Strategies to Support Care Partners and Improve Care Transitions

Welcome!

- All lines are muted, so please ask your questions in Q&A.
- For technical issues, initiate chat with the Technical Support panelist.
- Please actively participate in polling questions that will appear on the lower right-hand side of your screen.

We will get started shortly!

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Strategies to Support Care Partners and Improve Care Transitions

Presented by:
Mark Toles
Jennifer Heston-Mullins

May 26, 2022

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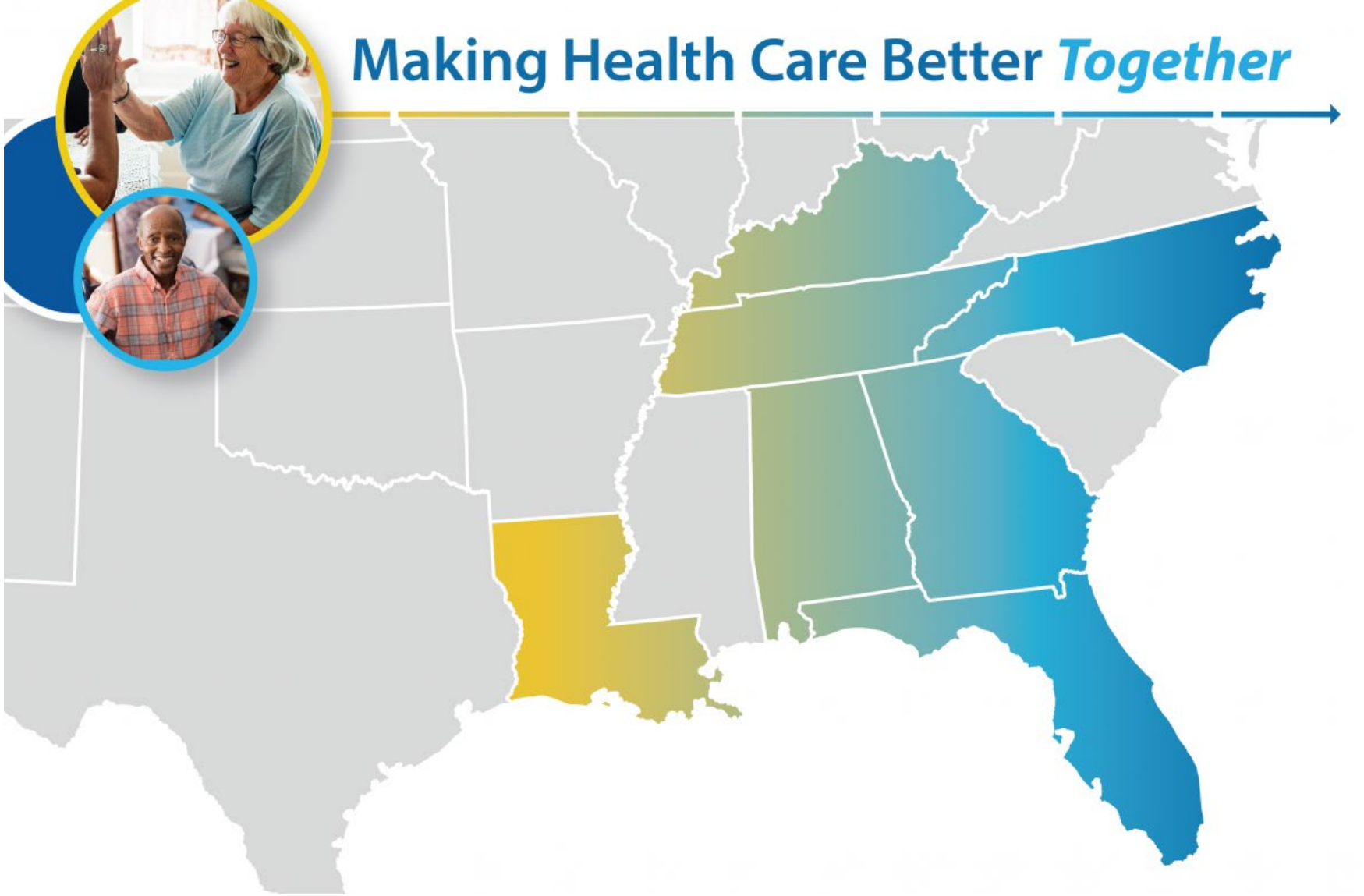
Making Health Care Better *Together*



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Carolyn Kazdan, MHSA, NHA

SENIOR DIRECTOR, CARE COORDINATION AND NURSING HOME

Ms. Kazdan is the senior director of health care quality improvement for IPRO, the Medicare Quality Improvement Organization for New York and 11 other states. Ms. Kazdan led IPRO's work with Project ECHO® and serves as the care transitions and nursing home lead for Alliant Health Solutions.

Ms. Kazdan previously led IPRO's work with the NYS Partnership for Patients and the Centers for Medicare & Medicaid Services (CMS) Special Innovation Project on Transforming End of Life Care in Nassau and Suffolk counties of New York State. Before joining IPRO, Ms. Kazdan was a licensed nursing home administrator and the interim regional director of operations in skilled nursing facilities and continuing care retirement communities in New York, Pennsylvania, Ohio and Maryland.

Ms. Kazdan has served as a senior examiner for the American Healthcare Association's National Quality Award Program. Currently, she serves on the NY State MOLST Statewide Implementation Team and Executive Committee and on PALTC's Education Subcommittee. Ms. Kazdan earned a master's degree in health services administration at The George Washington University.

"We live in a rapidly changing world, where we need to spend as much time rethinking as we do thinking" – Adam Grant

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Mark Toles, PhD, RN

ASSOCIATE PROFESSOR
UNC-CHAPEL HILL SCHOOL OF NURSING

Mark Toles, Ph.D., RN, FAAN, is an associate professor with expertise in nursing care of older adults, the quality of care in nursing homes and transitional care of older adults as they transfer between settings and providers of healthcare. His prior studies have used epidemiological and case study approaches to describe health outcomes and services for transitioning older adults.

In his current research, Dr. Toles continues to develop and test Connect-Home, a transitional care intervention for older adults transitioning from SNFs to home. Dr. Toles is also a co-investigator in studies of comfort care of older adults in nursing homes and cardiac rehabilitation for adults transferring from hospital-based to home-based care.

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Jennifer Heston-Mullins, PhD, LISW

ASSOCIATE DIRECTOR OF RESEARCH AND A SENIOR RESEARCH SCHOLAR WITH SCRIPPS GERONTOLOGY CENTER AT MIAMI UNIVERSITY

Jennifer Heston-Mullins is the associate director of research and a senior research scholar with Scripps Gerontology Center at Miami University. Dr. Heston-Mullins has been a licensed social worker in Ohio for 25 years. Her practice has included adult protective services, hospice, home- and community-based care management, skilled nursing, discharge planning, and assisted living. Her research includes exploring the experiences and roles of direct care workers; home care; person-centered care; communication and care coordination within caregiving families; dementia-inclusive and capable communities; end-of-life decision-making; and program evaluation.

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Objectives

Learn Today:

- Identify key elements of transitional care in skilled nursing facilities (SNFs).
- Identify barriers and facilitators to providing transitional care in SNFs.
- Define problems in family communication that can cause conflicts when discussing care and support.
- Introduce the Our Family, Our Way process and materials, how they work and how to access them.

Use Tomorrow:

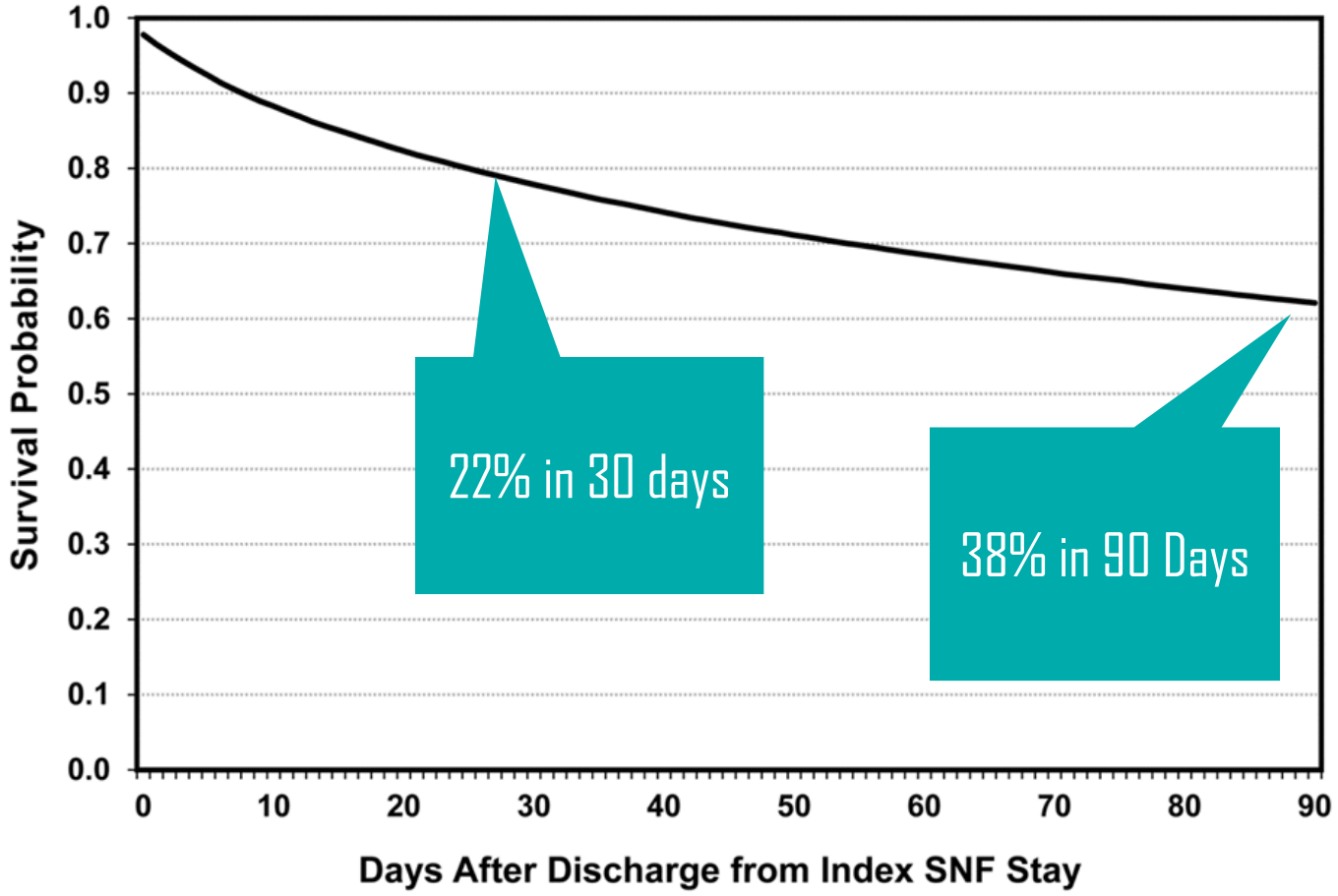
- Implement a family-centered way to navigate transitional care both in and out of SNFs.

Transitional Care Skilled Nursing Facilities

Mark Toles, PhD, RN
University of North Carolina at Chapel Hill

Transitions: SNF to Home

Acute care use after returning home



Transitional Care

Time-limited services,

to ensure health care continuity and avoid preventable poor outcomes,

among at risk populations,

as they move between providers and settings of care.

Moving beyond the walls of the nursing home

- Staff tend to ask, "Is the patient ready for discharge?"
- Help them learn a new question, "Is the patient ready for the first two weeks at home?"

Addressing Key Care Needs

1. Home safety and level of assistance
2. Surrogate decision makers and prior written advance directives
3. Symptom management
4. Medication reconciliation
5. Function (transfers, mobility and preventing falls)
6. Coordination of care

Transitional Care Basics

1

Identify transition risks and set goals for continuing care at home

2

Plan routines for care at home, in a care plan meeting

3

Prepare for discharge, train caregivers, activate community support

4

Reinforce training at home, call or visit within 72 hours at home

Intervention Supports

Tools

- Schedule for delivering care
- EHR template, checklists

Staff training

- Transitional care
- Quality improvement

Technical Assistance

- Leadership
- Data monitoring

A Prepared SNF Patient

They have been watching my Dilantin levels here. They have adjusted that medicine and my levels will return to normal. My doctor knows about that too.

Connect-Home

Existing SNF staff prepare patients and caregivers to manage the patient's serious illness at home.

MODELS OF GERIATRIC CARE, QUALITY IMPROVEMENT, AND PROGRAM DISSEMINATION

Connect-Home: Transitional Care of Skilled Nursing Facility Patients and their Caregivers

Mark Toles, PhD, RN, Cathleen Colón-Emeric, MD, MHS,†‡ Mary D. Naylor, PhD, RN,§ Josephine Asafu-Adjei, PhD,* and Laura C. Hanson, MD, MPH**

BACKGROUND: Older adults that transfer from skilled nursing facilities (SNF) to home have significant risk for poor outcomes. Transitional care of SNF patients (i.e., time-limited services to ensure coordination and continuity of care) is poorly understood.

OBJECTIVE: To determine the feasibility and relevance of the Connect-Home transitional care intervention, and to compare preparedness for discharge between comparison and intervention dyads.

DESIGN: A non-randomized, historically controlled design-enrolling dyads of SNF patients and their family caregivers.

SETTING: Three SNFs in the Southeastern United States.

PARTICIPANTS: Intervention dyads received Connect-Home; comparison dyads received usual discharge planning. Of 173 recruited dyads, 145 transferred to home, and 133 completed surveys within 3 days of discharge.

INTERVENTION: The Connect-Home intervention consisted of tools and training for existing SNF staff to deliver transitional care of patient and caregiver dyads.

MEASUREMENTS: Feasibility was assessed with a chart review. Relevance was assessed with a survey of staff experiences using the intervention. Preparedness for discharge,

CONCLUSION: Connect-Home is a promising transitional care intervention for older patients discharged from SNF care. The next step will be to test the intervention using a cluster randomized trial, with patient outcomes including re-hospitalization. J Am Geriatr Soc 65:2322–2328, 2017.

Key words: transitional care; skilled nursing facilities; quasi-experimental clinical trial

Older Americans, who complete care in hospitals, use Medicare benefits for rehabilitation in skilled nursing facilities (SNF), and subsequently, transfer home, are an especially vulnerable group. More than 70% of these patients are aged 75 years or older, 49% are dependent on others for at least three activities of daily living, and 37% are eligible for Medicare and Medicaid.[1] Moreover, this patient group frequently relies on spouses and children for intensive caregiving following their transition from SNF to home.[2,3] Within 30 days of discharge from SNFs, one in five of these patients use emergency services or are re-hospitalized.[4,5]

Mark Toles, PhD, RN

https://transitional.care

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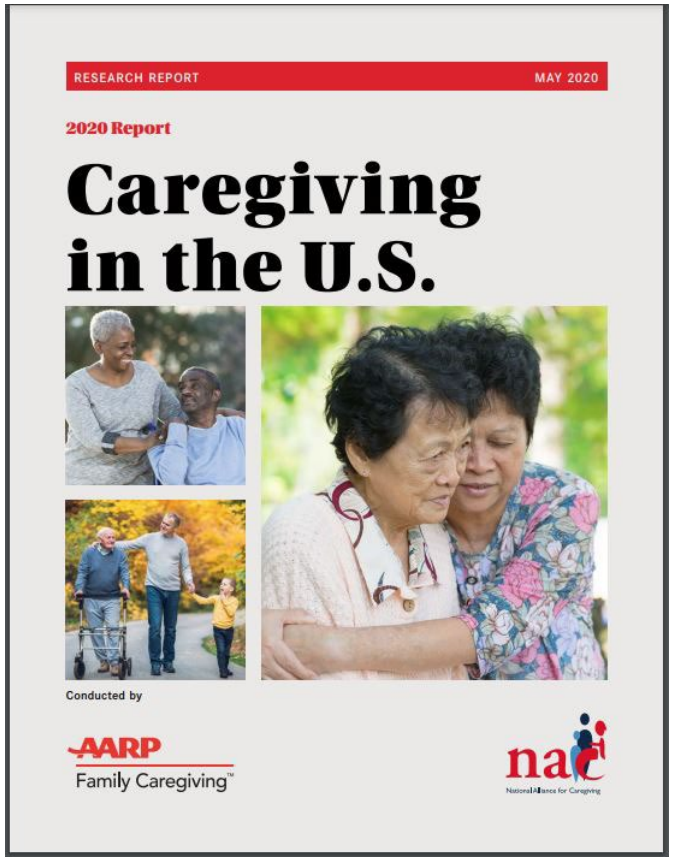
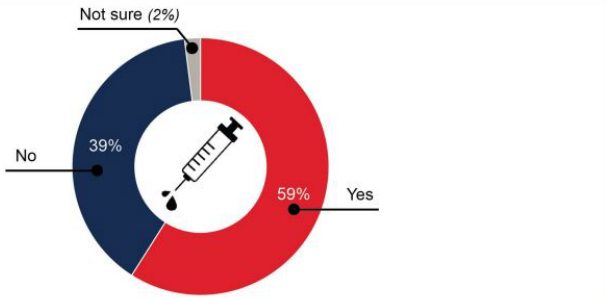
A Communication and Care Coordination Resource for Caregiving Families

Jennifer Heston-Mullins, PhD, LISW



Assistance with Medical/Nursing Tasks

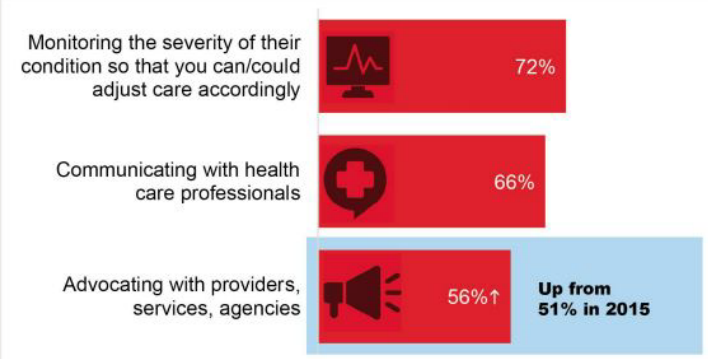


N3. Do/did you help your [relation] with any medical/nursing tasks? This might include giving medicines like pills, eye drops, or injections, preparing food for special diets, tube feedings, or wound care. You could be monitoring things like blood pressure or blood sugar, helping with incontinence, or operating equipment like hospital beds, wheelchairs, oxygen tanks, nebulizers, or suctioning tubes.

2020 Base: Caregivers of Recipient Age 50+ (*n* =1,204)

Notes: Results are rounded and may not add to 100 percent.

Help with Other Key Activities

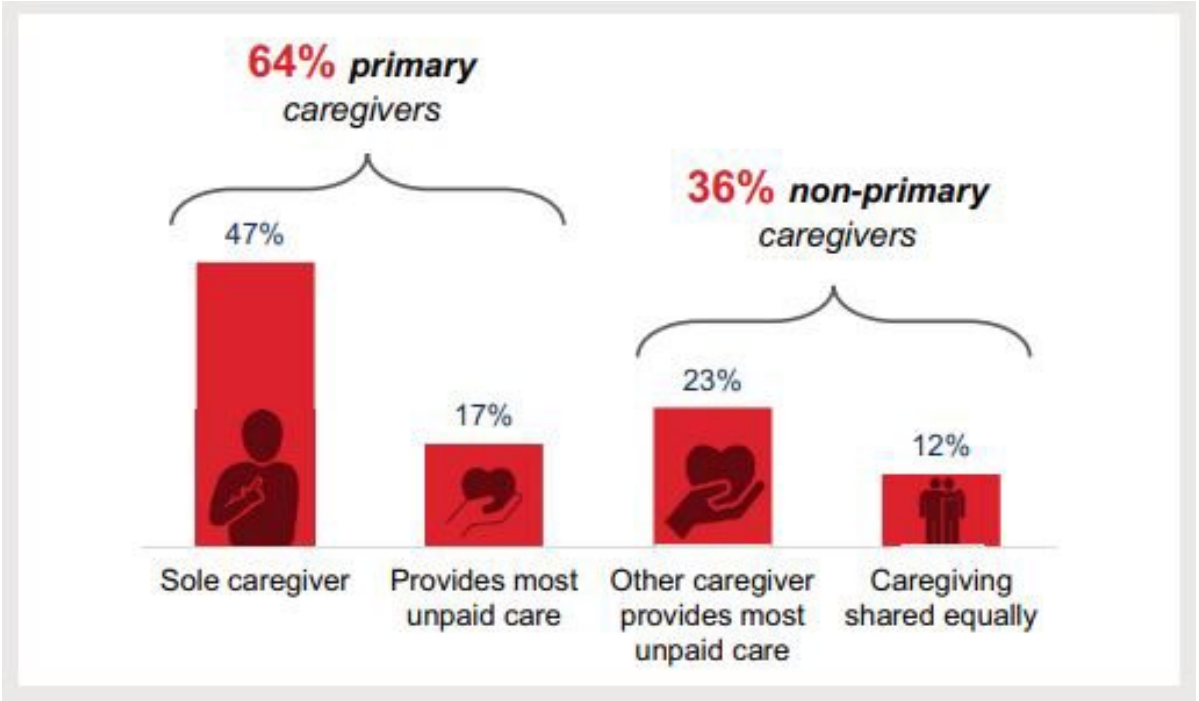


Q23_1. And do/did you provide help to your [relation] by . . . ?

2020 Base: Caregivers of Recipient Age 50+ (*n* = 1,204)

Notes: Arrows indicate a significant increase or decrease vs. 2015. Results are rounded and multiple response; results will not add to 100 percent.

National Alliance for Caregiving & AARP Public Policy Institute (2020)



National Alliance for Caregiving & AARP Public Policy Institute (2020)

Communication Problems in Caregiving Families

- Not seeing eye-to-eye about what's needed, wanted and possible
- Failing to acknowledge that each family member's decisions affect other family members
- Doing without talking or without actually deciding
- Excluding some family members from the process

Goals of *Our Family, Our Way*

- Improve communication between family members about care and support
- Ensure that the person with care needs is included in conversations and decisions about care and support
- Increase the involvement of family members and others so that one caregiver is not responsible for all care and support

Our Family, Our Way
Family Meeting Materials

- Individual tools
- Family meeting
- Shared assessment
- Family care and support plan
- Follow-up plan

Individual Tools

Health Consideration	I'm not sure	No limitation	Some limitation	Major limitation
Hearing				
Vision				
Taste/Smell				

The home...	N/A	I'm not sure.	Yes	No	Notes
Has rooms and hallways clear of clutter.					
Has non-skid rugs.					
Has safe stairways (clutter free, handrails, clearly marked, well lit).					

Care or support activity		What PERSONAL help is required?				Who is helping now?			What DEVICES are used and needed?		
How much personal help do you require with the following activities:	N/A	I'm not sure	I require no help	I require some help	I require much help	I'm not sure	Who provides the help?	No one is helping, but I need help.	I'm not sure	What devices are USED?	What devices could be helpful?
Bathing or showering											
Dressing											

Shared Assessment

Health Consideration	No limitation	Some limitation	Major limitation	Can't agree
Hearing				X
Vision		X		
Taste/Smell	X			

The home...	N/A	Yes	No	Can't agree	Notes
Has rooms and hallways clear of clutter.				X	Mom does not feel "her papers" are a problem
Has adequate outdoor lighting.			X		front porch light is burned out
Has an emergency response system. (e.g., Lifeline)		X			

Care or support activity		What PERSONAL help is required?				Who is helping now?			What DEVICES are used and needed?		
How much personal help does your PWCN require with the following activities:	N/A	Requires no help	Requires some help	Requires much help	Can't agree	Who provides the help?	No one is helping, but help is needed.	Can't agree	What devices are USED?	What devices could be helpful?	Can't agree
Bathing or showering				X		Mom and Tonya - Tue,Thur, Sat	Mon, Wed, Fri, Sun			shower bench	
Dressing		X									

Family Care and Support Plan

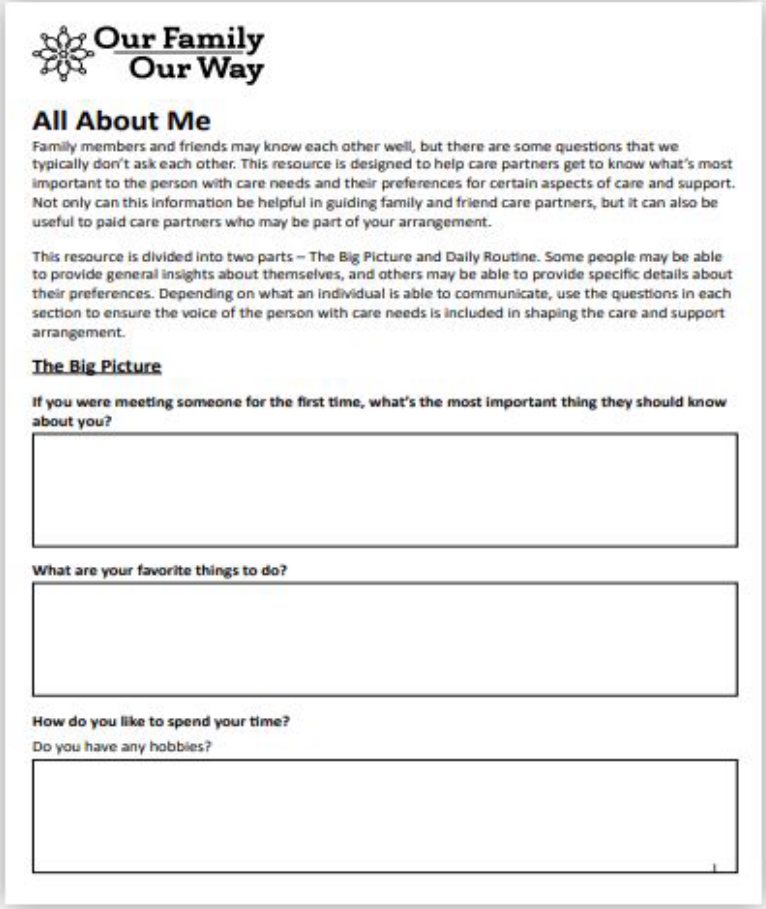
Who will do what and when to address...	N/A	Steps we might take	Who will take the lead	Who else will be involved	When we will take these steps	Can't agree or Undecided
Hearing		hearing test for Dad				X
Bladder or bowel control		Dad wants a urinal next to his bed at night.	Mom will order a urinal from the pharmacy and make sure it's by Dad's bed at night.	Tonya will pick up the urinal from the pharmacy.	Mom will order the urinal this week and let Tonya know when it's ready for pick-up.	
Physical mobility		Physical therapy	Dad will talk to Dr. Mullins about therapy at his next appointment	Tonya will drive Dad to the therapy appointments	Dad's next appt. with Dr. Brown is August 2nd.	

Who else is available to provide care and support?			
Extended family or friends	**What might they do?**	**Community Services**	**What might they do?**
Neighbor Dean (Tim's dad)	mow lawn or shovel snow when Tim's not available	Meals on Wheels	provide lunch so mom doesn't have to cook during the day
Cousin Kathy	drive Dad to appointments when Becky isn't available	Home Care Agency	help with bathing Dad
Mom's friend Margie	take Mom out to lunch so she can get a break		

Additional Resources for Families

- Instructions and video for downloading and printing materials
- **Videos**
  - *What can a family meeting do for us?*
  - *How do we hold a family meeting?*
- **Tip sheets**
  - *Who should be included in our family meeting?*
  - *Should the person with care needs attend the family meeting?*
  - *Preparing for your family meeting*
  - *General communication tips for your family meeting*
  - *How do we deal with major differences in our family meeting?*
  - *How can I provide meaningful support from a distance?*
- Helpful Caregiving Resources booklet
- Sample agenda for follow-up meetings

Beyond the Physical



Our Family Our Way

All About Me

Family members and friends may know each other well, but there are some questions that we typically don't ask each other. This resource is designed to help care partners get to know what's most important to the person with care needs and their preferences for certain aspects of care and support. Not only can this information be helpful in guiding family and friend care partners, but it can also be useful to paid care partners who may be part of your arrangement.

This resource is divided into two parts – The Big Picture and Daily Routine. Some people may be able to provide general insights about themselves, and others may be able to provide specific details about their preferences. Depending on what an individual is able to communicate, use the questions in each section to ensure the voice of the person with care needs is included in shaping the care and support arrangement.

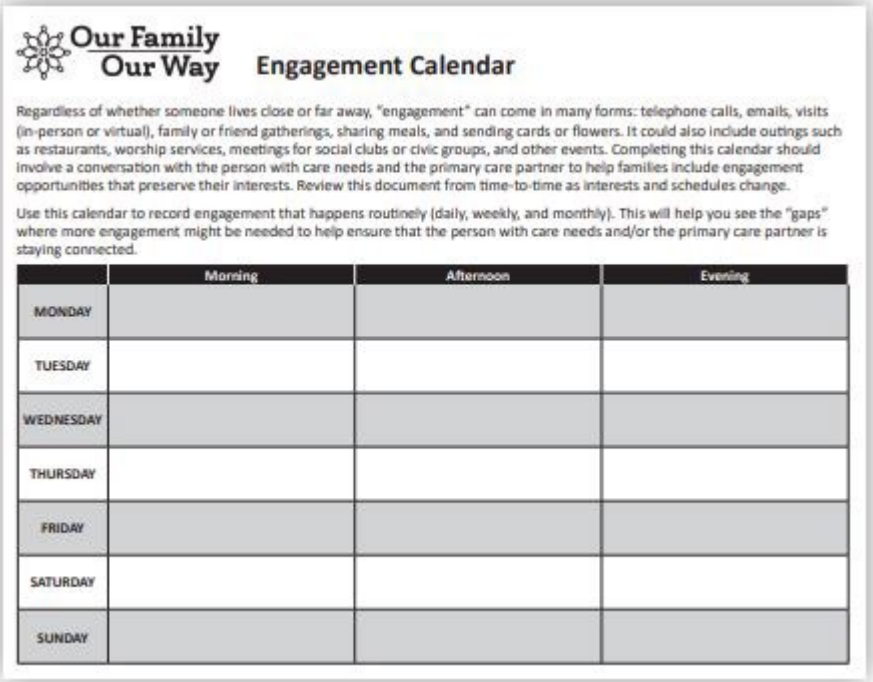
The Big Picture

If you were meeting someone for the first time, what's the most important thing they should know about you?

What are your favorite things to do?

How do you like to spend your time?

Do you have any hobbies?



Our Family Our Way

Engagement Calendar

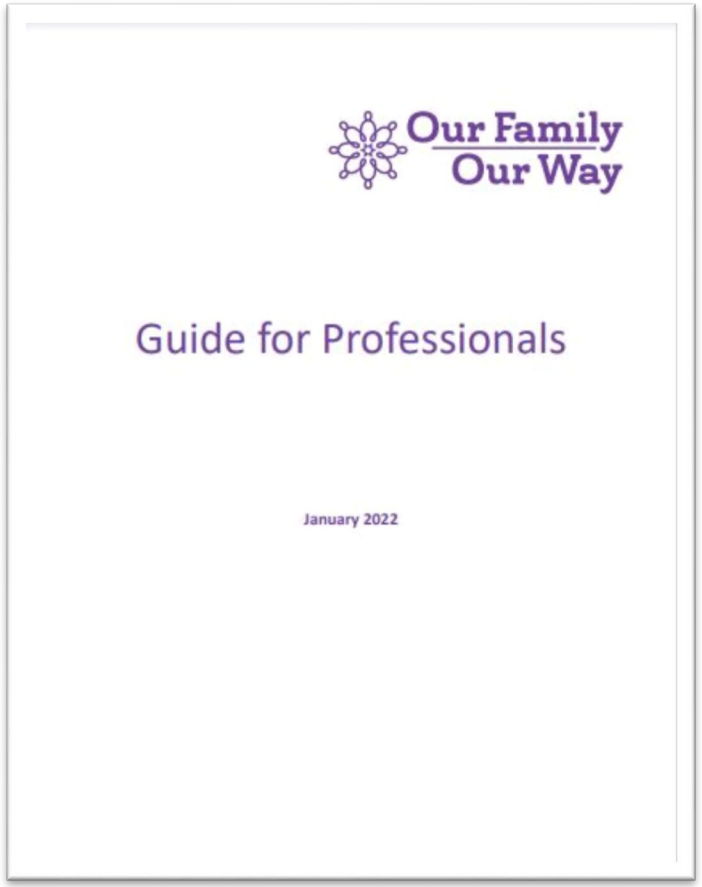
Regardless of whether someone lives close or far away, "engagement" can come in many forms: telephone calls, emails, visits (in-person or virtual), family or friend gatherings, sharing meals, and sending cards or flowers. It could also include outings such as restaurants, worship services, meetings for social clubs or civic groups, and other events. Completing this calendar should involve a conversation with the person with care needs and the primary care partner to help families include engagement opportunities that preserve their interests. Review this document from time-to-time as interests and schedules change.

Use this calendar to record engagement that happens routinely (daily, weekly, and monthly). This will help you see the "gaps" where more engagement might be needed to help ensure that the person with care needs and/or the primary care partner is staying connected.

	Morning	Afternoon	Evening
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			
SATURDAY			
SUNDAY			

OFOW Guide for Professionals

- Families who do not have access to a computer, Wi-Fi or printer.
- Families who can use OFOW as a self-guided resource
- Families who are skeptical about the helpfulness or usefulness of holding a family meeting
- Families who are not sure how to get started
- Families who need coaching to stay accountable
- Families who need facilitation during their family meeting



Our Family, Our Way

FREE Communication and Care Coordination Resource for Caregiving Families

What's Our Family, Our Way?

When we need care and support, family is usually first to help. However, arrangements are often made without any discussion about what works best for everyone involved. Our Family, Our Way provides carefully designed materials to walk your family through the process of holding a family meeting where you can talk about what kinds of care and support are needed and wanted, and how you can work together to make it happen.

Our Family, Our Way can help your family:

- Talk to each other about who will do what, where, when, and how.
- Create a family plan for how to address care needs now and in the future.

To access our free family meeting materials, videos, tip sheets, and other resources, visit:

www.MiamiOH.edu/ScrippsAging/ofow

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www.MiamiOH.edu/ScrippsAging/OFOW

Give us your feedback!

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and

The Ohio Long-Term Care Research Project

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For a deeper dive please check out Jennifer's Bite Sized Learning Session:

https://youtu.be/O0RjsGAj_P4

Objectives Check-In

Learn Today:

- Identify key elements of transitional care in SNFs.
- Identify barriers and facilitators to providing transitional care in SNFs.
- Define problems in family communication that can cause conflicts when discussing care and support.
- Introduce the Our Family, Our Way process and materials, how they work, and how to access them.

Use Tomorrow:

- Implement a family centered way to navigate transitional care both in and out of SNFs.

How will this change what you do? Please tell us in the poll.

Closing Survey

Help Us Help You!

- Please turn your attention to the poll that has appeared in the lower right-hand side of your screen.
- Completion of this survey will help us ensure our topics cater to your needs.

CMS 12th SOW Goals

Behavioral Health Outcomes & Opioid Misuse

- ✓ Promote opioid best practices
- ✓ Decrease high dose opioid prescribing and opioid adverse events in all settings
- ✓ Increase access to behavioral health services

Patient Safety

- ✓ Reduce risky medication combinations
- ✓ Reduce adverse drug events
- ✓ Reduce C. diff in all settings

Chronic Disease Self-Management

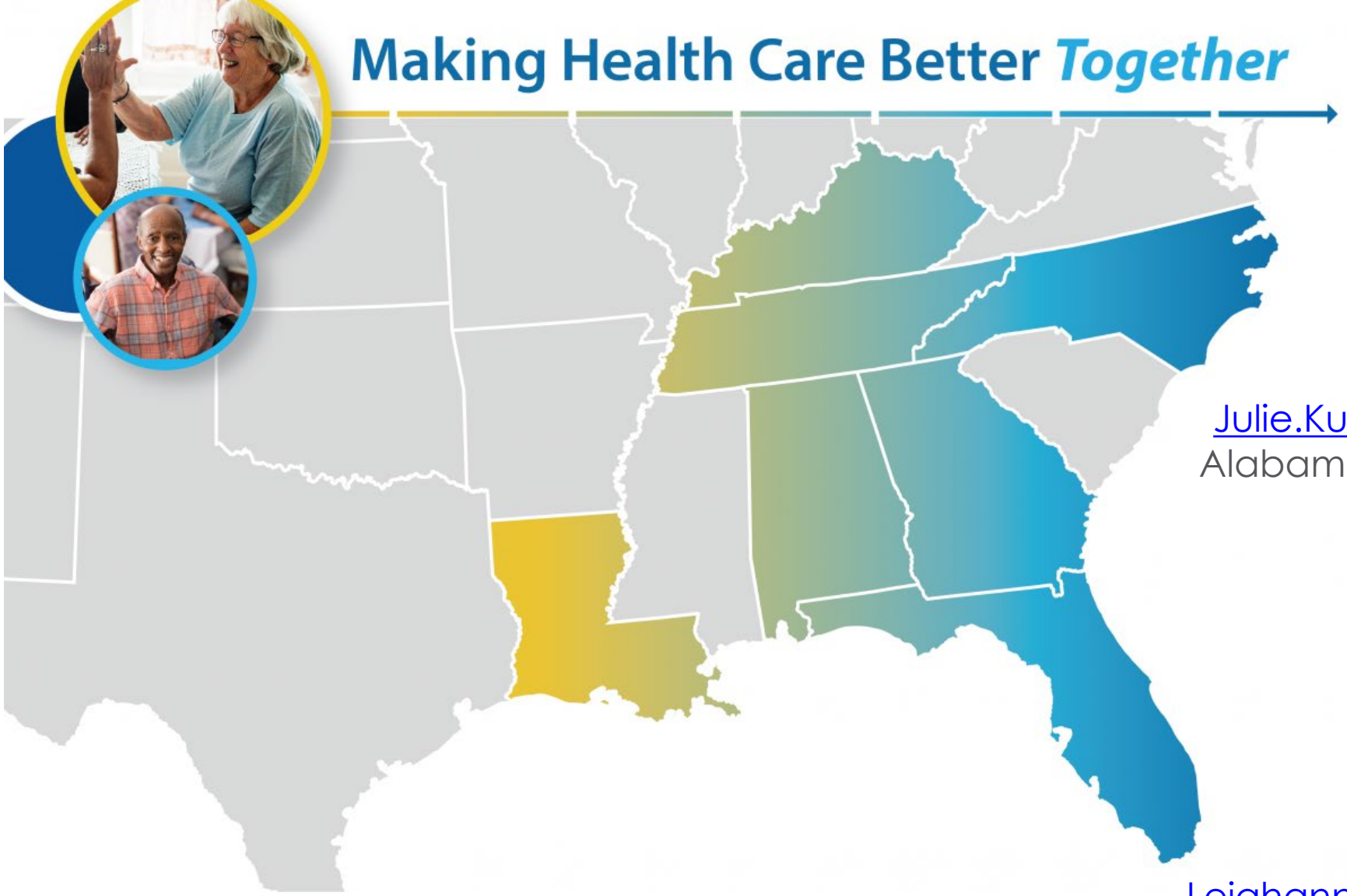
- ✓ Increase performance on ABCS clinical quality measures (i.e., aspirin use, blood pressure control, cholesterol management, cardiac rehab)
- ✓ Identify patients at high-risk for developing kidney disease & improve outcomes
- ✓ Identify patients at high risk for diabetes-related complications & improve outcomes

Quality of Care Transitions

- ✓ Convene community coalitions
- ✓ Identify and promote optical care for super utilizers
- ✓ Reduce community-based adverse drug events

Nursing Home Quality

- ✓ Improve the mean total quality score
- ✓ Develop national baselines for health care related infections in nursing homes
- ✓ Reduce emergency department visits and readmissions of short stay residents



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