

Family Involvement in Transitional Care Among Medicare Beneficiaries

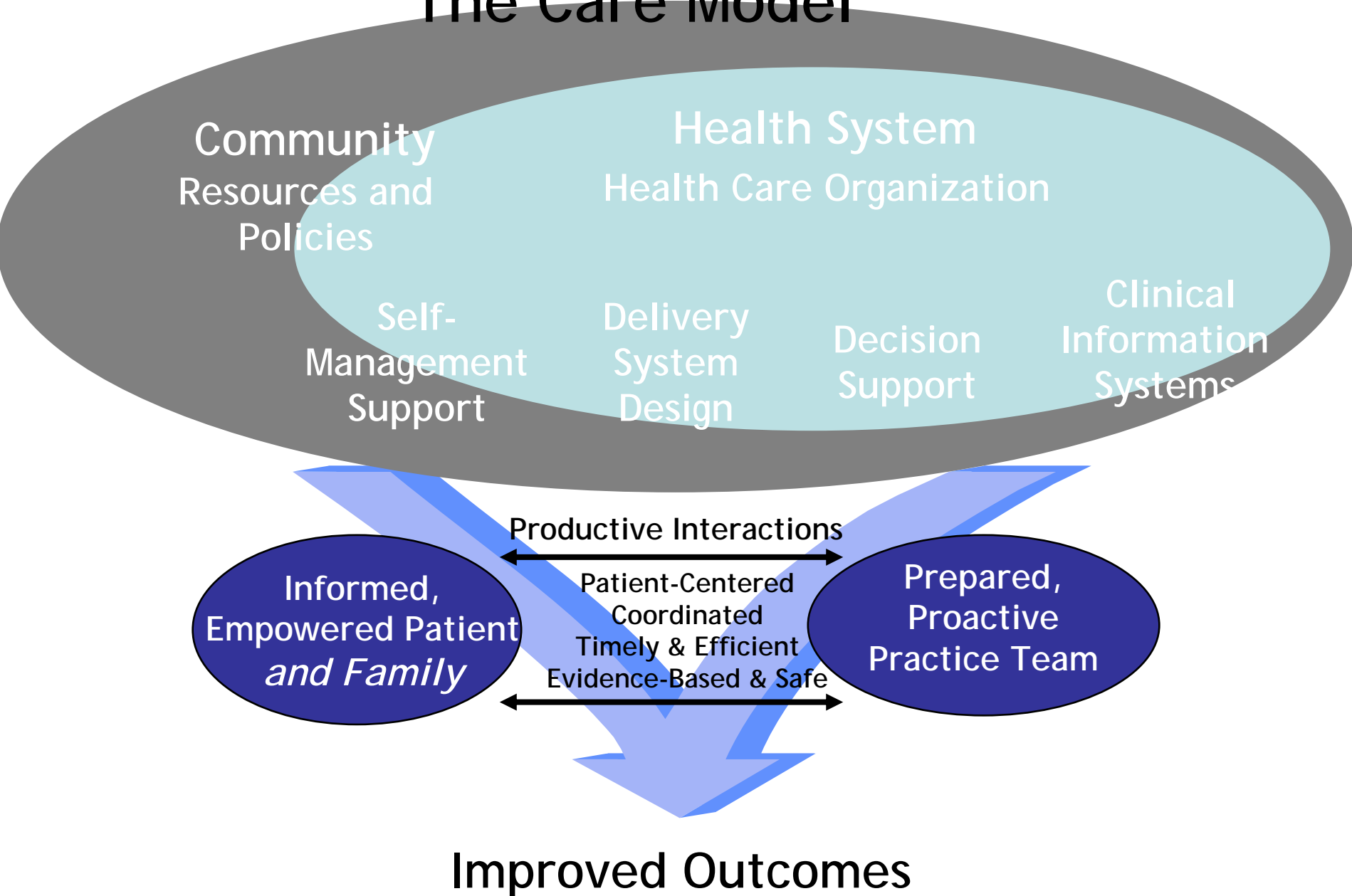
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What do we know about Family Involvement in Older Adults' Health Care?

- Families recognized as caregivers for disabled, proxy respondents, surrogate decision-makers for incapacitated or cognitively impaired
- Large literature documenting favorable effects of social support, emotional support for mortality, health
- ~80 percent of chronically older adults receiving personal care exclusively reliant on family/friends
- 42% of caregivers to chronically disabled Medicare beneficiaries help with administration of medication.
- <2% of Medicare home health patients live alone with no help from a family member or friend.
- 39% of Medicare beneficiaries ages 65 and older accompanied to routine physician office visits (typically older, disabled, less educated, more costly to Medicare).

The Care Model



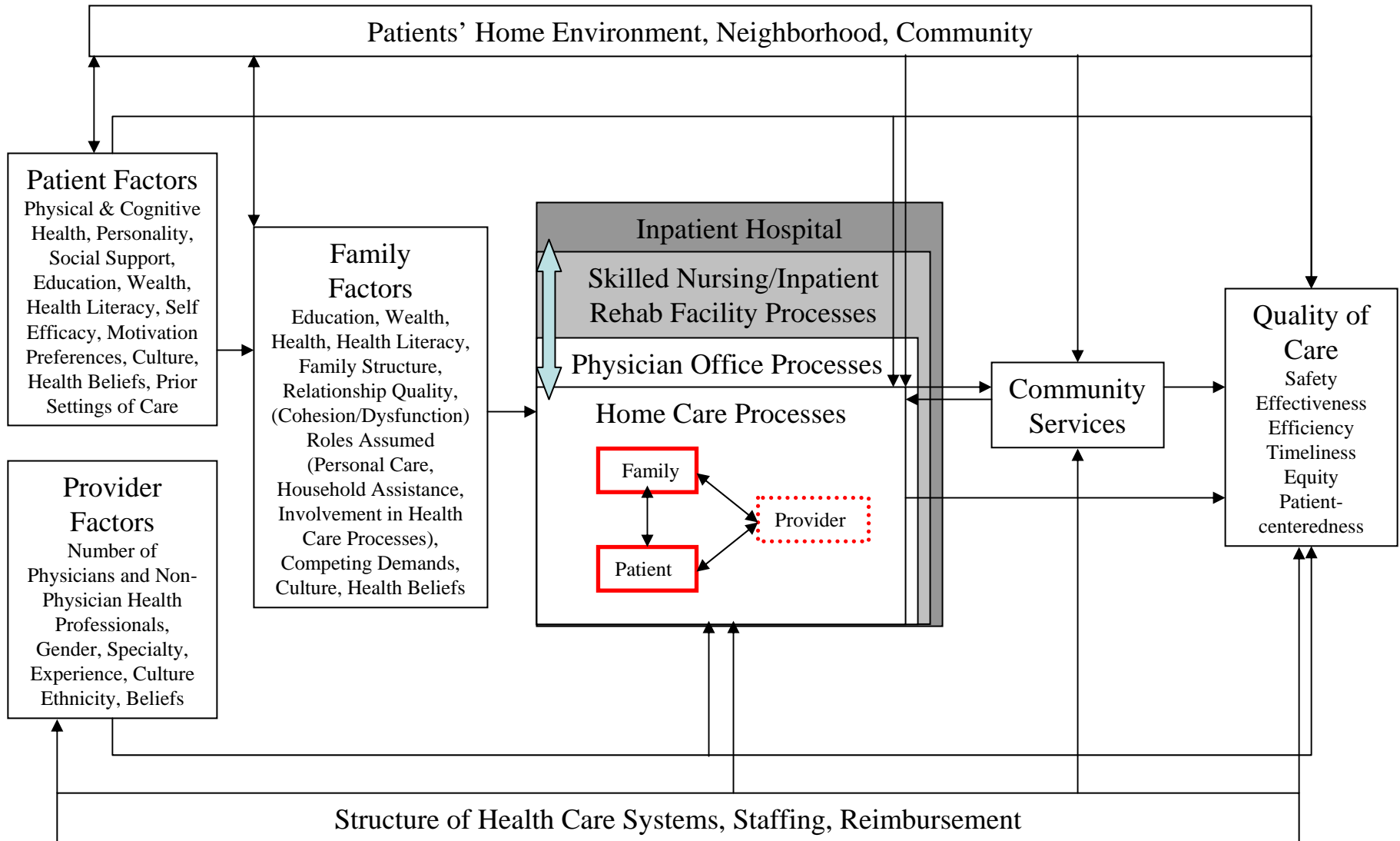
Family/Companion Roles and Behaviors in Medical Care

Family/Companion Roles	Examples
Technical Interpreter: Facilitate patient understanding	Clarify physician explanations; Clarify technical terms; Ask questions; Record or remember discussion
Patient Extender: Facilitate provider understanding	Clarify or expand patient history; Introduce medical topics
Coach: Encourage patient involvement in decision making	Prompt patient to discuss topics or ask questions; Encourage patient to express opinion, expectations, preferences
Navigator: Coordinate care across provider and care settings	Clarify arrangements for scheduling and follow up
Advocate: Request services	Request specific tests, procedures, or medications
Assistant: Facilitate treatment in the community (task assistance)	Physician clarifies for family issues around treatment regimen (medications, nutrition, physical activity)

Implications of Family/Companion Involvement for Quality

Dimensions	Examples
Safety	Clarify (for patients and physicians) patient history, drug name, description, dose, schedule, purpose, side effects, monitor patients' health
Effectiveness	Support patient adherence with treatment recommendations by facilitating patient understanding & motivation as well as provision of direct assistance
Patient-Centeredness	Advocate for patient wishes, prompt patients to discuss concerns & opinions; facilitate informed decision-making
Timeliness	Initiate contact with health professionals, report on emerging conditions/changes in health, arrange transportation to care
Efficiency	Coordinate care across providers, services, settings of care (transitional care)
Equity	Advocate for benefits, services, provider attentiveness to patients' preferences and needs

Conceptual Model -- Family Involvement in Health Care Transitions



Primary Domains of Care Transition Measure

- Information Transfer
- Patient and Caregiver Preparation
- Self-Management Support
- Empowerment to Assert Preferences

(EA Coleman, 2002)

Caregiver Experiences in the Hospital

- K.A. Vom Eigen and others (Medical Care 1999) conducted telephone survey of 1,800 recently discharged patients and caregivers
- Caregivers' perceptions of patients' hospital experiences highly correlated with patient ratings care
- Commonly reported problems by caregivers include: emotional support (23.9%), discharge planning (20.3%), family participation (17.6%) and communication/information/education (14.6%)
- Attributes associated with caregiver problems were: worse patient health & emergency hospitalization, low income, younger age, less involvement in routine care, less involvement in hospitalization, less time with patient after discharge
- 40% of caregivers believed providers did not sufficiently solicit their views on patient treatment; 20% reported not as involved in decision-making as they would have liked

Caregiver Experiences in Transitional Care

- A. Driscoll conducted study of 40 patients and caregivers in Melbourne (Journal of Advanced Nursing, 2000)
- Caregivers typically receive less information than patients regarding post-hospital care regarding:
 - activities patient can do (22.5% versus 45% of patients)
 - foods patient can eat (30% versus 37.5%)
 - Potential complications of concern (20% versus 45%)
 - When to return to the hospital (25% versus 37.5%)
- Provision of information to patient AND caregiver influential to patient's subsequent medical problems after discharge (provision of information with fewer problems)
- Salient themes surrounding discharge included: information provision, psychological well-being, task assistance, community linkages

Caregiver Experiences in Transition from Hospital to Home Care

- FM Weaver and others conducted 3 focus groups of home care workers and hospital discharge planners, interviewed 44 home care patients & 21 caregivers regarding transitions from hospital to home care (HHSQ, 1998)
- Home care workers/discharge planners identified themes :
 - Patient/family lack of preparedness at time of discharge; Patient/family unrealistic expectations
 - Importance of education; Need for improved written materials (greater specificity, more concrete)
 - Need for improved communication (importance of meeting between home care providers and families in hospital, before discharge)
- Patients and caregivers:
 - Relatively well satisfied, receipt of information important to satisfaction, feeling prepared, caregiver burden
 - 55% of patients & 67% of caregivers would have preferred a home care visit prior to hospital discharge
 - 67% of caregiver stated desire for more ongoing communication with home care staff (most commonly stated preference)

Coordination between Formal Providers & Informal Caregivers, Post-Acute Care

- DB Weinberg and others, (Health Care Manage Rev, 2007) studied 222 patients before and 12 weeks after knee replacement surgery, 91 caregivers at 6 weeks postsurgery
- Key factor “relational coordination” frequent, high-quality communication supported by shared goals, knowledge, mutual respect
- As hypothesized, relational coordination associated with to caregivers’ preparation to provide and manage care
- Caregiver-reported preparation for providing care favorably related to patient’s freedom from pain, functioning, and mental health
- Implication is that coordination of care both coordination across formal providers as well as lay caregivers

Transitional Care: Focus on Cognitive Impairment

- M.D. Naylor and others (AJN, 2005) screening for cognitive impairment among hospitalized older adults at 3 facilities, 25 interviews with 5 patient/caregiver dyads at hospitalization, 48 hours, 2 weeks, 6 weeks postdischarge
- 35% of hospitalized older adults found to be cognitively impaired (51/145 patients) using MMSE & BDSRS
- Greatest concerns/unmet needs: managing/negotiating care with multiple providers, managing illness, psychosocial support/coping
- Patient/caregiver needs changed over time
 - During hospital: loss of function, recovery
 - 48 hours: symptom management, managing/coordinating care
 - 2 weeks: motivation, powerlessness/frustration (psychosocial)
 - 6 weeks: based on recovery trajectory of patient

Summary

- Family involvement in transitional care relatively unstudied
- Evidence generally consistent with CTM (education, information exchange, recognition of psychosocial needs and community services)
- Substantiates potential benefit of more explicitly recognizing family as partners in care, preparing them for their roles
- Which aspects of family involvement in transitional care & specific approaches most successful unknown

Family Roles and Behaviors in Medical Care: Which Approaches Will Generate Highest Yield?

Family/Companion Roles	Implications
Technical Interpreter: Facilitate patient understanding	Develop processes/tools to record & store information by family, skills for communication with patient
Patient Extender: Facilitate provider understanding	Increase provider support for family input, greater recognition of families
Coach: Encourage patient involvement in decision making	Decision aids to align family/patient expectations; motivational techniques for family to encourage adherence
Navigator: Coordinate care across provider and care settings	Teach family about care plans (and provide to them), establish processes for communication with providers
Advocate: Request services	Assertive communication, advocacy
Assistant: Facilitate treatment in the community (task assistance)	Provide information, education, skills, confidence, psychosocial support (traditional caregiver support programs)