Improving Transitions in Care

Barnabas Health’s program for frail older adults with dementia and a chronic health condition

SUMMARY

From July 2011 through September 2013, Barnabas Health, a hospital system in northern New Jersey, developed and launched the Transitions in Care program, which sought to improve transitions for frail adults age 65 and older with dementia and at least one other chronic condition as they moved from the hospital to their home or another care facility (for example a rehabilitation hospital or nursing home).

Monmouth Medical Center, one of six hospitals within the Barnabas Health system, was the initial site for the Transitions in Care program. The other hospitals and partner organizations—the Visiting Nurse Association of Central Jersey, CareOne at King James, HealthSouth Rehabilitation Hospital of Tinton Falls, and Aetna—served on the program’s advisory board.

Transitions in Care developed personalized care plans based on input from the patient and the patient’s caregiver that covered the patient’s diagnoses, treatment, and upcoming care transitions. The plan included goals and actions to meet those goals, and clear instructions for taking and administering medications.

Health care providers, case managers, social workers, and support staff from Monmouth Medical Center and the partnering organizations (except Aetna) met weekly to review the care of each patient.

After hospital discharge, case managers called patients and caregivers with a reminder to see the referring physician and to follow up on the care plan. They also sent the care plan to the referring physician or facility. The Visiting Nurse Association of Central Jersey made home visits. CareOne at King James and HealthSouth Rehabilitation Hospital of Tinton Falls provided rehabilitation and therapy services.

Key Results

The Transitions in Care program:

- Enrolled 640 frail older adults with dementia and at least one other chronic condition
• Developed a multidisciplinary team to manage transitions in care and trained 272 health care professionals, social services staff, and others at Monmouth Medical Center and partnering organizations (rehabilitation hospital and facilities, long-term care facilities, and hospice and palliative care facilities)

• Reduced the readmission rate at Monmouth Medical Center by more than 39 percent (from 14.8% to 9%) among program patients.

**Funding**

The Robert Wood Johnson Foundation (RWJF) provided $300,000 to the Saint Barnabas Health Care System Foundation to support this *New Jersey Health Initiatives* project. The Wallerstein Foundation for Geriatric Life Improvement provided $25,000.

*New Jersey Health Initiatives* supports innovative community-based projects that improve the health and health care of residents of the Foundation’s home state. Most projects in *New Jersey Health Initiatives* focus on RWJF’s core interest area and specific state needs.

Read the [Program Results Report](#) on *New Jersey Health Initiatives*.

**CONTEXT**

As patients move from one health care setting or provider to another, such as from a hospital to home or nursing home, poor communication and coordination during this transition in care often lead to more health problems and increased health care costs.

Frail adults\(^1\) aged 65 and older who have dementia and one or more other chronic conditions (such as heart, lung, or kidney disease) are more likely than other people to get sicker, be readmitted to the hospital, or die due to poor transitions in care.

**New Jersey Health Initiatives Transitions in Care Grants**

In 2011, *New Jersey Health Initiatives* supported nine projects to improve transitions for adults with multiple chronic health conditions and complex social circumstances, as they move across health care settings and providers. Barnabas Health (through its foundation) was one of the grantees. Another project, in Woodbury, N.J., helped high-risk seniors avoid hospital readmissions through a care transitions program.\(^2\) See the [Program Results Report](#) for more information.

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\(^1\) Symptoms of frailty include general exhaustion, weakness, and a slow walking speed.

\(^2\) Grant ID# 69117 ($300,000, July 1, 2011 through June 30, 2013).
THE PROJECT

The Transitions in Care program at Barnabas Health sought to improve transitions for frail adults age 65 and older with dementia and at least one other chronic condition as they moved from the hospital to their home or another care facility (for example a rehabilitation hospital, nursing home, or other long-term care facility).

Roles of Project Partners

Barnabas Health is New Jersey’s largest integrated health care delivery system, with six hospitals, a behavioral health center, outpatient care, and hospice and home care programs. The system serves more than 2 million patients each year in Essex, Ocean, and Monmouth Counties.

Monmouth Medical Center, one of the Barnabas Health hospitals, was the initial site for the Transitions in Care program funded by RWJF. Senior medical staff and administrators from all Barnabas Health hospitals and from partner organizations served on the program’s advisory board.

Partner Organizations

Those partner organizations were:

- The Visiting Nurse Association of Central Jersey (Red Bank, N.J.)
- CareOne at King James (Atlantic Highlands, N.J.), which offers rehabilitation and long-term care
- HealthSouth Rehabilitation Hospital of Tinton Falls (N.J.)
- Aetna (Hartford, Conn.)

All partners participated in multidisciplinary case conferences about patients enrolled in the Transitions in Care program and helped implement the program within their organizations.

The Visiting Nurse Association of Central Jersey also made home visits. CareOne at King James and HealthSouth Rehabilitation Hospital of Tinton Falls also provided rehabilitation and therapy services. Aetna offered benefits counseling for its members in the program and provided data on health care utilization and cost.

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3 Clara Maass Medical Center, Community Medical Center, Kimball Medical Center, Monmouth Medical Center, Newark Beth Israel Medical Center, and Saint Barnabas Medical Center.
Program Components

Project staff and partners developed the Transitions in Care program; trained health care providers, case managers, social workers, and support staff at Monmouth Medical Center and partner organizations; and implemented the program at Monmouth Medical Center.

All patients age 65 and older who came into medical center’s emergency department or were admitted to the hospital were screened for dementia, frailty, and chronic conditions. Staff enrolled patients who met the criteria of frailty, dementia, and one or more chronic condition in the Transitions in Care program, which has eight components:

1. **Patient-identified goals and activities**: Health care providers and case managers worked with patients and caregivers to identify achievable goals and activities to meet those goals.

2. **Barriers and support resources**: Health care providers and case managers worked with patients and caregivers to identify barriers to care and available resources. They developed a plan to overcome barriers and use support resources, with referrals to community-based support services as needed.

3. **Patient and caregiver education**: Health care providers and case managers taught the patient and caregivers about the patient’s diagnoses, treatment, and upcoming care transitions while the patient was in the emergency department or the hospital.

4. **Prescription reconciliation and education**: Pharmacists helped health care providers develop efficient and safe medication schedules for each patient. They gave patients and caregivers clear instructions and personalized weekly timetables for taking or administering medications.

5. **Multidisciplinary case conferences**: Health care providers, case managers, social workers, and support staff from Monmouth Medical Center and partner organizations met weekly to review the care of enrolled patients and enhance their care transitions.

6. **My Care Plan**: A detailed, reader-friendly electronic plan was created for each patient with:
   - A complete list of a current medications
   - Instructions for taking the medications
   - Goals and activities to meet the goals
   - Barriers to care and steps to deal with the barriers
   - Education about the patient’s health problems

7. **Provider notification**: Case managers reinforced the need for the patient to visit the referring physician after leaving the hospital and notified the physician about the hospitalization and discharge.
8. **Follow-up calls and/or home visits:** Case managers made follow-up calls after hospital discharge and arranged home visits by the Visiting Nurse Association of Central Jersey as needed.

**RESULTS**

The project team reported the following results to RWJF.

**Program Launch**

Project staff and partners:

- **Screened 3,093 Monmouth Medical Center patients who were age 65 and older and enrolled 640 frail older adults with dementia and at least one other chronic condition in the Transitions in Care program.**

- **Developed a multidisciplinary team to manage transitions in care and trained 272 health care professionals, social services staff, and others at Monmouth Medical Center and partnering organizations (the Visiting Nurse Association of Central Jersey, CareOne at King James, HealthSouth Rehabilitation Hospital of Tinton Falls, and Aetna) in providing program services.**

  Geriatricians and other physicians, nurses, pharmacists, physical therapists, social workers, case managers, performance improvement staff, and support staff took the half-day course developed for the program, *The Care and Transitions of the Frail and Elderly With Dementia: How to Meet the Complex Challenges.* During the grant, the course was approved for continuing education credits for nurses and social workers.

  The multidisciplinary team, comprised of 12 to 15 health care professionals, case managers, social workers, and performance improvement staff, met weekly. “We worked together to come up with a good plan for the patient,” said Jessica Israel, MD, a geriatric medicine specialist at Monmouth Medical Center.

- **Improved transitions in care from the hospital to the home or another facility** by:
  - Giving patients and their caregivers a personalized care plan
  - Calling them within a few days of discharge, and one, three, six, and 12 months after discharge to ensure the patient saw his/her referring physician and received the necessary care
  - Sending a copy of the patient’s care plan to the referring physician and/or facility
  - Arranging home visits by the Visiting Nurse Association of Central Jersey, as needed
The multidisciplinary approach, and the inclusion of patients and caregivers as decisions-makers, is key to improving care, says Israel. “The frail elderly with dementia require services across the continuum of care and coordination by professionals, as well as input of the patient and the caregiver.”

Read the sidebar “Finding Safe Care for a Husband and Father.”

Results

- The hospital readmission rate at Monmouth Medical Center decreased by more than 39 percent (from 14.8% to 9%) among Transitions in Care program patients.

- 91 percent of Transitions in Care program patients saw their primary care provider within two weeks of hospital discharge.

- Patients and/or their caregivers were satisfied with the Transitions in Care program:
  - 96 percent of patients and/or their caregivers agreed or strongly agreed (51% strongly agreed and 45% agreed) that they understood the purpose of taking their medications.
  - 97 percent agreed or strongly agreed (52% strongly agreed and 45% agreed) that hospital staff considered their preferences and their caregiver’s preferences when planning care after leaving the hospital.
  - 92 percent agreed or strongly agreed (48% strongly agreed and 44% agreed) that they had a good understanding of things they were responsible for in managing their health.

Read the sidebar “Keeping a Husband at Home.”

LESSONS LEARNED

1. Include a pharmacist on care teams for older adults with dementia and other chronic conditions. Caregivers need help ensuring that these patients take their medicines correctly. Having a pharmacist on team to who provided a list of a current medications and instructions for taking the medications was very helpful. (Report to RWJF)
AFTERWARD

The Transitions in Care program at Monmouth Medical Center continues, and has expanded to include all frail older patients with complex medical conditions (e.g., chronic diseases and many medications, emergency room visits, and hospitalizations).

“The grant has helps us to form a clearer focus on our approach to the elderly,” said Israel.

That approach includes continuing the education program, working more closely with older adults with complex medical conditions and their caregivers, and expanding services for older adults with complex medical conditions.

Barnabas Health plans to implement Transitions in Care programs at all of its hospitals.
SIDEBARS

Finding Safe Care for a Husband and Father

A 76-year-old man who lived at home with his wife and son began hiding hammers and other tools. Then he walked into the middle of a busy highway. The wife and son put locks on the doors to keep him inside and away from them.

Soon after that, he was admitted to Monmouth Medical Center with an altered mental status and weakness; there he was enrolled in the Transitions in Care program.

When he was ready for discharge, his dementia and aggressive behavior made it difficult to find a facility to take him. After more than 10 rejections, the Transitions in Care program team found a facility that agreed to accept him and closely managed his behaviors and medications. Three weeks later, when his aggressive behaviors had been controlled, he was transferred to an assisted living facility with a locked unit. He is doing well there.

The patient’s wife knows he is safe but struggles with him not being home. The Transitions in Care program is helping her deal with this, and has connected her with an elder law attorney for help with financial and legal issues.

Keeping a Husband at Home

A wife was able to continue to care for her 75-year-old husband at home, thanks to the Transitions in Care program. Before being admitted to Monmouth Medical Center with weakness, dehydration, and an altered mental status, the man’s behavior had become negative and sometimes hostile.

During the hospitalization, doctors diagnosed him with dementia and enrolled him in the Transitions in Care program. After discharge, the man went to a rehabilitation facility, which notified the Transitions in Care program’s team when he went home.

The patient’s wife who was his caregiver was distraught and overwhelmed when a Transitions in Care program team member contacted her 30 days later. The team member arranged for her to attend Monmouth Medical Center’s caregiver support group and introduced her to the Monmouth County Office on Aging’s caregiver specialist.

The man has not been readmitted to the hospital and his behavior has improved. The wife said that she would not have been able to keep her husband at home without the support she received from the Transitions in Care program team and the caregiver support group.