Information Sharing to Information Networking: Improving Care Transitions in Community Eldercare

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A goal without a plan is just a wish.

The goal of this project is to answer the question:

Does regular and standardized communication among providers and caregivers reduce health care utilization over time?

Let’s get up on the balcony and watch the dance floor.

~Heifitz, 2004

What’s the context for this project?

Guiding Principles

Drafted by the Advisory Committees to the Long-Term Care Task Force, are intended to guide the work of the Task Force and provide criteria for evaluating recommended changes to the long-term care system in Washington State.

Core Values:

- Support autonomy, self-determination, individual choice and personal responsibility;
- Support informal caregivers/families through respite and other services, training support groups and information;
- Guarantee access to information for all citizens of the state;
- Assure access to culturally-appropriate, high quality services and supports;
- Further, we need a state and system-wide effort to assure the delivery of high quality care and services in a cost-effective and efficient manner.

- ~Chronic Care and Finance Committees to the Task Force

Four conclusions . . .

Pursuing Perfection in Chronic and Complex Conditions

Dr. Marc Pierson, June 14, 2006

1. Patients are competent in their world and we are not the center of their worlds and never will be nor should be.

2. We need patients as partners if we are going to take responsibility for the quality chasm – symmetric relationships are more fun and humane for everyone.

Conclusions

3. Care Management & Personal Health Care Information Technology (HIT) must work for the patient across organizations including providers and payers. – It must add value to providers (workflow) and payers, as well as patients.

4. Health information, technology and interactions can and will move to the patient world. We should all help – Especially for chronic conditions, prevention and lifestyle.

Our Fifth Conclusion

5. We should start from where we are, not from where we think we should be.

Backfilling the Void

"…. High quality care and services delivered in a cost-effective and efficient manner."

~The Long-term Care Task Force Interim Report

There is only one way to get there:

- Information collected and, particularly, information that is shared with those who need it – and done often.

What is a “hand-off” and how often does it occur?

What is the relationship to “injury”?

Injury: The Definition

Injury, in geriatric literature, is based in the notion that elders are vulnerable to therapeutic misadventure at any time that a transition in provider, setting, or therapeutic intervention occurs.

Injuries are not accidents. They are the result of systemic failure in the forecasting and execution of prevention strategies.

Incidence of Elder Injury

As much as 80% of therapeutic injury in elders (those over the age of 65) occurs at handoff or care transitions

~

Joint Commission on Accreditation of Healthcare Organizations, 2006

Examples of therapeutic injury in community-based care settings:

a. The information gap between acute and long term care—Formal communication between such facilities is virtually unheard of. Information, rather, is given to the patient and/or caregiver, individuals who are least likely to know what to do with it or understand its meaning for continued care;
b. Compromised cognition, over-treated and under-tested—rarely considered at intake or handoff (reliability of informant) in any setting;
c. Use of restraints resulting in bruises or fractures;
d. Immobility from restraint use leads to decubitus ulcers, reduction in strength and stamina, and infection.

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Using an integrated database of elder information to reduce handoff errors:

- Medications
- Falls and injuries
- ER visits
- SNF days; inpatient days
- Depression as a co-morbid condition affecting outcome

Project participants include frail elders living in:

- Adult family home
- Boarding home
- Private/personal home
- And who attend an adult day health center at least two days per week

Relationship of Handoffs to Outcomes of Community Elder Care

- Virtually no data examine the rate of injury at handoff in community-based settings;
- Handoffs occur daily for elders between private/personal homes, adult boarding homes, adult family homes, and adult day health centers;
- The incidence of injury in such situations is unknown, but has both high probability and high potential for injury or death;
- Individuals (caregivers/clients) who have the most day-to-day information are generally unprepared to report this information at handoff because they do not understand the implications.

Reduce Health Care Utilization Associated with Handoff Injury by Standardizing and Improving Communication among Community Providers and Caregivers

Community-based Care Organizations: Core responsibilities

- *Information Nexus*
- Adult Day Health Center
  - Comprehensive assessment
  - Medications
  - Assessments: PT/OT, nursing, social work
  - ID primary caregiver
  - Data collection for transmission/storage

Seattle University: Project Management Core responsibilities

- Technology training & assistance
- Information exchange training
- Central storage of data for analysis;
- Statistical analysis and results
- Report write-ups
- Budget management and reconciliation

Project Specifications (cont.)

- Monthly
- Written communication: shared with other care providers and primary caregiver;
- Current med list, day-health-initiated ER visits/falls;
- Query: numbers of ER visits, hospital days, nursing homes days, falls, reconciliation of medications between care provider and adult day health

- Quarterly
- Treatment goals and plan;
- Review information provided in monthly updates;
- Solicit feedback from caregiver related to outcomes of adult day health care activities.

Project Specifications

- Primary Caregiver
  - Family member
  - AFH operator
  - Neighbor
  - Parish nurse
  - Boarding home staff

- Formal Care Providers
  - Home Health Care
  - Physician
  - Family member
  - Adult Family Home
  - Home Care
  - Boarding Home

This project will:

- Enhance caregiver ability to communicate with service providers including primary care;
- Extend the primary care provider reach into the community of caregivers who are providing care largely based on primary care orders;
- Integrate/utilize data currently being collected at adult day health centers into formal/informal plans of care;
- Raise the bar on utilization of measurable data among community-based LTC providers.

Budget Justification

- Project Manager
- Adult Day Health Providers
- Principal Investigator
- Co-Investigator
- Caregiver Incentives
- Project Space
- Private Foundation Funding
- Total Project Costs/Total Donated and In-Kind Support

Summary

- Washington State funds a service-rich long-term care community providing professional care to a highly disabled population

This project is one example of how we can maximize our capacity to care for frail elders in the community.