

Mobilizing Community Volunteers To Improve Care Transitions: Lessons Learned From Stepping Stones

The Care Transitions Project Of Whatcom County

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At a time when one in five hospitalized Medicare patients is readmitted within 30 days¹, techniques that enhance patient activation and self-management have the potential to reduce readmissions, improve the overall health of a community, and lower healthcare costs. The Coleman Care Transition Intervention coaching model is shown to successfully activate patients and families and reduce readmission rates. A coaching program has been implemented in “Step-

The Coleman Care Transition Interventionsm (CTIsm) model includes 5 patient encounters occurring over the 30 days post-hospital discharge, with content covering essential elements of safe patient self-management. See www.caretransitions.org.



ping Stones: The Care Transitions Project of Whatcom County,” a CMS-funded (2008-2011) project led by Qualis Health, the Medicare Quality Improvement Organization (QIO) for Idaho and Washington. This takes place in north-west Washington, in a community with Medicare providers that has one hospital, nine skilled nursing facilities, two home health agencies, one hospice, and approximately 400 physicians.

Because the providers had limited staffing resources, the project sponsors (including Qualis Health) turned to the community and the local four-year university to develop a volunteer coaching

program. In coordination with the project hospital, PeaceHealth St. Joseph Medical Center, Qualis Health implemented a structured program to recruit, educate, and coordinate a cadre of dedicated volunteer coaches, including managing the coaches’ interface with the community’s hospital.

The program demonstrated that volunteers, even without formal clinical background, can become effective coaches with adequate training, structure, and processes. Active coordination with the hospital and clinical support in the context of a local community of practice are key elements to the success of non-clin-

ical coaches. With the highly mobile nature of volunteers, continuous efforts to recruit and train new coaches must be built into the process. Attentiveness to the volunteers’ needs and provision of ongoing educational opportunities are key elements. With all of these pieces in place, a strong and cohesive cadre of hospital volunteer coaches was achieved.

In this article we discuss coaching in the community through use of a trained and supervised, but unpaid, workforce and the positive impact of the coaching experience on the volunteer coaches themselves in terms of personal and professional growth.

Early Challenges

The lack of community-based financial resources for coaching led the project sponsors to implement a volunteer program. The program would not have been possible without the significant support of the hospital, including office space and IT access for the program coordinator. Volunteer coaches are integrated into the hospital volunteer department to address patient access, privacy, and supervisory affiliation issues. A Qualis Health Care Transitions Specialist (CT Specialist) serves as coach coordinator, designing structures and processes for implementation. Since CTI is not oriented toward volunteers, this involved a significant commitment of resources, including initial and ongoing coach recruitment, with careful screening and selection of volunteers. Once recruited, the volunteers receive intensive training in the model and then ongoing support and mentoring as they begin coaching in the community. The level of supervision decreases as the coaches' skill and confidence increases. A coaching "community of practice" was formed to address the challenges relating to all aspects of volunteer coordination.

Working with volunteers demands consistent coordination. The volunteer coaches sign a non-binding letter of agreement that stipulates commitment to a minimum number of hours per week. However, variables such as vacations, "snow-birding" (retired individuals moving south during the winter), relocation, and family and community commitments take priority. Of the current volunteer coaches, none coach more than 15 hours a week. Many coach within a specific geographic territory, and lay coaches are not assigned to cases that are clinically complex.

Volunteer Coach Training

In April 2009, the first formal training occurred, with 39 individuals attending. Attendees included potential coaches and other interested individuals from the hospital, a Medicare clinic, a tribal health center, both home health agencies, the Area Agency on Aging, two Medicare

Advantage Plans, faith-based community nurses², a case manager from an elder law practice, and unaffiliated community volunteers.

In October and November 2009, six senior psychology majors from Western Washington University were also trained as coaches. Four of the six students shadowed experienced coaches in the hospital and community. One became independent and continued to coach as a hospital volunteer coach after graduation. During the same period, a group of community volunteers and faith-based community nurses were also trained in the model. From that group, two faith-based nurses began coaching within their congregations, and one RN and one lay person became hospital volunteers and now coach independently.

The group of active volunteer coaches remained small. As a result, the CT specialist, a CTI master trainer, instituted one-on-one training for additional hospital volunteers and university students who became hospital volunteers. At present, active independent volunteer coaches include four nurse volunteers, one community-based lay coach, four graduates (two in psychology, one in social work, one in pre-med), and one current senior psychology student from the university program noted above.

The group became tight-knit and attrition was almost nonexistent. The coaching office is run like a department, with monthly meetings, ongoing training and support, a communication book, and a schedule that is maintained by the coaches themselves with CT specialist supervision. The success of the volunteer coaching model can be attributed to the sense of community thus created.

Lay Coaches

Successful use of lay volunteer coaches is a unique element of this project. One of the coaches trained in October 2009 became an independent lay coach. She had previous experience volunteering in the community with the "Friendly Visitor" program for isolated seniors. After for-

mal CTI training, she shadowed clinician coaches. She was then mentored by experienced coaches and assigned to patients who were not as medically complex as the patients assigned to the clinician coaches. She consults frequently with the CT specialist or another clinician coach. Over time, the coaches developed a Troubleshooting Guide, highlighting common issues. The Troubleshooting Guide was provided to all coaches and became part of new coach orientation. Once the lay coach became independent, she was able to mentor other lay coaches and students as they became coaches. Since lay coaches could become intimidated by nurse coaches, they were able to focus on the process of coaching better when shadowing another lay person.

One of the six trained psychology students continued to coach after graduation. A senior human services pre-MSW student became a coach as an internship. A pre-med student coached as part of her senior project. The project staff developed a relationship with the university's psychology and allied health professional departments. This collaboration between the university and the hospital volunteer department is unique to this coaching model.

On-going Challenges

Lay coaches' lack of clinical knowledge or experience is an inherent challenge. They must develop not only a general knowledge of the health care system and community support mechanisms but also the ability to work effectively with patients and their caregivers, through individualized training or while being mentored. Yet lay volunteers bring their own unique experiences that can be leveraged for the benefit of others.

Working with students is even more time-intensive for both students and the CT coach coordinator, due to class-related demands and the need for additional training and oversight in the hospital and in the field. It takes longer for students to

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become independent, as they may not have critical thinking skills or the maturity necessary to meet the demands of coaching interactions with patients. This challenge is offset, however, by the benefit of exposing these individuals to patient self-management and activation concepts early in their careers.

Coordination Commitments

An individual dedicated to coordinating the multiple needs of a new program is a significant factor in the success of a volunteer coach program. These include all aspects of recruitment, volunteer training, ongoing education, clinical oversight, scheduling, and reporting. To facilitate this program, it was necessary to develop orientation and training tools, documentation tools, consenting processes, and coordination within the community, including oversight of coaches while in the hospital and in the field. In any community interested in implementing a volunteer coach project, all elements of recruitment, orientation, and coordination must be taken into consideration and provided.

Volunteer Evaluation

Metrics of volunteer hours and patients coached were tracked over time. In addition, volunteer coaches' perceptions of their experience were assessed through a fifteen-item open-ended questionnaire designed by the coaches themselves. One of the key insights that emerged was the impact coaching had on the coaches. Their responses indicated that they had learned skills in CTI coaching that applied to other aspects of their lives including "advocacy for self and others" and the ability to "coach a friend or family member." Another questionnaire component related to "helping others in goal setting and identification." The volunteer coaches described the rewards of "seeing the patient or caregiver becoming empowered." They also identified "improved patient safety" and their own "personal and professional growth." Feedback from the student coaches indicates that they found the coaching experience enhanced their graduate school applications and job opportunities.

Volunteer coaches verbalized great satisfaction in seeing patients' overall health outcomes improve through coaching:

"I believe I am contributing to my community. I have seen poor outcomes when patients leave the hospital not fully comprehending discharge orders. I am helping to prevent these experiences for other families."

They also celebrated empowering patients through their coaching skills:

"In working with people in training or mentoring situations I find myself doing less for them and doing more demonstrating of desired behaviors for them to mirror."

Community Value

While it is difficult to put quantifiable measures on the value of volunteer coaches, they provide a significant contribution to their community. In 2010, from 2 to 9 coaches at a time donated a total of 1,838 hours (averaging 153 hours per month), coaching 150 patients who would not have otherwise benefitted from this intervention. An in-depth analysis shows that volunteer coaches are as effective as employed coaches in reducing readmissions and increasing activated behaviors³. Patient and family members respond positively when notified they are working with volunteers, and compliment them on their dedication to the community.

The final outcome, less quantifiable but also vital to the community, is enhanced community pride and community involvement on the part of the volunteer coaches. Volunteer coaches not only gain the benefits of volunteerism, but also become ambassadors for the CTI model of patient activation. They share this emphasis on patient and family awareness and activation with their community contacts and their own extended families.

Summary

The sponsors of the Stepping Stones project emphasized sustainability from the onset, striving to build community capacity to extend beyond the period of CMS project funding. This emphasis influenced the evolution of the coaching

program, fostering a community of practice among staff and volunteer coaches resulting in developing the program's structure and tools.

The volunteer aspect of the coach program emerged out of necessity rather than by design. However, coaching has become a fully developed community program due to ongoing commitment on the part of the coaches themselves and the QIO CT Specialist. There is an as-yet untapped group of both clinical and lay persons in this community who have expressed interest in becoming coaches. The university is interested in having more students exposed to the model. This approach to coaching has been successful for the Whatcom County community. As this or any community moves forward in reducing unnecessary hospital re-admissions, this approach to coaching should be considered.

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References

1. Jencks, S. et al., "Re-hospitalizations among Patients in the Medicare Fee-for-Service Program", *N Engl J Med* 360:1418-1428.
2. Nurses who practice in a congregational setting, focus on the intentional care of the spirit, promote whole person health, and prevent or minimize illness within the faith community are known as Faith Community Nurses from the professional nursing perspective. They may be recognized in their own faith community by another term such as parish or congregational nurses. They are guided by the standards published in the American Nurses Association's "Faith Community Nursing: Scope and Standards of Practice."
3. A Qualis Health statistician tracks readmission rates for QIO employed coaches and community volunteer coaches. There has been no difference in variation in readmission rates or patient activation rates between the paid coaches and the volunteer coaches.