

Community Partnerships for Older Adults is a national program funded by the Robert Wood Johnson Foundation to help communities develop leadership, innovative solutions, and options to meet the needs of older adults over the long term.



Bridging Elder Care Networks (BECN) Advocacy Transitional Care Management Program Baptist Report-March 2009

In 2006 Life: Act 2, a community collaboration led by United Way of Northeast Florida, received a four-year \$750,000 grant from The Robert Wood Johnson Foundation (RWJF) through its *Community Partnerships for Older Adults* (CPFOA) national program to help communities develop leadership, innovative solutions, and options to meet the needs of older adults over the long term. With matching support and the foundation's initial \$150,000 planning grant, Life: Act 2 has leveraged over \$1 million in total funding to improve local services for older adults.

Under the ATCM program an Elder Care Advocate (ECA) networks with hospital discharge planners to assist seniors identified as having additional social needs once leaving the hospital. To date, over 800 patients from both Baptist Medical center and Shands Jacksonville have been referred by Discharge Planners. Seniors can receive purchased services, referrals to community agencies, follow-up phone calls after discharge to ensure they have transitioned well, and tool kits of useful resource information. This initiative will assist seniors as they navigate home from the hospital and allow them to recover well at home. Among the goals over the four years of the RWJF grant are to:

- 1. Decrease the number of days older adults unnecessarily stay in a hospital due to the unavailability of, or ineligibility for, long term care or independent living support services.*
- 2. Increase the knowledge of the community as a whole, but particularly older adults and /or their caregivers, on how to access health and long term care information and services.*
- 3. Implement hospital-specific system changes that will improve delivery of health services to older adult patients.*

During Phase I, Baptist Health Downtown incorporated the ATCM program and the Elder Care Advocate model into its usual discharge procedures within the social services department. Social services staff referred patients with identified needs for post discharge services to the Elder Care Advocate for additional assistance. In March 2009, Baptist Health adopted the Elder Care Advocate program model as part of the facility's newly expanded Senior Services department. **This report reviews some of the events and findings of the ATCM program during the full program period of June 11, 2007-March 21, 2009 at Baptist Health Downtown.**

Staff:

Director, Life: Act 2: Mark LeMaire
Program Manager, BECN: Jeannie Burhans *Project Assistant: Jennifer Ozanne-Tolman*
Elder Care Advocate: Amy Surber *Elder Care Advocate: Kristy Miller*

To contact Life: Act 2: 1301 Riverplace Blvd, Suite 400, Jacksonville, FL 32207, 904-390-3234, markl@uwnefl.org

Baptist Report-2009



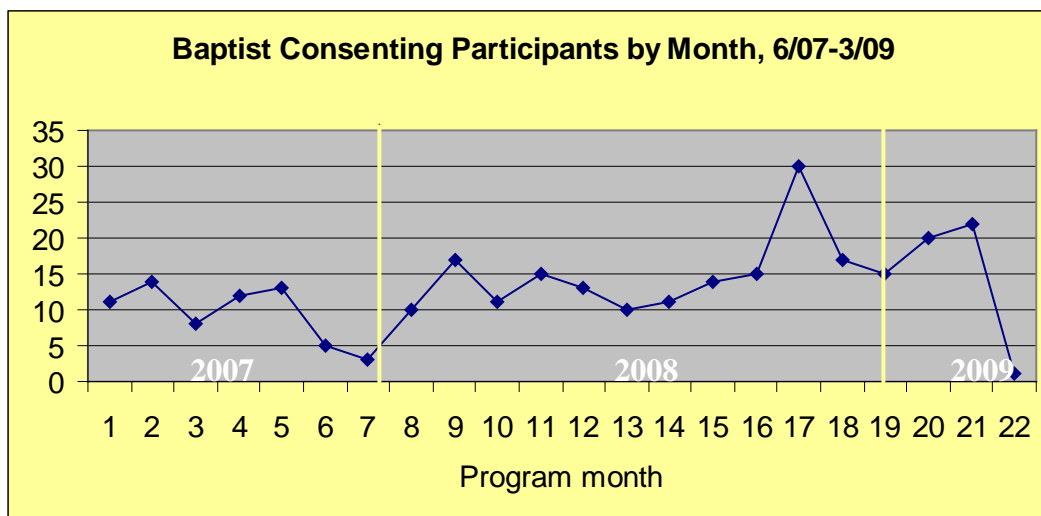
WHAT DID WE DO?

WHO WE HELPED

Total patients receiving assistance from ECA: 507

Average patients seen by ECA each month: 23

Patients consenting to targeted program services: 287



Patients seen:

The Elder Care Advocate began providing services to seniors at Baptist in June 2007. Among the tasks faced by the ECA was to raise program awareness among staff so that discharge planners knew of the services that were offered through the program.

Over the 22 months that this program has operated at Baptist monthly participation (considered to be consent by the patient to receive identified post discharge services by the ECA) has steadily risen. In total, more than 500 patients have been referred to the ECA for help by hospital staff. 287 of those patients chose to be assessed to receive services to target their needs when they returned home from the hospital.

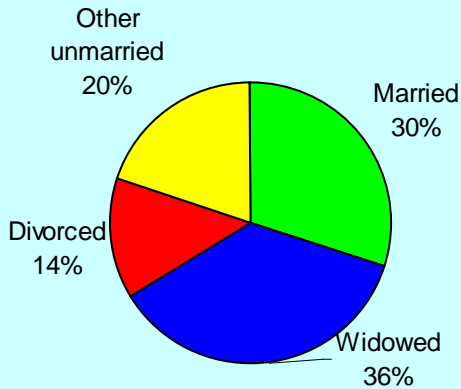
One trend to note is a seasonal decrease in referrals and services provided during the November and December months when holiday-driven reduced patient loads and fewer staff impacts participation directly. **In addition, the program saw a decrease in March 2009 as the United Way ECA withdrew as Baptist Health adopted the program; the ATCM program operated for only one week in March.**

Overall, the ECA saw on average, 23 patients a month and some months reaching over 45- 50 referred patients. Patients were thoroughly assessed for services, family was contacted if necessary, and appropriate referrals and services were provided. After the patient returned home, the ECA contacted him/her regularly to ensure that all needs were met.



WHAT DID WE DO? WHO WE HELPED

Marital Status, Baptist



Participant characteristics:

Average age: **72.9 years**

Male to Female ratio: **1:3**

Average income: **\$1,423/month**

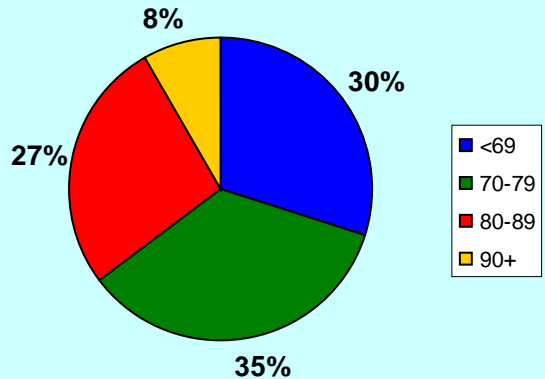
Race: **White: 60%**
Black: 37%
Other: 3%

Participant characteristics:

ECA program participants reflected a diverse cross section of area seniors in need. Program participants come from all backgrounds. There were more White than Minority participants, and three of every four patients was a woman. Among those consenting participants, **35 percent were above the age of 80**. We certainly see evidence of the aging of the population here, a trend that is expected to continue in future years. On the other hand, **18 percent of participants were below the age of 65**, and therefore ineligible for many benefits that older seniors often rely on to maintain their health.

An interesting finding that hints at the root of the needs of seniors is a full **70 percent of participants were not married**. Therefore, most of the seniors who desired ECA services lacked what is often the primary caregiver—a spouse. These trends have been evident since the beginning of the program.

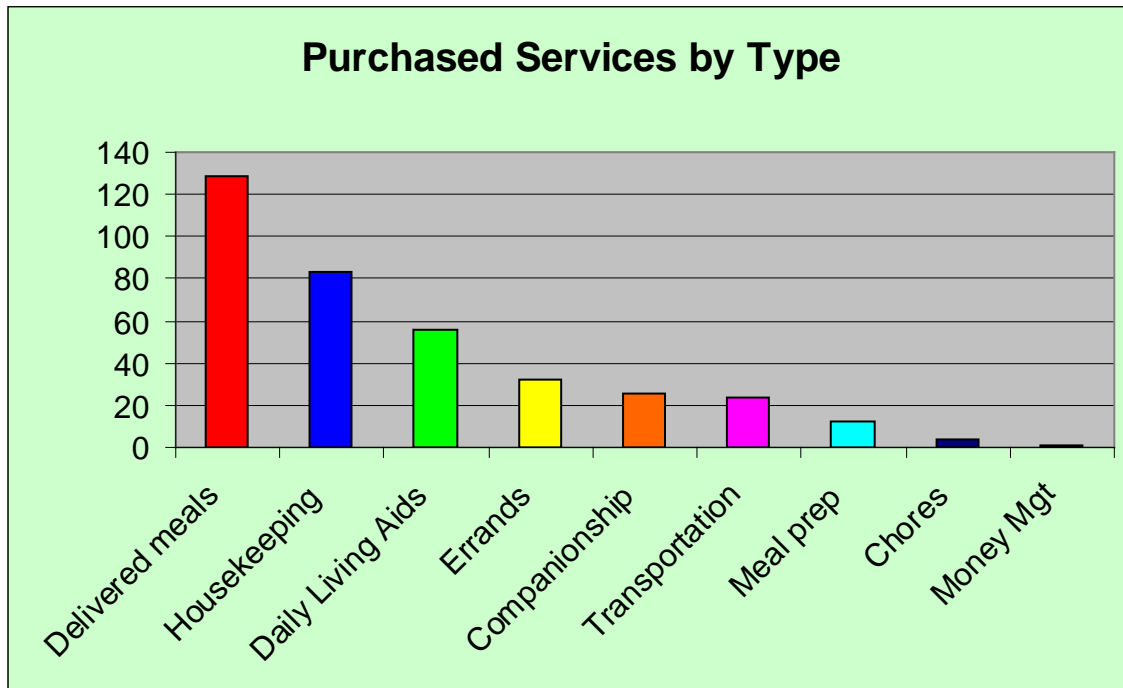
Age of Participants, Baptist





WHAT DID WE DO? SERVICES PROVIDED

Participants receiving purchased services: 198

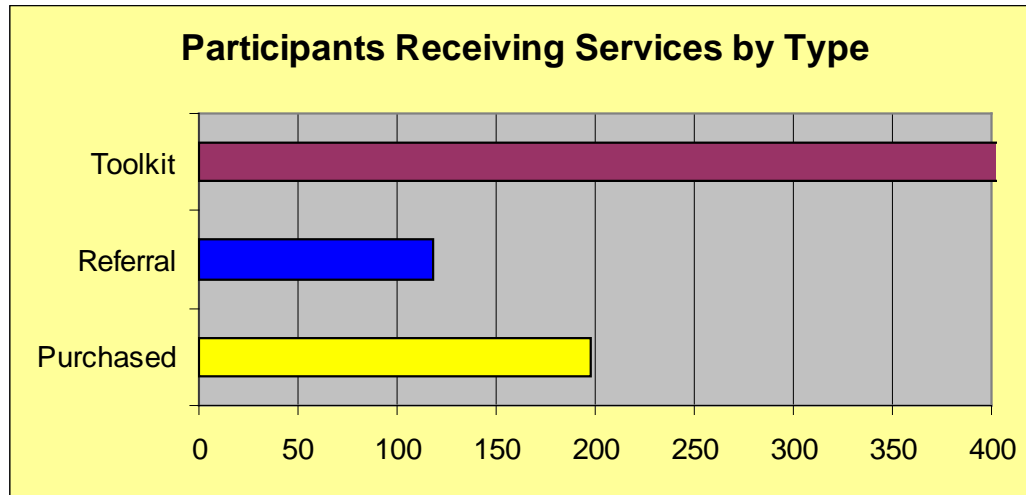


Services to afford a safe discharge from the hospital: During this program at Baptist the ECA has purchased services for nearly 200 participants. The most often purchased service was providing meals for patients when they returned home from the hospital. Recently discharged patients are often frail and have a difficult time preparing nutritious meals to aid in their recovery; the ECA provided over 2,500 either delivered meals or meal preparation. Housekeeping was provided for many patients who are frail and unable to do their own cleaning when they return home from the hospital. Other services provided:

- Daily living aids, such as Emergency Medical Systems so that seniors can return home alone safely
- Errand services, to allow seniors to remain at home and recover instead of traveling for errands
- Companionship, for short periods when the senior is most vulnerable at home alone
- Transportation, for important doctor visits that promote health
- Chores, to ensure that a senior's home is safe to return to
- Money management, for a few seniors who need immediate help managing a problem that may impact their health



WHAT DID WE DO? OTHER ECA HELP



Multiple resources: It is important to note that the ECA provides more than just purchased services to hospital patients. **In fact, purchased services comprise only a small portion of the aid patients receive.** The ECA makes direct referrals to community agencies to help patients identify and qualify for long-term aid. The ECA also is knowledgeable about community resources and provides information to the vast majority of people seen daily. The ECA helps patients navigate the confusing world of long term care after an illness.

Referral to a Friend:

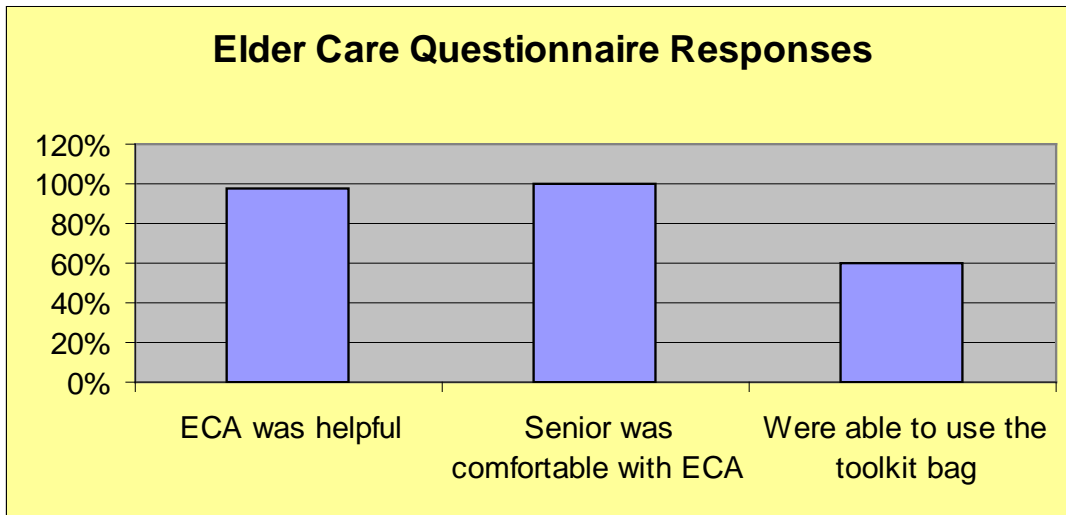
The ECA networks with community agencies throughout Northeast Florida to help match seniors with organizations who can help in their time of need. Often these agencies provide free or reduced cost services to the senior who was often unaware of these services before meeting with the ECA. A partial, but by no means exhaustive, listing of these agencies follows:

- | | | |
|-------------------------------|----------------------------------|---------------------------------|
| American Eldercare | COJ HUD | Nassau County Council on Aging |
| American Home Companion | Division of Blind Services | Putnam County Elder Affairs |
| Baker County Council on Aging | DOEA EARS | Senior Life Foundation |
| BRITE | ElderSource | Soutel Optical |
| Builder's Care | Housing Partnership of NE FL | Temporary Loan Closet |
| Care-A-Van | JTA | Urban Jacksonville, Inc, |
| Cares | Lion's Club | Visiting Physicians |
| Carter's Park & King Pharmacy | Live United Corporate Volunteers | Volusia County Council on Aging |
| Clay County Council on Aging | Jewish Family Community Services | MV Transportation |



HOW WELL DID WE DO IT?
THE ELDER CARE QUESTIONNAIRE

Overall Elder Care Questionnaire score (of 10): 9.8



An important source of feedback—the ECQ:

Since August 2007 we have conducted the Elder Care Questionnaire (ECQ)—a survey of ATCM participants administered roughly two weeks following discharge from the hospital. The ECQ helps to gauge program effectiveness from the perspective of the senior. This survey is conducted by a hospital volunteer or staff member who contacts the senior via phone to determine the level of satisfaction with services. This call also serves as an additional point of contact to check on the senior’s well being. Any concerns or questions are referred to the ECA for follow-up. The ECQ helps to gauge the effectiveness of the program from the perspective of those who benefit from it. 119 participants from Baptist graciously shared their feedback.

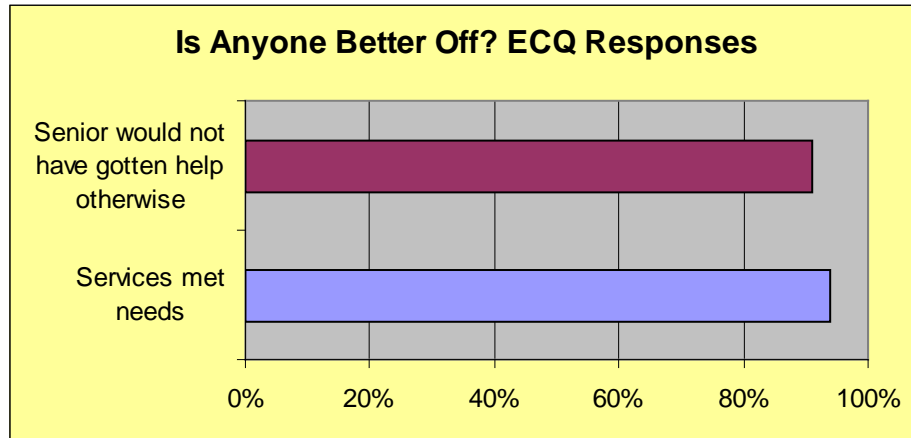
ECQ respondents remain satisfied with the program and the level of service received from the ECA. Respondents give an average satisfaction score of 9.8 out of 10, and have consistently reported a high level of satisfaction since the beginning of the survey. Virtually 100% of respondents were pleased with the ECA; they found the ECA helpful in their time of need and were comfortable speaking with her despite less than optimal conditions.

The question “Have you been able to use anything from the toolkit bag of information,” is also positive—60 percent of respondents answered “yes” to this question. The toolkit bags are a low cost way to distribute detailed information to seniors who are in a vulnerable situation and may soon need it.



IS ANYONE BETTER OFF?

CASE STUDIES



ECQ Responses:

During the ECQ seniors are asked if the help they received made a difference in their recovery by meeting their needs and providing a service they would not have gotten elsewhere. More than 91% agreed.

CASE STUDIES

ATCM participants are unique individuals with different needs. It is essential to recognize how ATCM affects individuals in order to demonstrate the program's true value. For this reason, we often share case studies as examples of program effectiveness.

Mrs. Allen Mrs. Allen is a 67 year old woman who came to Baptist with congestive heart failure. When seen by the ECA, Mrs. Allen had been weak from her illness for some time and did not feel comfortable returning home alone. She had also been unable to clean thoroughly for some time, and worried that allergens in her home were worsening her condition by making it harder to breathe. The ECA ordered delivered meals for Mrs. Allen while she recovered. To make her feel more secure the ECA purchased an Emergency Response System. The ECA also purchased deep cleaning to reduce allergens.

How the ECA benefited Mrs. Allen: The ECA provided services that impacted Mrs. Allen's physical, nutritional, and psychological health. This allowed her to return home comforted that she would be taken care of, and that there was someone to turn to in time of need.

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