

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 Shands 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 Shands Jacksonville and Baptist Medical Center 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, Shands Jacksonville 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. Currently Shands social services staff works closely with the ECA to identify and assist senior patients who are in need of help on their return home from the hospital. **This report reviews some of the events and findings of the ATCM program during the full program period of September 9, 2007-March 31, 2009 at Shands Medical Center.**

Staff:

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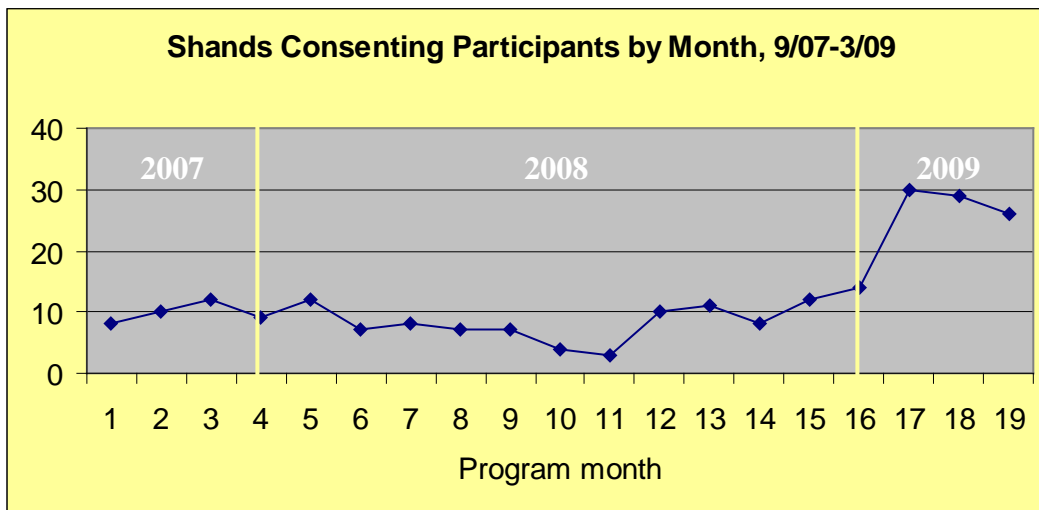
WHAT DID WE DO?

WHO WE HELPED

Total patients receiving assistance from ECA: 322

Average number of patients seen by ECA each month: 17

Patients consenting to targeted program services: 227



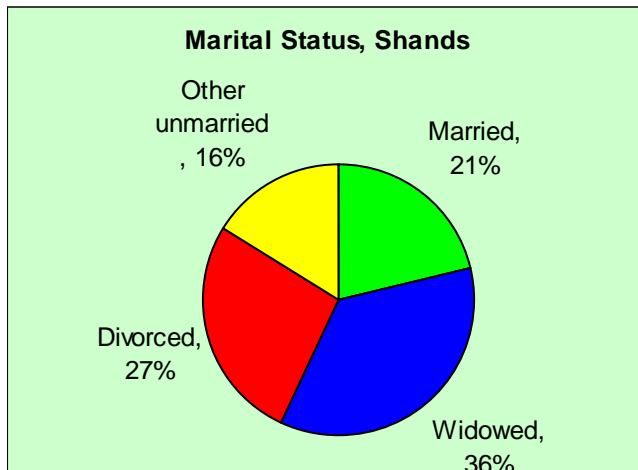
Patients seen:

The Elder Care Advocate began providing services to seniors at Shands in September 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 19 months that this program has operated at Shands 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 300 patients have been referred to the ECA for help by hospital staff. 277 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 that participation increased dramatically from July 2008 (month 11). This month marks the introduction of a full time ECA at Shands. This increase indicates a need for services beyond the patients served part time. Overall, the ECA saw an average of 16 patients a month and some months assisting over 45 referred patients, ensuring that they were thoroughly assessed for services, family was contacted if necessary, and that 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



Participant characteristics:

Average age: **72.9 years**

Male to Female ratio: **2:3**

Average income: **\$996/month**

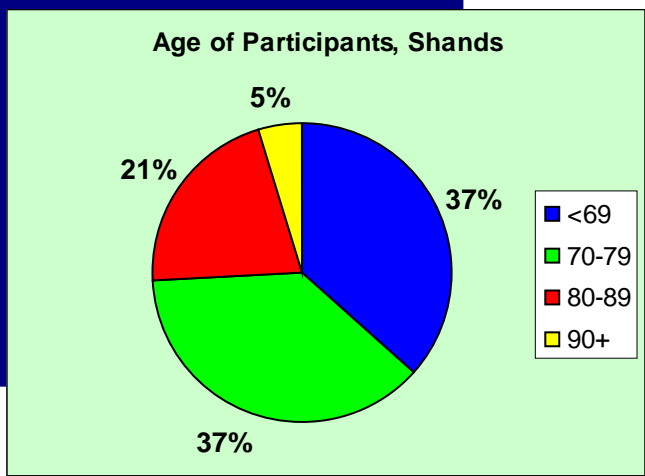
Race: **Black: 60%**
White: 38%
Other: 4%

Participant characteristics:

ECA program participants reflected a diverse cross section of area seniors in need. Program participants come from all backgrounds. There were more Minority than White participants, and three of every five patients was a woman.

Among those consenting participants, **26 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 these seniors is that nearly **80 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.

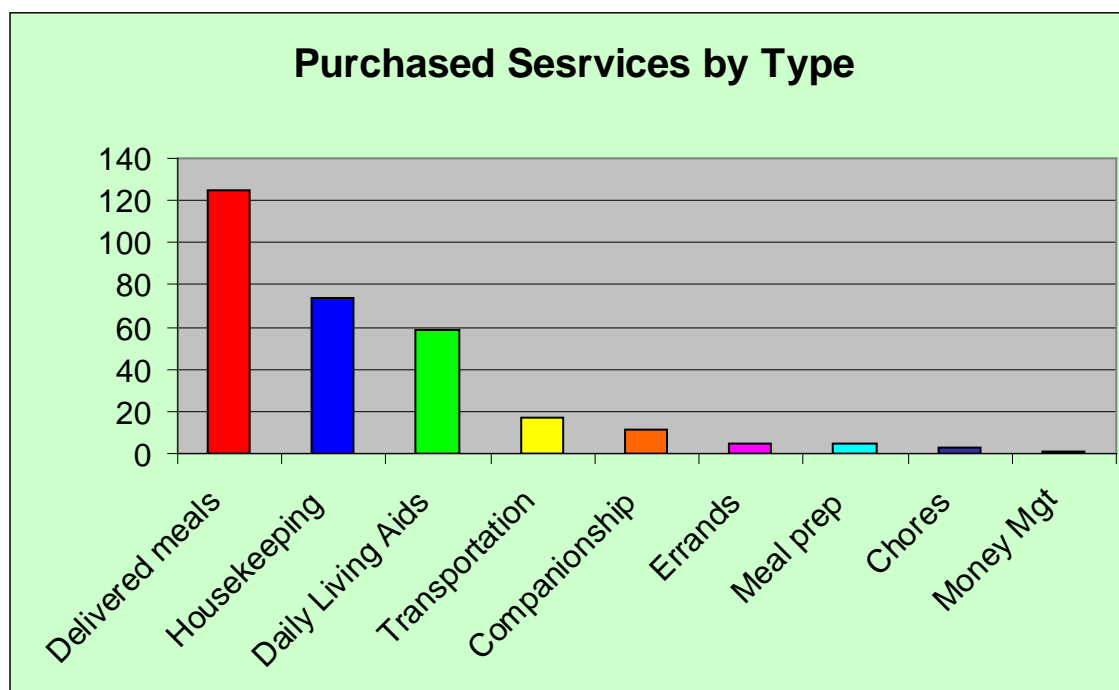




WHAT DID WE DO?

SERVICES PROVIDED

Participants receiving purchased services: 156

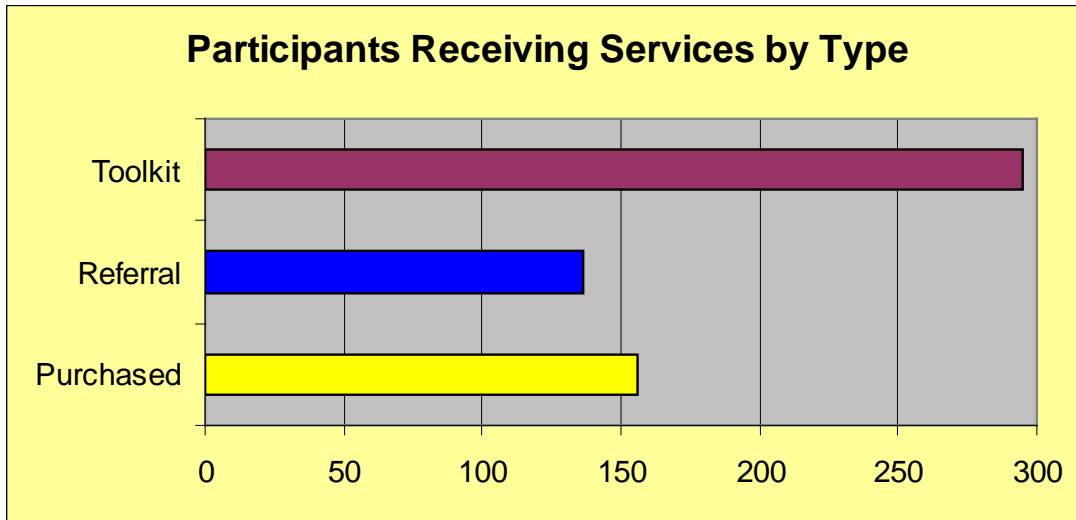


Services to afford a safe discharge from the hospital: During this program at Shands the ECA has purchased services for more than 150 participants. The most often purchased service was providing meals for patients when they returned home from the hospital. Recently discharged patients are often frail and have a difficult time preparing nutritious meals to aid in their recovery. **The ECA provided over 2,750 either delivered meals or meal preparation.** Housekeeping was provided for many patients who are often 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 in community resources and issues that senior patients face, and provides information to the vast majority of people she sees daily. The ECA helps patients navigate the confusing world of long term care after an illness.

Referral to a Friend:

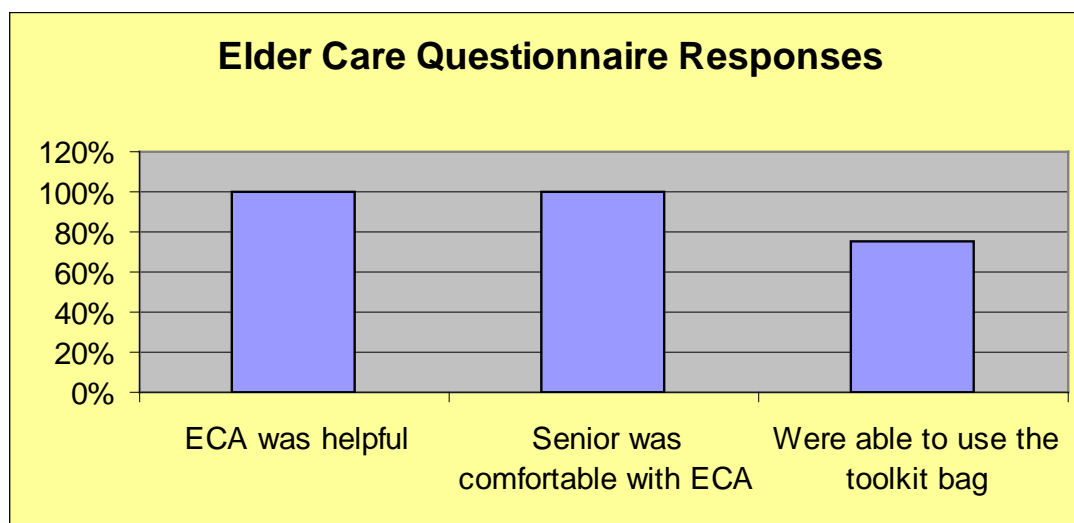
The ECA networks with community agencies throughout the Northeast Florida region to help match seniors with people who can help in their time of need. Often these agencies provide free or reduced cost services that the senior was unaware of before meeting with the ECA. A partial, but by no means exhaustive, 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): 9.9



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 the effectiveness of the program from the perspective of those who benefit from it. This survey is conducted by a volunteer or staff member who contacts the senior via phone to determine 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. 106 participants from Shands graciously shared their feedback.

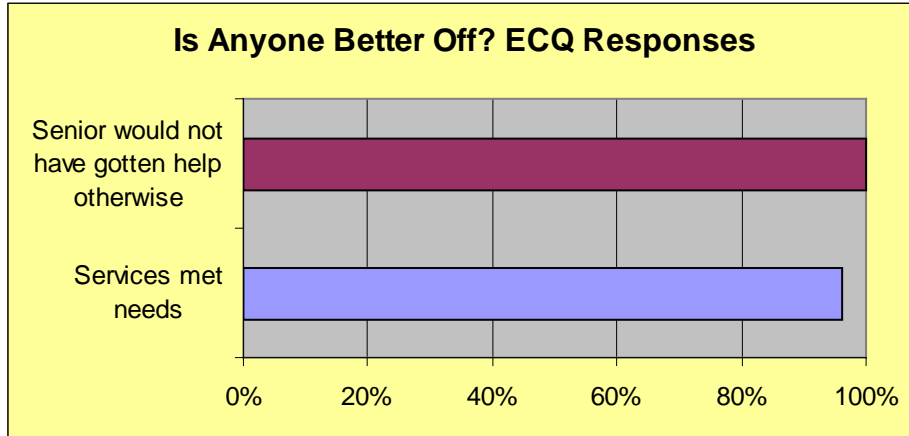
As usual, ECQ respondents remain satisfied with the program and the level of service received from the ECA. Respondents give an average satisfaction score of 9.9 out of 10, and have consistently reported such a high level of satisfaction since the beginning of the survey. 100% of respondents were pleased with the ECA; they found her 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—75 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 96% agreed.

CASE STUDIES

ATCM participants are unique individuals, and everyone seen by the ECA have different needs. It is essential to recognize how ATCM affects individuals to demonstrate the program's true value. For this reason we often share case studies as examples of program effectiveness.

Mr. Crawford Mr. Crawford is a 70 year old man who lives home alone and was admitted to the hospital for a surgery. Though he expected to gain his strength back, he was most concerned about preparing meals and housecleaning upon his return home. Because Mr. Crawford is very particular about what he eats, the ECA offered a home helper to come in to assist with meal preparation (rather than standard delivered meals) and homemaking to meet his needs. Mr. Crawford also needed assistance with completing a Medicaid application. ECA discussed community resources and provided a referral to Eldersource for Medicaid application assistance and homemaking services. Mr. Crawford was thankful for the services provided and he told the case manager that the ECA really focused on his needs which made him feel more comfortable about returning home.

How the ECA benefited Mr. Crawford:

The ECA was able to tailor the type of assistance given so that it was most useful for Mr. Crawford; simply delivering frozen meals would not have been adequate in this case. The ECA was also able to connect Mr. Crawford with the appropriate community service agencies so that he could benefit from the full range of services available to him.

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