Program funds teamwork to assist elderly in care transitions

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Western New York providers of care to the elderly are finding new ways to reduce injury and improve outcomes for patients as they move between care settings.

The changes are the result of an initiative sponsored by the Community Health Foundation of Western & Central New York through its Quality Improvement Collaborative: Improving Care Transitions.

The program is designed to boost quality improvement at organizations serving frail elders. The program provides funding to bring together health-care providers to jointly work on improving care for the elderly. The program focuses on the transitions between care settings, such as when individuals move from the hospital to home or from an assisted-living facility to a nursing home.

After 18 months, 13 teams made up of hospitals, nursing homes and assisted-living facilities are finding that small changes can make a big difference in outcomes. Participants and others involved in health care came together to discuss outcomes and best practices at a conference Nov. 5.

Ann Monroe is president of the Community Health Foundation, which invested $550,000 in the initiative. She says the goal is to reduce hospital re-admissions or the revolving door that occurs with people moving in and out of the hospital or going home and not understanding what they're supposed to do.

"The idea is to take a very narrow issue, figure out what's going to make a difference and then apply that same skill set and process to other problems," Monroe says. The program is already helping to stimulate changes in care delivery and policies that will ultimately result in better care for the elderly, she says.

One of the teams, Community Concern of Western New York and the Southern Tier TLC Health Network, found that by offering a transition coach to patients and their families, they were able to reduce hospital re-admissions by 50 percent. Additionally, those who did have to go back to the hospital stayed out twice as long as those who did not receive coaching.

It's these transitions between care settings where care is most likely to fall apart, when people are moved from one setting to another. Sometimes a medication order doesn't follow in the transfer, or a family member doesn't understand exactly what their role or responsibilities will include. The program gave each of the participating teams access to a transition coach, national experts and consultants and technical assistance. Problems and progress were tracked monthly.

Monroe says she's hopeful the program will also result in a common language and experience around the topic so organizations that don't replicate the projects will at least become more interested in the topic.

This was the second round of the program, following a pilot three years ago with eight teams. Plans call for funding a third round of participants with 12 to 14 teams, this time including family caregivers as a major aspect of the care process.