmissions should be discussed and plans to monitor each set of symptoms are discussed with the patient. Needed referrals for social services, specialist care, or other services should be initiated early in the follow-up period. The APN assures continuity of care through communication with the provider(s) who will continue to follow the patient. Discharge summaries and letters are written to each provider and a specific discharge plan created for the patient with a revised action plan included and personal health record. These summaries provide a progress update on meeting goals and on-going/unresolved issues with the plan of care or social services requests that are wait-listed. The APN will facilitate access to palliative care or hospice services, assisted living, or chronic case management, as needed, and within their scope of practice. The APN remains available to the patient

for questions after discharge but does not re-open the care episode.

Current barriers to widespread adoption of the TCM include the organization of current systems of care, regulatory barriers, lack of quality and financial incentives, and culture of care issues. The CCTP demonstration program offers a unique opportunity for the Penn team and health care systems to redefine care through adopting and adapting the TCM widely. As noted before, the RCTs greatly informed our understanding of interventions needed to improve the transitions of older adults from hospital to home or other settings and importantly has informed our partnerships with health systems, insurers, and other key stakeholders in conducting ongoing translational efforts (Naylor, Bowles, et al., 2011). These experiences have been critical in our development of an educational program for the nurses and other providers who will be called upon to lead the implementation efforts and opportunities provided by the CCTP and have also informed our “next steps” in the refinement of the TCM with new populations.

Case Study

TL was enrolled in the TCM program during his acute episode of care. He was followed by the advanced practice nurse (APN) for 85 days. He received twelve visits – ten in his home and two at his physician’s office. The visits were front loaded with greater than six occurring in the first 30 days post-discharge. Telephone calls to the patient served as reminders and status checks during the follow-up period.

TL is a 78 year-old African-American male with a primary diagnosis of heart failure. TL was admitted to the acute care facility via the emergency room after arriving at an unrelated routine follow-up appointment acutely short of breath after walking three city blocks at a moderate pace in winter temperatures - a normal walking distance in his usual state of health. At the time of emergency room evaluation he was found to be volume overloaded with +3-4 pitting edema to his lower extremities, severe shortness of breath, a (+) S3 and frank jugular venous

distention with the head of bed elevated at 90 degrees.

He reported being in his usual state of health until approximately one month prior. Since that time he has noted an increased weight gain and decreased exercise tolerance which he attributed to decreased workload at home and lack of activity due to seasonal change. He was treated with intravenous diuretics and admitted to telemetry for further evaluation where was diagnosed as having new onset heart failure (HF) with an ejection fraction of 25%. He lives with his wife in a one-bedroom apartment in a three-story urban home. TL was independent in all daily activities of living. His past medical history included: glaucoma, bilateral cataracts, and colon cancer successfully removed ten years prior to admission.

TL’s case could have followed two different trajectories:

Without APN services:

1. No Visiting Nurse (VN) or Physical Therapy services – TL was not referred as he was not “homebound” thus did not qualify for services despite need.
2. Poor patient education – Nursing staff utilize non-customized pre-printed medication and dietary teaching forms which do not incorporate individualized behaviors, needs, literacy level, or learning style. Teaching is routine with handoff of learning responsibility to the patient during the acute episode. No mechanism for reinforcement and validation of learning provided for those not receiving VN services.
3. Caregiver exclusion from teaching and development of the plan of care – Mrs. L, the primary caregiver, was unable to visit the hospital regularly thus unable to participate in educational activities or identify needs. Lack of inclusion limited opportunities to reinforce teaching and need for follow up and adherence with the plan of care.
4. Probable poor medication adherence given distrust of need

for medication regimen – Prior medication use consisted of medications of limited duration (antibiotics, antacids, etc.). In TL’s past experience he was required to use eye drops for the remainder of his life as the result of a poor surgical outcome during cataract removal. He could not easily shake the idea that the physicians had somehow misdiagnosed or poorly treated him thus requiring these new medications for life.

5. Probable lack of follow up with cardiologist care, worsening HF and rehospitalization, followed by significant morbidity (including decreased functional status), and possible mortality (if HF not managed optimally) – TL was followed by a generalist who may have attempted to manage his HF but active cardiology involvement was essential to limit disease progression. TL was unhappy to be assigned a female cardiologist despite clinical reputation and did not entirely believe he had HF or that his condition was as critical as diagnosed. At discharge he would not have been scheduled for follow up nor would verification of attendance at appointments been assured.
6. Caregiver hospitalization for untreated/under treated conditions – It was apparent that Mrs. L also had some unrecognized or under-treated health issues. During the initial home visit the APN offered to check her BP and discovered it was elevated as she had run out of prescribed medications and was waiting until her husband was well to seek follow up. The APN encouraged Mrs. L to schedule follow-up and, luckily, during the intervention was able to arrange for her to be seen by her husband’s cardiologist for treatment of her hypertension. At discharge she was adherent to treatment and normotensive.
7. Low satisfaction with care
8. Increased/reinforced suspicion of health care system.

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With APN services:

1. Mutually developed goals which respected patients perspective, incorporated his ability to learn and develop trust for APN and collaborating – providers and physicians.
2. Medication adherence – On TL's enrollment the APN discussed case challenges with the attending cardiologist and collaborated to develop a simplified discharge plan. On discharge the patient was prescribed three medications for HF and had struck a deal with the APN and cardiologist to adhere for one month if reevaluation of need would be made at that point. An appointment to evaluate progress and medication need was scheduled prior to discharge from the facility with goal of the patient, caregiver, and APN to work on the plan with the cardiologist.
3. Dietary adherence – Mrs. L. reported serving a near-perfect diet despite ample evidence of high sodium foods in the kitchen and pantry. As she did all cooking and grocery shopping the APN addressed teaching related to label reading and dietary principles toward her. This teaching was also repeated to TL stressing basics such as avoiding adding salt at the table, avoiding high sodium fare when out of the home, and need to limit fluid intake to less than two liters a day. The couple reported eating out rarely but was able to identify restaurants which they enjoyed. The APN worked with each to identify favorite items and reviewed selections and triaged them as to be totally avoided, rarely consumed, or enjoyed in moderation and marked these menus accordingly.
4. Appropriate prescription of diuretic, beta-blocker, and ace inhibitor – Despite minimizing the regimen, APN-cardiologist adherence to guidelines for HF treatment

and current clinical evidence was high. On telephonic contact at 26 and 52 weeks after discharge from APN follow up he remained stable without subsequent rehospitalization.

5. Cardiology involvement- limited progression of disease, and no rehospitalization – TL denied severity of HF diagnosis but was willing – after developing trusting relationship with the APN – to receive care from cardiologist and was willing to continue after APN follow up ended as a trusting relationship fostered between physician, patient, and caregiver by the APN.
6. APN-MD care collaboration to patient benefit - The APN worked closely with the cardiologist to develop a trusting relationship and obtained her buy-in to work closely with the patient to reinforce the need for his medications and streamline his treatment plan. At 12 months post-enrollment the patient remained adherent to his treatment plan and was in close follow up with the cardiologist.
7. Physical Therapy (PT) assessment and resumption of ADLs/IADLs - Prior to admission, TL was very active maintaining his home, two apartments, and a large flower and vegetable garden. In a typical day he climbed two to three flights of stairs up to six times a day often carrying tools. In the summer he was very active in digging, carting, and planting large plants. Given degree of symptoms and severity of HF, APN requested PT evaluation during hospitalization and insisted on PT evaluation in home given TL's prior level of activity. The APN worked with TL to implement PT plan of care and gradually add more activity into his routine while being monitored for response. TL was able to resume his prior level of activity without onset of HF symptoms or untoward reaction to his medications. He was happily working in his garden when discharged.
8. High patient, caregiver, and physician satisfaction with APN services

9. No rehospitalizations during 52 weeks of follow up. One rehospitalization following follow up for cataract removal. Continues to receive care from his cardiologist and continues to do well at age 87.

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Helping Reduce Hospital Readmissions Using Seven Key Elements

By Cathy Jo Cress, MSW

Introduction

This article discusses the elements of transition in care based on the National Transitions of Care Coalition's evidence-based "Crosswalk" of transitions of care program. It documents how geriatric care managers can implement all seven transition elements, thus saving patients, aging families, the long-term care system, and hospitals money. It covers how GCMs can help prevent unnecessary hospital readmissions, implement Medicare savings, and ensure adequate follow-up care.

CMS 2012–2013 Penalty for 30-Day Hospital Readmissions

The Centers for Medicare & Medicaid Service (CMS), a branch of the U.S. Department of Health and Human Services, will penalize doctors and hospitals that have high 30-day readmission rates starting in FFY 2013.

A recent study in the *New England Journal of Medicine* (Jencks, Williams & Coleman, 2009) demonstrated that within a month of discharge, over 20 percent of Medicare beneficiaries were rehospitalized for the same condition they had been treated for earlier. This is very costly for Medicare and U.S. taxpayers. The NEJM article suggests that patients are being released, before they are fully stabilized, to a home situation unable to cope with the demands of their serious condition. The penalty is designed as an incentive to be sure patients are being

Geriatric care managers can become an essential part of the long-term care system and the hospital-to-home team.

discharged responsibly with adequate follow-up care.

Geriatric Care Managers Can Be an Integral Part of the Long-Term Care System

Geriatric care managers can become an essential part of the long-term care system and the hospital-to-home team. That team can provide the necessary coaching and support to patients and their families so that patients are not readmitted, stay in the community, and save everyone money.

To make this difficult transition successful and support the family caregiver, geriatric care managers should have a significant role with families and elderly patients before, during, and especially after discharge from the hospital.

The role of the geriatric care manager with an elderly client in the hospital mirrors care management tasks in general: educate, assess, advocate, move the client through

the continuum of care smoothly, and coordinate care.

All these skills are needed during hospitalization but are critical before admission and at discharge. The geriatric care manager coordinates transitional care. Yet so often, because of hospital policy, geriatric care management is not implemented in the hospital or when patient and family transition to home, thus contributing to unnecessary readmission (Cress, 2009).

Discharge planners, usually nurses and social workers, are overwhelmed by heavy case loads, so they do not have time to give individual service to patients. Skilled GCMs can render highly individualized service, 24/7, making the discharge planner's job easier.

Seven Tasks That GCMs Can Perform to Prevent Readmissions

National Transitions of Care Coalition put together an evidence-based "Crosswalk" of seven key elements of a transitions of care program based on transition intervention research (National Transitions of Care Coalition, 2011).

TASK 1:

Medication Management—A method to ensure the safe use of medications by patients and their families, based on patients' plans of care

The first task the GCM does before hospitalization is to update routine risk

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Helping Reduce Hospital Readmissions Using Seven Key Elements

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assessments, including depression screening, home safety, psychosocial and functional assessment, and current medications, which GCMs routinely do with new clients. This medication risk assessment is then integrated into the patient's updated care plan before hospitalization. The GCM can then share this information with hospital staff at admission with the patient's and other providers' permissions, in a HIPAA-compliant environment.

The GCM can transfer medication information to a computer disc or USB drive and give it to the hospital admissions department and family director, under HIPAA compliance. At discharge the GCM updates the medication list. The GCM ensures that the patient has a realistic plan for getting the medications and can pick them up if necessary to make sure the patient has them.

For families who wish the GCM to provide a high level of support, this is an excellent way to educate the patient's family at any transition of care, especially at discharge, when meds are often changed. The GCM counsels the family about medications, explaining what medications are being taken, emphasizing any changes in the regimen, and reviewing each medication's purpose, how to take each medication correctly, and important side effects to watch for.

TASK 2:

Transition Planning— A formal process that facilitates the safe transition of patients from one care setting to another, or from one practitioner to another

A GCM's job is to do transitions planning. Transition from one setting to another, especially into and out of the hospital, can be perilous for older people and their families. The change in surroundings, new providers, and new medications can be very

disorienting. The patient often cannot speak for him- or herself. The family often lacks some degree of health literacy and might not be included in the plan of care. This, coupled with hospital understaffing, makes the GCM valuable in making sure transitions are planned and executed.

The initial full assessment and care plan that the GCM creates can be shared with the hospital doctor and all care professionals throughout hospitalization. The GCM can also assess the family caregiver and identify skill level and training needs, so that at discharge there is a workable transition plan coordinated with the discharge planner, home health agency, and the health care provider team.

Before discharge, the GCM can alert hospital discharge planners to problems in the patient's home environment such as lack of grab bars, loose wires, or steps. The GCM can solve problems before discharge, greasing the wheels of the transition through the home safety assessment.

The GCM can also refer families to the hospital social worker for additional support and access to services in the hospital. This helps the family be more prepared to take on the care, post discharge, increasing the chances that the patient will not cycle back into the hospital within thirty days.

TASK 3:

Patient and Family Engagement/Education— Family meetings in the hospital

Embracing a family-centered perspective is critical to achieving quality of care and engagement for people with chronic or disabling conditions. This perspective helps the GCM, along with the hospital staff and others on the health care team, successfully engage and organize the patient, family caregivers, and friends through all transitions. At the transition from home to hospital admission, the GCM can be a valuable conduit of information to the discharge planner, physician, and rehab or home

health agency about the family and the level of dysfunction that will affect a transition to home.

Because of the ongoing relationship, the GCM can distinguish who represents the patient's family, who will be caregivers, who will be the main spokesperson communicating with the discharge planner and others. If the client does not have mental capacity, the GCM can smooth the transition to home by organizing the family around this spokesperson.

To further engage the family, the GCM can arrange a family meeting in the hospital. Family communication can break down in the hospital, especially for dysfunctional families. The GCM can ask the hospital staff and attending physician to schedule a family conference. A plan of care should come out of the meeting, which the GCM will create and submit to the family and the attending physician for consideration. The GCM can help the family add an ongoing list of questions they wish to ask staff about regarding care, procedures, and problems.

The GCM can assist the family with health literacy. This can include condition-specific information in multimedia formats (print, DVD, discs, internet sites, and so on).

The GCM can interpret and enhance the health information given to the family about hospital procedures and the post-acute care that will be needed for a successful transition to home.

TASK 4:

Information Transfer— Sharing of important care information among patient family, caregiver, and health care providers in a timely and effective manner

The GCM always shares patient care information across the continuum of care in a timely and effective manner. The GCM can give a copy of the disc or USB drive with the patient's health record to the hospital admissions and family director, under HIPAA compliance, to ensure that updated patient information is transferred and shared at every

transition. The personal health record can include a copy the GCM's client data sheet with meds, diagnosis and care plan, and medical history.

Throughout the hospital stay, the geriatric care manager encourages the family to use the personal health record. This record can be managed with the GCM's support and helps to formulate the patient's and family caregiver's questions. These questions may include reasons for taking medications, reason for a worsening condition, and problems in the hospital. This helps the family to share clear information with the hospital and to collect shared information from hospital providers.

A personal health record can be as simple as a piece of paper in a file folder. GCMs can encourage the family to transfer the information to a computer disc or USB drive, and there are many personal care record products and programs on the market.

The GCM shares the critical legal documents and care information with the hospital admissions (with HIPAA compliance), such as power of attorney for health care, durable power of attorney for health care, a living will, or a do not resuscitate order. The GCM gets this information at intake, before a medical crisis and hospitalization occur. This legal information, already checked and shared, helps the hospital and ensures that the kind of care the older patient wants delivered is delivered.

TASK 5:

Follow-Up Care—Facilitating the safe transition of patients from one care setting or care provider to another through effective follow-up activities

The GCM's family-centered approach ensures safe transitions, especially at discharge, and effective follow-up activities. The GCM helps organize the family into a unit of care to help with all transitions.

Unit of care is a term that means the focus of a plan of care. Including the family was originally a major goal of hospitalization and discharge

planning. The GCM's approach is that it is not the care recipient who is the client, but the "client system"—including the family, the family caregiver, and friends—that is the client. The GCM can encourage the "unit of care" to be actively involved in the discharge plans, ensuring safe transition to home.

The care manager also alerts the family that if they feel the discharge is premature, the family and patient have a right to appeal the decision, thus ensuring that the patient goes home only when it is safe.

Hospitals are required to give every Medicare patient or family caregiver a copy of the statement about appealing discharge decisions, "An Important Message about Medicare." They must make sure the family and patient, if competent, understand the process. This document spells out the patient's rights to all needed hospital care and post-discharge follow-up. The hospital must also give a written notice explaining the discharge, a "Hospital-Issued Notice of Non Coverage" or HINN. The HINN includes the phone number of the local peer review organization (PRO) and other organizations that review contested cases. Care managers can help the family understand that the hospital cannot force family caregivers to take patients home or pay for continued care before the PRO makes a decision. The GCM works supportively, not adversarially, with the discharge planner and physician to mediate the situation and answer the family's or patient's questions about a nonreadiness for discharge to try to resolve the disagreement so that the patient family and discharge planner get what they need. Physicians and discharge planners are pushed by DRGs and too many patients. So the GCM's extra support can provide a way to get the patient to the point of safe discharge.

The GCM is key, post discharge, to keeping the patient from readmission. At discharge, the family's health literacy becomes critical to follow-up care. While the older family member is in the hospital, the GCM networks

with local, state, and national agencies on aging to arrange condition-specific information and training on post-acute tasks at discharge. For example, if the client has had a stroke, the GCM contacts a local or national American Heart Association for information (multimedia, DVD, web, print, if possible) about aftercare. The GCM contacts the local stroke association to find out if they have training for family members to care for family at home and if they will come to the hospital pre-discharge to do the training.

The GCM can ask the physician if the hospital has a checklist of specific information about the medical conditions and needs of the elderly patient during the transition to home. This involves the family and caregivers in discharge and helps to make the transition to home smooth. The GCM can also request that the physician, discharge planner, or RN review the checklist with the patient and family to make sure the family understands the home care needs of the patient.

If the physician or the hospital has not taken steps to involve the family in the unit of care, the GCM gets the family involved through follow-up training. The GCM can ask the physician if the PT and OT can train family members in transfers and use of medical equipment pre-discharge. If this does not happen, the patient has a much greater risk of readmission because the family caregiver did not know how to render care. In addition family members could injure themselves by lifting, giving injections, or managing complex machines that they are not trained to manage.

TASK 6:

Health Care Provider Engagement

GCMs work with the patient's primary care physicians, specialists, home care agencies, and local caregiver organizations at admission, while the patient is in the hospital, and at discharge to ensure health care

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provider engagement and to help the physician support the family caregiver. The GCM can arrange caregiver training for post-acute tasks (bathing, lifting, injections, and self-care for caregivers).

Involving a Home Care Agency

Another key health care provider is the private duty home care agency. Except for very brief coverage for post-hospitalization, Medicare does not cover home care or what it defines as long-term chronic care. So the patient and family must pay for home care unless they have long-term care insurance. The GCM will have assessed whether the patient can afford home care as part of the initial assessment. The GCM can share the patient's financial information with the discharge planner. If the patient needs 24/7 care, with the help of the discharge planner and the hospital staff, the GCM can assess the patient's present level of care and help the patient, discharge planner, and family find the correct affordable care. All these arrangements can be the key to keeping someone at home as opposed to sending him or her back into the hospital.

The GCM and the discharge planner evaluate whether the family member who plans to render care can really do so. If the GCM compares the family members' abilities (such as ability to lift, ability or willingness to be trained in injections and in managing medical equipment such as a Hoyer lift or wheelchair) with the patient's condition at discharge, the GCM and the discharge planner can help the family member decide whether the family member can render care safely. If not, the GCM can help build a support system that may involve informal support from other family members, close neighbors, or friends who can give injections or be trained to give injections.

TASK 7:

Shared Accountability Across Providers and Organizations—Enhancing the transition process through accountability of care of the patient by both the healthcare provider (or organization transitioning) and the one receiving the patient

It is critical for the GCM to assess the patient's home before the patient goes home. This risk assessment ensures shared accountability, a key to preventing hospital readmission. The GCM will have done this assessment as part of the original assessment. Before the older patient is released from the hospital, the GCM reevaluates the home assessment in terms of the patient's changed condition as a result of the hospitalization and shares this information with the discharge planner, family, and Medicare agency, if they are involved. This increases shared accountability by putting everyone on the same page about a safe discharge. For instance if the patient could climb stairs before the hospitalization and now cannot, the GCM may have to investigate a ramp or first-floor bedroom. Alternative housing or placement will have to be made if modifications are not possible. The family must be involved in either case. The GCM sharing this information with all players creates shared accountability and a safe transition to home and helps prevent readmission.

In summary, the GCM is a professional who can carry out key elements of transition in care based on the National Transitions of Care Coalition's evidence-based "Crosswalk" of seven key elements of a transitions of care program. The GCM can and should be a key team player in the long-term care system that works together to meet CMS mandates to avoid unnecessary hospital readmission.

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Cathy Cress holds an MSW in Aging from U.C. Berkeley. Her book *Mom Loves You Best, Forgiving and Forging Sibling Relationships* (New Horizon Press) came out in October 2010. *Cress's Handbook of Geriatric Care Management, 3rd edition* (Jones and Bartlett, March 2011) is the bible of geriatric care management. *Care Managers, Working With the Aging Family* (Jones and Bartlett, 2008) is one of the few major books on the aging family. Ms. Cress is the founder of GCM Consult, which works with local and national groups that want to add or launch GCM businesses. She is on the faculty of the online master's program in geriatric care management at the University of Florida.

Reducing Hospital Readmissions—One Hospital’s Journey to Implement Safer Transitions in Care

By Robin Jones, RN

The passage of the Affordable Care Act (ACA) and the release of the \$500 million in CMS (Centers for Medicare & Medicaid Services) funding have catapulted preventable readmissions into the forefront of healthcare agendas across the nation, posing the question for us all to ponder – How can we make discharging patients from the hospital safer? As you probably already know, there is no simple answer or quick fix. Besides managing the medical condition, you must factor in personalities, family members, education, socio-economic status, religion, and readiness to engage. This involvement is not only with the patient, but the downstream providers and the community as a whole.

Working In My Silo

Valley Baptist Medical Center – Brownsville was first approached about working on a little known CMS demonstration project in the fall of 2008 by TMF Health Quality Institute. TMF is the Quality Improvement Organization contracted by CMS for the State of Texas. This was long before the time of the glitz and glam that successful readmission initiatives have now, so you can imagine the difficulty in engaging the key stake holders within the hospital and even worse – the local medical community as a whole. The general mentality at the time was “Once they leave here—they’re out of my control!” So with lots of hand holding, TMF gently pushed us into the sea of readmission

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issues plaguing the patients in our local community. We soon discovered this was not a one-man dog-and-pony show. It was going to take a village, a very large village, to put together all the pieces in this complicated puzzle.

Step #1 • Figuring out where to start was the first challenge: patients were coming back, when were they coming back, why were they coming back, who was sending them back, and which returns were preventable?

Deciphering The Medical Maze

Step #2 • Once we had some concrete readmission data about our patients and medical community, we were able to dive into working on solutions. Our first conclusion was that communication was one of the biggest factors in this whole equation. Communicating with EVERYONE was of the utmost importance, including patients, families, doctors, therapists, pharmacies, and downstream providers. We decided that Boston University’s Medical Center’s Project RED (Re-Engineered Discharge) was the most appropriate intervention model

for our facility. Project Red (see table on next page) focuses on ensuring the patient/family has and understands the vital medical information needed to care for the patient.

At this point you may be asking, how does this relate to me? The answer is COMMUNICATION, and it does not matter from what part of the medical community you come from. It is all about

the patient – patient communication, education, understanding, and experience. First of all, does the patient know and understand what disease or condition they have? If they do not, either educate the patient and their family or find a resource that could assist them. Help the patient to understand what symptoms are normal for their condition, which symptoms they should be contacting their physician for, and which symptoms warrant a trip to the emergency department. Patients should always have the contact numbers to all of their healthcare providers and should know which one they should contact for any questions, depending on their symptoms.

Make sure the patient understands when their next appointment is and has transportation to get there. Once patients go to appointments, it is very important to follow-up with any testing or procedures they have pending. Ensure the patient or family knows how to make these arrangements, and again, make sure they can get there. If any testing or procedures are done, make sure the patient follows up to get any

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pending results if they are not immediately given. Does this patient have any services – home health, palliative care, meals on wheels, healthcare provider, rehabilitation? Ensure the patient understands what benefits they have, the services each provider is responsible for supplying, and how to reach them when they need them.

Do not forget one of the biggest parts: The Medication List. Make sure the patient has a current medication list. They need to understand why they take the medication, how to take it, its side effects, and, most importantly, we need to make sure they are able to obtain all of their medications. Create a realistic plan for patients to obtain medication whether it is from a pharmacy that delivers, getting samples from a physician's office, or having a medication changed to a more affordable one. Patients should understand that they own their medication list. They are not a courier of the medication list between healthcare providers. It is essential that they understand the importance of this list, taking it with them to every single medical appointment and keeping it updated.

Patients should be taught how to keep and manage a personal health record as well. As time goes on and memories fade, it becomes very hard to remember what conditions, procedures, and surgeries you had done, where you had them done, and which physician did what. Keep a running list that can be easily added to or updated.

Every time a patient has been provided information, assess the patient's degree of understanding and provide reinforcement for any instructions they did not understand. The more patient-centered you can make your interventions, the more successful you will be. There are several free helpful websites available for medication schedules, electronic calendars, and personal health records. Most older adults continue to like using paper schedules and lists. Most of these websites have

Components of the Re-Engineered Discharge (RED)

1. Educate the patient about his or her diagnosis throughout the hospital stay.
2. Make appointments for clinician follow-up and post discharge testing and
 - Make appointments with input from the patient regarding the best time and date of the appointment.
 - Coordinate appointments with physicians, testing and other services.
 - Discuss reason for and importance of physician appointments.
 - Confirm that the patient knows where to go, has a plan about how to get to the appointment; review transportation options and other barriers to keeping these appointments.
3. Discuss with the patient any tests or studies that have been completed in the hospital and discuss who will be responsible for following up the results.
4. Organize post-discharge services.
 - Be sure patient understands the importance of such services.
 - Make appointments that the patient can keep.
 - Discuss the details about how to receive each service.
5. Confirm the Medication Plan.
 - Reconcile the discharge medication regimen with those taken before the hospitalization.
 - Explain what medications to take, emphasizing any changes in the regimen.
 - Review each medications purpose, how to take each medication correctly, and important side effects to watch out for.
 - Be sure patient has a realistic plan about how to get the medications.
6. Reconcile the discharge plan with national guidelines and critical pathways.
7. Review the appropriate steps for what to do if a problem arises.
 - Instruct on a specific plan of how to contact the PCP (or coverage) by providing contact numbers for evenings and weekends.
 - Instruct on what constitutes an emergency and what to do in cases of emergency.
8. Expedite transmission of the Discharge Resume (summary) to the physicians (and other services such as the visiting nurses) accepting responsibility for the patient's care after discharge that includes:
 - Reason for hospitalization with specific principal diagnosis.
 - Significant findings. (When creating this document, the original source documents -- e.g. laboratory, radiology, operative reports, and medication administration records - should be in the transcriber's immediate possession and be visible when it is necessary to transcribe information from one document to another.)
 - Procedures performed and care, treatment, and services provided to the patient.
 - The patient's condition at discharge.
 - A comprehensive and reconciled medication list (including allergies).
 - A list of acute medical issues, tests, and studies for which confirmed results are pending at the time of discharge and require follow-up.
 - Information regarding input from consultative services, including rehabilitation therapy.
9. Assess the degree of understanding by asking them to explain in their own words the details of the plan.
 - May require removal of language and literacy barriers by utilizing professional interpreters.
 - May require contacting family members who will share in the care-giving responsibilities.
10. Give the patient a written discharge plan at the time of discharge that contains:
 - Reason for hospitalization.
 - Discharge medications including what medications to take, how to take them, and how to obtain the medication.
 - Instructions on what to do if their condition changes.
 - Coordination and planning for follow-up appointments that the patient can keep.
 - Coordination and planning for follow-up of tests and studies for which confirmed results are not available at the time of discharge.
11. Provide telephone reinforcement of the discharge plan and problem-solving 2-3 days after discharge.

an electronic version that are easy to update and print. A great resource for medications is My Medication Schedule at <http://www.mymedschedule.com/>. You can update & print medication schedules or pill box organizers in English or Spanish, even in wallet size, and adjust settings so you can even send text or email reminders of when to take medications and set up refill reminders automatically. The TMF website @ <http://caretransitions.tmf.org/> has several helpful forms and links for patient and the community, as well as patient self management tools for personal health records and advance directives. Lots of Helping Hands is a free web-based community to organize family and friends during times of need at <https://www.lotsahelpinghands.com/>. It can even be as simple as using the electronic calendar already programmed on your computer or cellular phone to schedule appointments and reminders. Incorporate what is easiest

to use and update in your and your patient's daily routine.

Outcomes—Did This Actually Work?

CMS's goal was to reduce readmissions by two percent in two years in 14 communities across the nation. Our facility and our community both succeeded. Our facility dropped our readmission rate by six percent and our community dropped it by two percent.

We also defined our success in several other areas. We saw that the number of patients who were actually seen by their physician between discharge and readmission nearly doubled. Additionally, we saw our patient satisfaction scores increase for discharge instructions, medication explanation, and communication. Our data shows that readmission rates dropped into the single digits for patients who received a 2-3 day

follow-up call from our intervention group to ensure they understood their discharge instructions and medication list. You may be asking yourself, is this replicable? It is. Our sister facility in another community reduced their readmission rate by three percent. As long as you know what issues cause your readmissions, you can reach out and partner with the entities that can help provide the solutions for your patients.

Next Steps

Step # 3 • Engage your local community. One of the most important things you can do for your community is set up and sustain the necessary infrastructure and support to care for this frail and vulnerable patient population. No one person or health care entity can provide the type of collaboration and partnerships necessary to accommodate every aspect of a person's total needs. Establish a community coalition meeting to discuss issues, barriers, and successes within your community. Use this forum to increase communication between providers and eliminate issues at each stage of a patient transition.

Set up a charter for your community coalition establishing your mission, vision, objectives, goals, and meeting requirements. Always remind community providers that we are here for a common mission. Providing the patient with the best and safest care needs to be first on everyone's list. There is always a fear of transparency amongst competitive providers in the community. Please always keep in mind that patient safety is not a competition and can never be compromised. There are so many other things that the medical community can compete on, such as who has the best CT scanner in town, who has the best Core Measures rates, or the shortest wait time. Work with your local medical community to develop "best practice" providers. Provide patients and families with local resources that best fit their needs and who care for their loved ones as if they were their own family members. Opening these lines of communication is vital to providing safe, optimal patient care.

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CT Project Results					
Hospital Disposition After Inpatient Hospitalization					
Quarter 4, 2010 based on Medicare Claims Data					
Region & Provider	Setting	Number of Discharges	Percentile of All Discharges	Discharges with a 30-day Readmit	Percent of Discharges with a 30-day Readmit
Harlingen Region	Home Health Agency (HHA)	770	17.1%	102	13.3%
	Home	2,677	59.4%	595	22.2%
	Inpatient Rehabilitation Facility (IRF)	301	6.7%	49	16.3%
	Long-Term Acute Care (LTAC)	220	4.9%	41	18.6%
	Skilled Nursing Facility (SNF)	537	11.9%	121	22.5%
	All	4,505	100.0%	908	20.2%
Your Hospital	Home Health Agency (HHA)	96	16.2%	8	8.3%
	Home	322	54.3%	56	17.4%
	Inpatient Rehabilitation Facility (IRF)	51	8.6%	3	5.9%
	Long-Term Acute Care (LTAC)	49	8.3%	10	20.4%
	Skilled Nursing Facility (SNF)	75	11.9%	12	16.0%
	All	593	100.0%	89	15.0%

Reducing Hospital Readmissions—One Hospital's Journey to Implement Safer Transitions in Care

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Conclusions

In essence, the best thing that you can do is get out of your comfort zone and form alliances with the gold standard achievers in your community. Do everything possible to ensure that your patients receive the best possible care by working with providers who step outside the boundaries of their four walls to provide patients with safe transitions at each step of their medical journey.

- Re-engineered Discharge (RED) <http://www.bu.edu/fammed/projectred/index.html> strives to minimize post-discharge hospital utilization by using a standardized discharge intervention that includes patient education, comprehensive

discharge planning, and post-discharge telephone reinforcement.

- TMF Health Quality Institute <http://caretransitions.tmf.org/> Care Transitions is a Medicare Quality Improvement program under the Centers for Medicare & Medicaid Services. Its goal is to reduce the rate of avoidable re-hospitalizations by improving the transition of patients across care settings.
- My Medication Schedule <http://www.mymedschedule.com/> Free website for medication schedules & reminders.
- Lots of Helping Hands <https://www.lotsahelpinghands.com/> Free web-based community to organize family & friends during times of need.

Robin Jones, RN, has over seventeen years of experience in the hospital setting and is a Quality Improvement Coordinator at Valley Baptist Medical Center

in Brownsville, Texas. Ms. Jones is the lead Care Transitions project facilitator at VBMC-B. She led the Hospital's implementation of Project RED components resulting in a 5.8% reduction in all cause readmission rates and a final rate that exceeds the national average. She has spoken on Care Transitions and Project RED for several conferences and webinars, including a National CMS Care Transitions Conference, Texas Hospital Association, Healthcare Coalition of Texas, and Case in Point. As a Quality Improvement Coordinator, Ms. Jones oversees VBMC-B's Joint Commission (JC) re-accreditation for the hospital and lab and re-certification stroke program. Additional projects include a Six Sigma Greenbelt Certification, Change Agent Training and initiative on anticoagulation, medication reconciliation, and readmissions.