Navigating Across Care Settings: Choices for Successful Transitions

Abstract. The Massachusetts Executive Office of Elder Affairs (Elder Affairs), in partnership with Aging and Disability Resource Consortium of the Greater North Shore (ADRCGNS), Massachusetts Rehabilitation Commission and MassHealth seeks to implement Navigating Across Care Settings: Choices for Successful Transitions (NACS), in order to provide the Care Transitions Intervention (CTI) to 300 people with congestive heart failure, chronic obstructive pulmonary disease or diabetes. The project will expand community partnerships to bolster CTI's effectiveness by connecting participants with peer supports, evidence-based programs and Options Counseling.

The goal is to expand capacity to promote healthy, successful care transitions by 1) strengthening communications around consumer health issues across settings; 2) fostering consumer health self-management; 3) increasing awareness among professionals about care transitions; 4) reducing consumer and caregiver stress; and 5) reducing hospital re-admissions, preventable hospitalizations, and premature nursing facility placements.

NACS will retain six trained CTI coaches, enhance agency partnerships and develop a formal evaluation in order to gauge these outcomes: 1) lower rates of rehospitalization within 30- and 90-day periods; 2) greater consumer and caregiver satisfaction and awareness regarding choice, supports and control surrounding health routines and regimens; 3) more effective communication between consumers and health providers; 4) more positive feeling among consumers about their health and well being; 5) greater caregiver confidence in problem solving abilities and ability to cope with stress and manage their lives; and 6) integration and awareness of Care Transitions supports into provider practice and referral networks.

Current Activities and Proposed Approach. ADRCGNS provides a "no wrong door" integrated system of information and access for elders and persons with disabilities seeking long-term services and supports throughout the twenty-five diverse communities comprising Massachusetts' Cape Ann and North Shore. Recognizing that our consumers are often at risk of complications and injury during shifts in care settings, ADRCGNS is actively involved in the development and implementation of evidence-based and consumer-centered care transitions programs that promote meaningful choices, independent living and self-determination. NACS is particularly critical for consumers with disabilities who typically experience significant health inequities and disparities, higher incidences of secondary conditions, and greater barriers to care. NACS, which creates a web of best practice transition supports around an

evidence-based transition intervention, is designed to provide consumers with skills for effective health self-management; and to strengthen the availability and accessibility of community-based long-term supports.

Current Care Transitions Activities. The foundation of NACS is the Coleman Care Transitions Intervention model, which includes consumer empowerment and choice as key components. Designed to encourage consumer participation in care transitions through the "four pillar" coaching approach, CTI has demonstrated results in promoting consumer health self-management and lower hospital readmission rates.[i] NACS is implemented in conjunction with North Shore Medical Center (NSMC) and Northeast Health Systems (NHS), which operate the major hospitals in the ADRCGNS service area. ADRCGNS is now implementing CTI at two hospitals within this system as follows:[ii] 1) ADRCGNS nurse liaisons[iii], based in each hospital, work with appropriate hospital staff to identify consumers to participate in the project; 2) Three Coleman-trained coaches, one nurse and two social workers based at Greater Lynn Senior Services, a GNSADRC partner, meet with the consumers and implement CTI, including home visits and follow-up calls; 3) Data from coaching, visits, and calls are entered into a database to track and compare consumer progress. Coaches provide consumers with information about other best practice supports available through ADRCGNS member organizations, including Options Counseling, community health education and support programs, volunteer/peer supports, caregiver supports and linkages with disability related agencies and resources.

ADRCGNS is also actively involved in the Massachusetts State Action to Avoid Re-hospitalizations (STAAR) Initiative.[iv] STAAR is directly informed by the Transitional Care Model (TCM) for reducing re-hospitalizations and embodies the TCM focus on improving processes in transitions in care, identifying and delivering supplemental services during transition, and promoting patient engagement based on health literacy principles[v]. Chosen as one of only three STAAR pilot states by the Institute of Healthcare Improvement[vi] in 2009,[vii] the Commonwealth identified 22 hospitals sites, including NSMC and NHS hospitals, to identify and track best practices for transitioning persons out of hospitals and into other care settings.[viii]

ADRCGNS staff are part of the STAAR Transitions Home Collaborative, which identified the CTI program as the most appropriate evidence-based mechanism to meet consumer needs, and which appointed ADRCGNS staff to take the lead in implementing CTI at NHS and NSHS. To enhance community engagement outside of the hospital setting, ADRCGNS member staff[ix] are working with The Medical Group, a 15-physician practice at NHS, to

implement a project involving Coleman-model transition coaching. The Medical Group has allocated a permanent space in which NACS can provide consumer education around transition choices.

To date, eleven ADRCGNS nurses and case managers have been trained in CTI by Dr. Coleman and his staff. The CTI project has identified a set of data elements (based on CTI tools and consumer satisfaction measures) and established a data tracking capacity. ADRCGNS participation in the STAAR initiative has promoted the development of clearer discharge protocols, stronger community linkages, and adoption of the CTI model in a physician practice and NHS hospitals in Beverly and Gloucester. It has also generated greater dialogue and willingness among our medical partners to incorporate best practice consumer-centered programming – such as chronic disease self-management programs (CDSMP), Options Counseling, and other evidence-based caregiver and peer supports – into an expanded care transitions program.

PROGRAM GOALS. NACS builds on these efforts, emphasizing health literacy, independent living and self-determination within the CTI model in order to create a higher impact care transitions model. The funding requested will specifically support an expanded NACS partnership between the ADRCGNS, NHS, the Medical Group, and MyWay Village/Connected Living (provider of computer technologies for elders and persons with disabilities) [x] that will serve 300 additional consumers with congestive heart failure, chronic obstructive pulmonary disease (COPD) or diabetes. The project will provide more sustained community-based transition supports, and reach more communities within our ADRCGNS area. The goals are to expand capacity to promote successful care transitions by:

A. Strengthening communications around consumer health issues across provider and community settings;

B. Fostering effective and sustained consumer health self-management;

C. Increasing awareness in the health and social service communities about the importance of care transitions;

D. Reducing consumer and provider stress around caring for complex/chronic conditions;

E. Reducing hospital re-admissions, preventable hospitalizations, and premature nursing facility placements.

<u>At the hospital:</u> ADRCGNS works with discharge staff at two NHS hospitals—Beverly and Addison Gilbert (Gloucester)—to identify patients with congestive heart failure, COPD or diabetes for enrollment into NACS. The Medical Group physicians notify NACS staff when their patients are hospitalized at one of these sites.

Tracking Consumers: NHS records managers will compile a comparison group with matching diagnostic, health and socio-demographic characteristics as NACS participants, and track both groups. (See Evaluation).

CTI and the Four Pillars. ADRCGNS will retain six additional CTI coaches, from the eleven who have been trained, who will administer all CTI tools to deliver the four pillars of support at the identified time periods and venues required by the protocols, ensuring optimal fidelity to the 30-day CTI model.

Options Counseling. Participants are offered opportunities to explore and access their long-term care options at multiple times and places, including hospital, residence, community centers, and participating medical practices. Options provided include home care, home modifications, assistive technology, peer support, and greater access to services from DEAF, Inc., the Massachusetts Commission on the Blind, and the Department of Mental Health.

Evidence-Based Community Health and Education Programs. Participants can access evidence-based community health and education including CDSMP and the ADRCGNS's Men's Health Project, which includes an ongoing support group incorporating the Partners in Health: How to Talk to Your Doctor curriculum.

Volunteer and Peer Supports. Participants are offered supports, including ADRCGNS Peer Support Groups[xi] and At Your Side Medical Advocacy Program, providing consumer-directed volunteer assistance from trained professionals such as preparation for or accompanying to medical visits, or helping to understand complex treatment regimens.

Caregiver Supports. ADRCGNS members deliver evidence-based caregiver programs emphasizing knowledge and skills for coping with the physical and emotional demands of chronic conditions.

Virtual Coaching Supports. Connected Living and It's Never 2 Late[xii] (a technology capacity currently available at an Greater Lynn Senior Services (GLSS) an ADRCGNS member site) provide consumers with user-friendly teleconferencing with family and providers. NACS can therefore offer virtual coaching supports at centers throughout the ADRCGNS area, including medical practice sites. The technology includes the capacity to create individualized programs to help manage medications, appointments, stress reduction and general health routines for elders and people with disabilities throughout the ADRCGNS service area.

CHALLENGES TO WHICH PROPOSAL RESPONDS: In seeking to reach 300 consumers, their caregivers, and their providers, NACS augments the current ADRCGNS CTI model to address these challenges: 1) It is difficult to establish critical relationships with consumers required for sustained transition success and self-management within

CTI's 30-day time frame; 2) the multiple potential transition support choices available to consumers are not coordinated under a single umbrella; and 3) community medical and social service providers are not sufficiently engaged in supporting care transitions. Among the advocates for broadening CTI as we propose is Dr. Eric Coleman, who argues that the "no care zone, the period following hospital discharge, must be filled by a rich tapestry of community partnerships offering ongoing and diverse supports. Thirty day interventions are insufficient to achieve the desired impact of greater consumer self-management, fewer transitions emergencies, more accessible community responses, and the meaningful reform of health care. [xiii] NACS responds by buttressing CTI with a menu of other options and empowering consumers to make informed choices to take control of their health.

ELEMENTS NACS WILL STRENGTHEN: AoA funding for NACS will significantly expand the numbers of consumers served (to over 300); provide consumers with more support options; more actively engage caregivers and providers; and offer consumers more time in which supports are provided to stabilize transitions. By dovetailing the CTI coaching component with a broader array of existing consumer support choices, and creating greater availability of those choices, AoA funding will strengthen NACS' capacity to offer a more seamless, more sustained, and ultimately more powerful intervention. Focusing on the partnership between the ADRCGNS and NHS, NACS will broaden present hospital-based collaborations and expand the web of partners, particularly our disability and mental health agencies, committed to successful consumer-centered care transitions.

OUTCOMES: 1) lower rates of rehospitalization within 30- and 90-day periods; 2) greater consumer and caregiver satisfaction and awareness regarding choice, supports and control surrounding health routines and regimens; 3) more effective communication between consumers and health providers; 4) more positive feeling among consumers about their health and well being; 5) greater caregiver confidence in problem solving abilities and ability to cope with stress and manage their lives; and 6) integration and awareness of Care Transitions supports into provider practice and referral networks.

MAJOR BARRIERS: Our approach is to work collaboratively within a newly expanded set of partnerships. In building new and deeper relationships, issues of communications across partner settings are always critical and always pose potential barriers. To overcome this potential obstacle, NACS will: 1) begin with a clear set of Memoranda of Understanding among all partners that clearly specify roles, responsibilities and referral procedures to existing

networks and resources; 2) establish a Care Transitions Coordination Committee (CTCC) that meets monthly comprised of the partners to oversee project management and activities; 3) create specific communication protocols that afford quick connections to—and responses between—CTCC members on an ongoing basis; develop policies for immediately addressing communication problems or delays; 4) document and review all project decisions and action steps to plan for expansion to other areas across the state. Provide regular monthly reports to the CTCC; 5) establish clear benchmarks within the work plan and measure progress at regular intervals; 6) provide regular consumer feedback to the CTCC; and 7) promote ongoing inter-staff cross-training and communications.

TARGET POPULATION AND GEOGRAPHIC COVERAGE: Care transitions supports in ADRCGNS communities are offered primarily through the hospital system and include the existing NACS, CTI, and STAAR components (described above) as well as patient education programs administered through NSMC which focus on highest-risk stroke and CHF patients. With the requested funding, NACS can serve 300 individuals of all income levels who are elders and/or persons with disabilities of any kind who present with diagnoses of COPD, CHF and Diabetes and who are identified through transition staff working with discharge planners. NACS expands the numbers of individuals served by CTI and provides the opportunity for medical practices to refer for transitions care through the hospital. Most NACS participants will reside in the NHS North Shore and Cape Ann catchment areas. ADRCGNS will work with Elder Affairs and MassHealth, the state's Medicaid program, to identify Medicaid enrollees to participate.

PARTNERSHIP REQUIREMENTS: NACS is a collaborative effort grounded in strong long-term working relationships among ADRCGNS and community medical partners. As outlined in the attached Memorandum of Understanding, the proposed project reflects even greater partner engagement and more seamless inter-partnership linkages. To resolve conflicts and ensure consistency in managing differences, procedures for continuous communications, debate and resolution will be established through the CTCC based on principles of consensus-building and informed by mutual and trans-disciplinary respect. Partners in this project will fulfill the following roles:

- NHS will assist in identifying participants, support coach's role in hospital, track and provide necessary data, participate in Care Transitions Committee

- Medical Partners will identify hospitalized participants, provide information and referral about NACS options, participate in focus groups, distribute surveys to provide feedback on consumer impact, and participate in the Care Transitions Committee.
- Connected Living will extend broadband access through ADRCGNS communities, provide "Ambassadors" to individuals and groups to facilitate use of technology, and work with ADRCGNS to develop web-based and downloadable care transitions support programming
- ADRCGNS will guide the project to ensure integrity, fidelity and rigorous evaluation, support, expand partnerships, publicize results, coordinate member programs to meet NACS participant needs, including: CTI coaching, Options Counseling, health education, CDSMP, caregiver supports, peer supports, information on housing, home modifications and assistive technology, and referrals to existing disability/aging networks.

STAFF REQUIREMENTS: Care Transitions Coordinators (coaches) are existing ADRCGNS staff who are licensed RNs or case managers and who have successfully completed the official CTI trainings. Under the direction of an experienced and CTI certified RN, the coordinators meet regularly to debrief and share experiences and identify areas where additional training and supports may be necessary from the CTCC and/or the Coleman Training Team.[xiv] Members of the CTCC will be pivotal in helping coaches to clearly identify and respond to challenges inherent in meeting the needs of a diverse target population. Six ADRCGNS staff will serve as coaches. Their coaching function will be a part of their broader staff roles, and so their caseloads will be relatively small. Based on current experience, coaches will carry between 2 and 3 unduplicated consumers per coach, per month. We anticipate a total of at least 300 unique hospital discharged participants through the 2-year grant.

SYSTEM REQUIREMENTS: The strong administrative and management capacities of the ADRCGNS fully support NACS. A NACS Leadership Committee, comprised of senior executives from North Shore Elder Services (NSES), the Independent Living Center of the North Shore and Cape Ann (ILCNSCA), Greater Lynn Senior Services (GLSS), and SeniorCare (SC) not only monitors NACS (these individuals are also a part of the CTCC along with key staff from NHG and the Medical Group) but will ensure that their organizations provide all appropriate resources for the project's success. NACS staff are based at the ADRC partner organizations through which they receive salaries, benefits, facility and communication supports and ongoing supervision. Several partners maintain large data

management functions capable of processing thousands of records through various SQL-based software applications. These system abilities enable NACS to maintain strong inter-partner communications, create and develop appropriately shared documentation, and manage and analyze project data.

The Project Director will coordinate all NACS CTI coaches. Supporting programs, delivered through each member organization, are also coordinated by the Project Director and the ADRCGNS leadership committee. Offices and meeting spaces are available at multiple locations throughout the 25 communities.

EVALUATION: ADRCGNS will work closely with the University of Massachusetts Donahue Institute (UMDI) to design and coordinate an overall project evaluation plan, including development of appropriate survey and focus group tools and protocols and a data analysis plan. UMDI will be the external evaluation consultant for NACS and will establish data sharing protocols with NHS and medical practices and conduct data analyses. The UMDI Research and Evaluation Unit has extensive experience developing and implementing comprehensive formative and summative evaluations and applied social science research studies in the areas of health and human services.

NACS focuses on three domains of inquiry in order to maintain quality and assess project impact:

1. Fidelity. ADRCGNS follows the protocols and tools as prescribed by the specific programs, with special attention focused on ensuring optimal fidelity with the CTI model. Coaches are provided with protocol checklists, reporting protocol adherence at each intervention. Each coach is observed implementing various aspects of the intervention at periodic intervals. NACS uses suggested CTI process indicators to monitor adherence and immediately addresses fidelity issues should they emerge.[xv] GLSS will lead this effort.

2. Consumer Satisfaction and Outcomes. NACS is designed to produce more successful transition outcomes—fewer re-hospitalizations and premature institutionalizations; increased independent living opportunities, self-determination, satisfaction; and enhanced life quality during and following the transition process. To determine changes in these areas, ADCRGNS is designing consumer surveys incorporating the CTI module and will conduct focus groups.[xvi] ADRCGNS will learn whether 1) consumers acquire and retain skills; 2) the skills are used; and 3) how using the skills affects satisfaction and life quality. Finally, we wish to know whether the CTI impact is strengthened when consumers and their caregivers have access to the other community programs NACS will offer. We plan to develop and implement a comprehensive evaluation that includes periodic short surveys, interviews, and focus groups and compare responses from a matched "CTI-only" group with one also participating in other NACS options.

3. Hospital Data. Assessing the impact of the NACS intervention on the critical issue of hospital re-admissions at 30- and 90-day time intervals will require matching of participant and control groups according to appropriate socio-demographic and health indicators. Each group will also include individuals identified through the medical practices. The intervention group will include "CTI-only" participants as well as those participating in other NACS options. NHS has agreed to share all appropriate data with NACS evaluators. (See attached Memorandum of Understanding.) The NACS partners believe that understanding how these data elements are interrelated will promote a stronger care transitions capacity and therefore support long-term project sustainability. Towards that end, NACS protocols and standards emphasize appropriate information-sharing while also protecting confidentiality. Data elements collected will include socio-demographic information, such as age, gender, race, ethnicity and language household composition, as well as level of formal and informal supports, ability to perform activities of daily living, date of previous hospitalizations, daily routines, completion in CTI and other programs, medications taken, reconciliation, provider follow-ups and consumer-provider interactions.

ORGANIZATIONAL CAPACITY: ADRCGNS has operated as a highly effective collaborative, launching and sustaining multiple successful initiatives since 2005. Comprised of four Area Agencies on Aging/Aging Services Access Points ("ASAPS:" NSES, GLSS, SC and Mystic Valley Elder Services), ILCNSA, the Elder Service Plan of the North Shore (ESPNS), and the North Shore Career Center, ADRCGNS offers a deep and mutually supportive organizational capacity for supporting the multi-dimensions of the proposed care transitions project. One of the Commonwealth's two initial ADRC pilots, ADRCGNS has pioneered several critical initiatives including Options Counseling, Regional Mobility Management, and Care Transitions supports. ADRCGNS members serve as champions of the fundamental principles of consumer self-determination, autonomy, full community inclusion and equal access, and the dignity of risk. (See attached organizational chart/key staff resumes.)

ASAPs are the state-designated organizations ensuring the delivery of home and community based services to elders, including information and referral, interdisciplinary case management and protective services. ILCNSCA provides information and referral, independent living skills development, self-advocacy, peer counseling, service coordination and system advocacy with individuals of all ages with all types of disabilities following the federal standards and assurances of independent living. ESPNS offers one-stop comprehensive health and social services

enabling individuals at-risk of nursing home placement to remain in the community. The depth of commitment, capacity, and cross-training within the ADRCGNS allows for effective implementation of NACS by multiple individuals and will not be adversely affected by staff turnover.

PROJECT MANAGEMENT. Cheryl Krisko, RN, Director of Health Services at NSES, will be responsible for day-to-day project management, reporting to the ADRCGNS Leadership team, comprised of senior executives with profound experience and expertise in delivering consumer-centered health care supports. Ms. Krisko is a certified CTI coach, and will supervise other coaches, chair monthly coaching debrief meetings, ensure CTI fidelity and on going coach training as needed, provide monthly updates to CTCC, develop quarterly progress reports, liaison with evaluation team and serve as a communications link across project partners and programs. Other project leadership includes:

Paul Lanzikos, Executive Director of NSES, will supervise Ms. Krisko, convene quarterly partner meetings to review progress, liaison with My Way Connected Living, Elder Affairs and Administration on Aging, convene post project seminar to discuss findings, and oversee progress and final reports. NSES will receive and manage the funds for the project.

Mary Margaret Moore, Executive Director of ILCNSCA, will oversee delivery of Options Counseling and peer supports, and will liaison with partners and ensure that the project is meeting the needs of people with disabilities.

Deborah Shih, MD at the Medical Group and Darcey Adams, Director of Community Programs at NHS will provide project oversight, networking, problem-solving and facilitation support.

Scott Trenti, Director of Home Care at SC, will oversee best practice delivery of CDSMP and provide general problem solving support.

Susan Brown, RN GLSS, will oversee participation of NACS consumers in Men's Support Group.

Valerie Parker Callahan, Director of Planning at GLSS, will oversee all non-hospital based evaluations, design and implement surveys and focus groups, analyze data, write reports and liaison with hospital evaluation efforts.

Emily Kearns, PhD, GLSSS, will design and implement surveys and focus groups, analyze data and write reports.

David Scott, GLSS, will design data bases and oversee data entry.

Christina Citino, UMDI, will oversee Donahue Institute's data analysis and liaison with other evaluation efforts.

James Dunne, CEO, NHS Senior Health, will ensure appropriate access to hospital data.

END NOTES:

[i] http://www.caretransitions.org/

ii Susan Rosenbeck, R.N., a member of Dr. Eric Coleman's Training Team, has been apprised of – and has approved – the protocols for this pilot.

[iii] The Nurse Liaison is employed by Greater Lynn Senior Services (GLSS), an ADRCGNS leadership organization.

[iv] http://www.ihi.org/IHI/Programs/StrategicInitiatives/STateActiononAvoidableRehospitalizationsSTAAR.htm

[v] Boutwell, A. Jencks S. Nielsen, GA. Rutherford, P. *State Action on Avoidable Rehospitalizations Initiative (STAAR): Applying evidence and experience in front-line process improvements to develop a state-based strategy.* Cambridge, MA: Institute for Healthcare Improvement; 2009. (found on website: http://ah.cms-plus.com/files/STAAR_State_Based_Strategy.pdf)

[vi] The Institute of Health Care Improvement is a national private non-profit organization supporting promising practices for better patient care through a variety of programs and supports. See http://www.ihi.org/NR/rdonlyres/98BA9790-07A1-4458-9C90-D5190272738/0/closingTheGapNEW.pdf

[vii] Massachusetts articulated these twin goals for its STARR initiative: 1) to reduce avoidable re-hospitalizations by 30%; and 2) to increase consumer satisfaction with the care they received.

[viii] Massachusetts STAAR objectives also include: achieving clinical excellence as reflected in evidence-based metrics; and t promoting strategically sound and collaboratively developed health care reforms.

[ix] This project is under the auspices of North Shore Elder Services (NSES), an ADRCGNS leadership organization.

[x] "The mission of MyWay Village is to enhance the lives of seniors by empowering them to connect with family, friends, and community. In 2006 after caring for aging relatives from a distance, the company's founders Chris McWade and Sarah Hoit, realized that simplified computer technologies combined with personalized support services could significantly improve the quality of life for a large, growing porti on of the population." http://www.mywayvillage.com/about.html

[xi] The Peer Support program is delivered through the Independent Living Center of the Greater North Shore and Cape Ann (ILCGNSCA), a foun ding member of the ADRCGNS

[xii] *Connected Living* provides a comprehensive training and support program for individuals who wish to connect with their loved ones through cutting edge computer communications technology. Also provided is a "living ambassador" service that provides individual and group education and training, including a curriculum with modules designed to facilitate group discussion. *It's Never2Late* offers an enhanced "group chat" capacity, a broad package of individualized assistive technology (including audio email), as well as evidence-based "virtual therapy" for consumers with dementia

[xiii] See for example, Coleman and Williams, *Executing High-Quality Care Transitions, A Call to Do it Right, 2007;* CHCF Care Transition Projects: Final Progress Report and Meeting Summary.

[xiv] The Coleman Training program includes ongoing connections with CTI coaching programs to support training needs as these emerge.

[xv] Fidelity to protocols required within the CDSMP, Options, and Caregiver programs is monitored using established tools and reporting mechanisms and is the responsibility of the respective program directors.

[xvi] ADRCGNS staff brings significant experience in survey and focus group design, implementation and analysis In fact, the ADRCGNS evaluation staff has recently pioneered an image-driven focus group technique which reduces facilitator bias and diminishes the complications of constituitive meanings that often undermines this important research tool. Staff were invited to present their work on imag e-driven focus groups at the GSA Scientific Conference in Atlanta this

past fall and the ASA/NCOA Conference in Chicago last March. This technique will be effectively integrated within our broader qualitative framework to assist in clarifying participant perceptions and decision-making.