



# Journal of Geriatric Care Management

VOLUME 21  
ISSUE 2  
WINTER  
2011

Published by the  
National  
Association of  
Professional  
Geriatric Care  
Managers

3275 West Ina Road  
Suite 130

Tucson, Arizona  
85741

520.881.8008 / phone

520.325.7925 / fax

[www.caremanager.org](http://www.caremanager.org)

## Rehospitalization: How Care Managers Help Decrease Hospital Visits

Guest Editor's Message ..... <i>By Cathy Jo Cress, MSW</i>	2
Bridging the Gap: The Role of Geriatric Care Managers in Reducing Avoidable Hospital Readmissions ..... <i>by Marisa Scala-Foley, MGS, Michelle M. Washko, PhD, Caroline Ryan, MA, Abigail Morgan, MSS, MLSP</i>	3
Do Geriatric Care Management Interventions Make a Difference? Prove It. .... <i>by Deborah Newquist, PhD, MSW, CMC</i>	10
Transitioning Care to the Home: Reducing Rehospitalization Among Frail Elders..... <i>By Rona Bartlestone, LCSW, BCD, CMC, C-ASWCM</i>	13
Evidence-Based Transitional Care for Chronically Ill Older Adults and Their Caregivers .. <i>By M. Brian Bixby, MSN, CRNP</i>	20
Helping Reduce Hospital Readmissions Using Seven Key Elements..... <i>By Cathy Jo Cress, MSW</i>	25
Reducing Hospital Readmissions— One Hospital's Journey to Implement Safer Transitions in Care ..... <i>By Robin Jones, RN</i>	29

# 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

*continued on page 14*

## Transitioning Care to the Home: Reducing Rehospitalization Among Frail Elders

*continued from page 13*

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

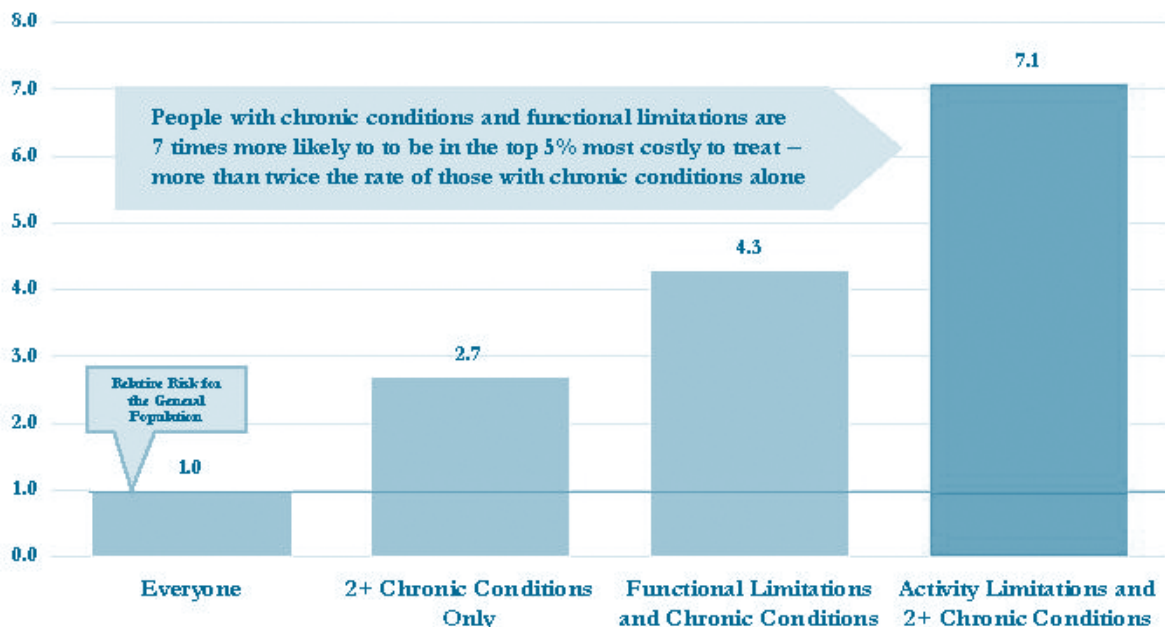
providers to assure that the services in the home are consistent with the physician-driven plan of care. In this manner, the care manager becomes the physician extender into the home setting, while assuring maximum use of primary care to forestall preventable use of emergency room visits and hospitalizations.

### 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

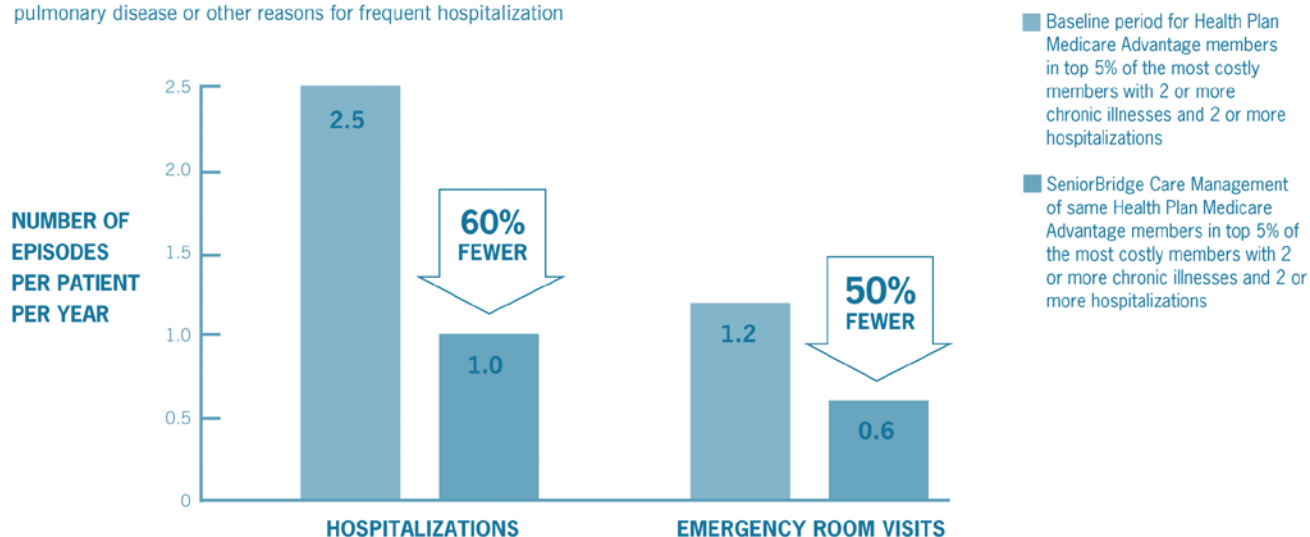
**Relative Risk of Being a High Cost Patient**



*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

*continued on page 16*

## Transitioning Care to the Home: Reducing Rehospitalization Among Frail Elders

*continued from page 15*

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.

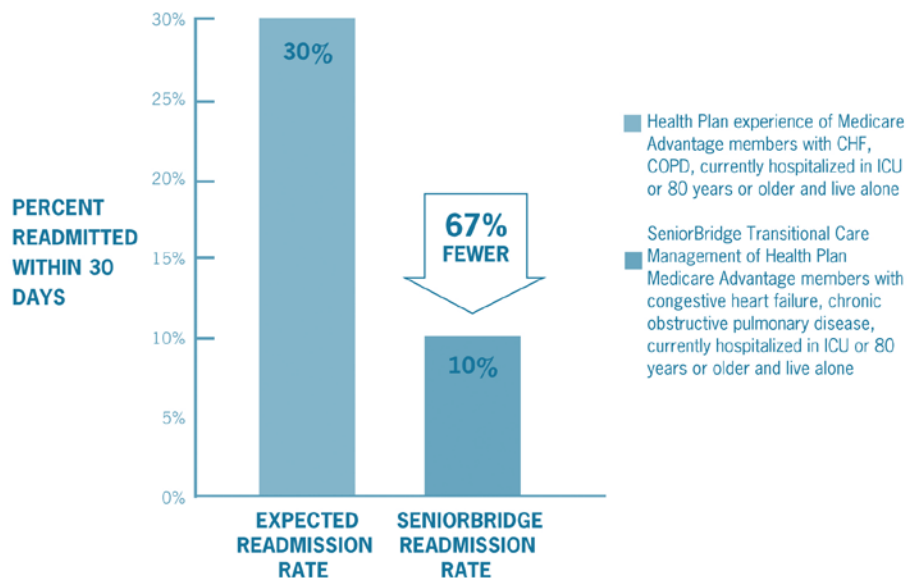
2. Engagement and communication with the involved team in a manner that respects the expertise and leadership of each component of care. This may include the use of mediation techniques to help assure that each member of the team is committed to the agreed upon plan of care. This can be a sensitive area, 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

*continued on page 18*

## Transitioning Care to the Home: Reducing Rehospitalization Among Frail Elders

*continued from page 17*

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

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

<a href="#">Main Info</a>	<a href="#">Info Sheet</a>					
<b>Clinical History</b>	<b>Contacts</b>	<b>Environment</b>	<b>Functional</b>	<b>Physiological</b>	<b>Med Admin</b>	<b>Med Profile</b>
<b>Background</b>	<b>Psychosocial</b>	<b>Financial/ Legal</b>	<b>Service Goals</b>	<b>Care Plan</b>	<b>Print</b>	<b>Status</b>

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.

### References

Jencks SF, Williams MV, Coleman EA. Rehospitalizations among Patients in the Medicare Fee-for-Service Program. *New England Journal of Medicine*, 2009; 360: 1418-28.

“The Medicare Beneficiary Population Fact Sheet”, AARP, 2007 [http://assets.aarp.org/rgcenter/health/fs149\\_medicare.pdf](http://assets.aarp.org/rgcenter/health/fs149_medicare.pdf)

“Medicare Hospital Stays: Comparisons between the Fee-for-Service Plan and Alternative Plans: Statistics Brief #66,” Healthcare Cost and Utilization Project <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb66.jsp>

“Hospital Discharge Information and Older Patients: Do They Get What They Need?” Flacker J, Park WS, Sims A. *J Hosp Med*. 2007; 2(5): 291-6.

Jencks SF, Williams MV, Coleman EA. Rehospitalizations among Patients in the Medicare Fee-for-Service Program. *New England Journal of Medicine*, 2009; 360: 1418-28.

The Robert Wood Johnson Foundation analysis of 2006 Medical Expenditures Survey, 2010

LewinGroup analysis of Medical Expenditures Panel Survey, 2010

Chan L, Beaver S, Maclehorse RF, Jha A, Macrejewski M, Doctor JN. Disability and Care Costs in the Medicare Population. *Archives of Physical Medicine & Rehabilitation*, 2002

Post Discharge Environmental and Socioeconomic Factors and the Likelihood of Early Hospital Readmission Among Community-Dwelling Medicare Beneficiaries, Alicia I. Arbaje, MD, MPH, Jennifer L. Wolff, PhD, Qilu Yu, PhD, Neil R. Powe, MD, MPH, MBA, Gerard F. Anderson, PhD, and Chad Boulton, MD, MPH, MBA; *The Gerontologist*, Vol. 48, No. 4, 495-504, p. 502

Anderson T et al. High-Cost Medicare Beneficiaries. Congressional Budget Office, May 2005

*Rona Bartelstone is Senior Vice President of Care Management for SeniorBridge. From 1981 - 2008 she owned Rona Bartelstone Associates an integrated care management and home care business. Rona is a founding member and the longest termed past President of NAPGCM, and is also a founding member and Vice President of NACCM. Rona is a family care giver.*