Research Prioritization Topic Brief: Effectiveness of different care coordination strategies to move chronically ill older adults from post-acute, short-term skilled nursing facility stays back into the community

PCORI Scientific Program Area:
Improving Health care Systems

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October 9, 2015

This report was prepared by NORC at the University of Chicago with consultation from Improving Healthcare Systems staff within the Patient-Centered Outcomes Research Institute (PCORI). All statements, findings and conclusions in this publication are solely those of the authors and do not necessarily represent the views of the Patient-Centered Outcomes Research Institute (PCORI) or its Board of Governors.

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Executive Summary

Comparative Research Question: What is the comparative effectiveness of different care coordination strategies designed to move chronically ill older adults from post-acute, short-term skilled nursing facility (SNF) stays back into the community in terms of reducing patient hospital readmissions and caregiver burden, and improving patient well-being?

Brief Overview of the Topic: Older adults entering SNFs today are often chronically ill with multiple comorbid conditions, some degree of cognitive impairment, and limited capacity to perform activities of daily living. Despite the complexity of their care needs, these patients generally have short SNF stays prior to release back into the community. The transition from SNF to community is particularly challenging for these complex patients due to limited coordination between providers and care settings and insufficient supports available to the patient in the home. Care coordination involves activities such as discharge planning, medication management, and continuous monitoring of care plans, among others. Literature specifically looking at these care coordination activities in SNF transitions focuses primarily on 30-day outcomes as opposed to longer-term outcomes that shed light on how to facilitate not only safe and effective transitions, but also positive outcomes for the longer term once individuals have returned to the community. Additional comparative effectiveness research is needed to understand which strategies work best for the specific population discharged from short-term SNF stays.

Patient-Centeredness: A majority of older adults hope to age in place. “Aging in place” is a concept defined by the CDC as “the ability to live in one’s own home and community safely, independently, and comfortably, regardless of age, income, or ability level” (CDC, 2013). However, many of these older adults lack appropriate coordination and support to make it possible. This can be especially burdensome for caregivers who also do not have necessary supports in place. Better understanding of effective care coordination can support aging in place and can empower caregivers to manage care during this vulnerable period while reducing their burden, which serves the patient-centered nature of this issue.

Impact on Health and Populations: In 2013, 1.7 million Medicare beneficiaries received care in nearly 15,000 SNFs. This represents 2.4 million stays and $28.8 billion in Medicare spending (MedPAC, 2015). Currently, caregivers spend over 30 billion hours per year providing informal care to chronically ill individuals or people with disabilities (Chari et al., 2015); therefore, with the increasing number of potentially frail older adults moving into communities, caregivers can experience loss of wages as well as depression and stress, which can affect the quality of care experienced by older adults.

Assessment of Current Options: Current literature highlights the effectiveness of care coordination strategies such as discharge planning and medication management, but is focused primarily on hospital discharge to home and on 30 days post-discharge outcomes rather than on longer term outcomes and maintenance of community-dwelling status. Although a rich body of evidence demonstrating the effectiveness of transitional care strategies exists, the evidence base around coordinating care from the SNF setting to community-based providers is emerging and borrows evidence-based practices from care transition initiatives (Berkowitz et al., 2013). In particular, there is a need for more research on longer-term care coordination strategies and outcomes beyond 30 days, given the frailty of the population.
involved in such transitions, the role and burden placed on caregivers to coordinate care, as well as public policy structured to promote individuals living at home in the community with adequate supports. The growing repository of existing transitional care models provide a strong evidence-based resource to strengthen the SNF transition.

**Likelihood of Implementation in Practice:** Research has demonstrated the effectiveness of care coordination strategies after hospitalization, such as comprehensive discharge planning and medication management. Literature suggests that many care coordination interventions have been successfully implemented and have yielded positive results for hospital-to-home transitions, both in terms of participant experiences and directly measurable outcomes. For example, the application of Project Re-Engineered Discharge (Project RED) to SNF transitions demonstrated that results of reduced re-hospitalizations can be successfully carried over from the acute care setting to SNF-to-community transitions (Berkowitz et al., 2013). Research in this area is also timely due to recent payment and policy changes for Medicare aimed at improving quality of care in SNFs (CMS, 2015), further incentivizing providers to implement coordination services in practice.

**Durability of Information:** Providing a variety of supportive services that meet the diverse needs of older individuals and their caregivers is crucial to enabling them to age in place and to remain healthy and independent in their homes and communities and to avoid unnecessary, expensive nursing home care. Evidence exists for a number of post-acute care coordination strategies, and as new payment models proliferate to encourage providers’ accountability for outcomes beyond a single service encounter, providers and care managers will be seeking out best practices in care coordination that improve patient safety, outcomes, and efficiency.
Topic: Effectiveness of different care coordination strategies to move chronically ill older adults from short-term skilled nursing facility stays back into the community

**Overall Comparative Research Question:** What is the comparative effectiveness of different care coordination strategies designed to move chronically ill older adults from post-acute, short-term skilled nursing facility stays back into the community in terms of reducing patient hospital readmissions and caregiver burden, and improving patient well-being?

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2. **Introduction:**
   Historically, older adults’ transition into nursing facilities was a long-term or permanent placement. The health care landscape has changed, and most who enter skilled nursing facilities (SNFs) today have short stays that last no more than one to three months (Toles, Young, & Ouslander, 2013) – the average length of stay in a SNF for Medicare patients was 37 days in 2013 (MedPAC, 2015). Individuals discharged from SNFs are often frail (Kramer et al., 2015) and particularly vulnerable to medical complications that result in re-hospitalization. Patients typically have a median age of 85 years, are often dependent upon caregivers for three or more activities of daily living, have six or more chronic health conditions, and have some degree of cognitive impairment (Toles, Young, & Ouslander, 2013). They are vulnerable to worsening symptoms, adverse effects from medications, failed follow-up testing, and excess emergency department visits and re-hospitalization (ASHP, 2015; Golden et al., 2011).

   The transition from SNF to community is particularly challenging because of the complex health care needs of this population, who often require outpatient primary care physicians to coordinate with caregivers and visiting nurses in order to manage complex medication regimens and fluctuating clinical status (AHRQ, 2015). The likelihood of poor outcomes is exacerbated when there are gaps in care once patients are in the community with fewer supports to coordinate among a set of several clinicians including primary care, specialists, physical therapists, pharmacists and home health providers. Many complications and their associated costs would likely be preventable with effective monitoring and care coordination strategies (Gardner et al., 2014), such as a detailed person-centered plan of care for medication management, self-care, and other strategies that will allow a patient to stay in the community for the long term.

3. **Patient-Centeredness:**
   Aging in place, defined by the CDC as “the ability to live in one’s own home and community safely, independently, and comfortably, regardless of age, income, or ability level” (CDC, 2013), is often
preferred by individuals and their families and is increasingly supported through policy; however, once patients return home, the burden associated with managing care and coordinating among providers across settings and specialties can be overwhelming to patients and their caregivers. Comparative effectiveness research on care coordination strategies for individuals returning home following short-term SNF stays would identify practices that promote safety and positive health outcomes for patients and their families at a time when they are at risk for medical complications and decreased quality of life.

4. Impact/Burden of the Condition:
In 2013, 1.7 million Medicare beneficiaries received care in nearly 15,000 SNFs. This represents 2.4 million stays and $28.8 billion in Medicare spending (MedPAC, 2015). Discharges from SNFs to the community currently comprise 38% of SNF discharges, and these discharges have trended upward in recent years (MedPAC, 2015), reflecting a growth in state policies that favor patient-centered approaches to long-term services and supports (LTSS) and fostering independence by keeping and treating individuals in their homes and community settings to the maximum extent possible (Naylor et al., 2015). While the rate of community discharge has increased, the rate of re-hospitalization has remained consistent at 15% (MedPAC, 2015). Earlier data on nursing home transitions suggests that the re-hospitalization trend has been persistent, with 13% of nursing home residents re-hospitalized or requiring a trip to the emergency department within 30 days of their transition to home (Murtaugh & Litke, 2002).

Caregivers are also subject to the burden associated with such a transition. Americans spend over 30 billion hours per year providing informal care to disabled or chronically ill individuals (Chari et al., 2015). On average, caregivers spend 20.4 hours per week providing care to individuals of all ages, and those caregivers who live with their care recipient spend 39.3 hours per week caring for that person (Family Caregiver Alliance, 2012). Caregivers suffer loss of wages, health insurance and other job benefits, retirement saving or investing, and Social Security benefits; in 2007, a reported 37% of caregivers quit their jobs or reduced their work hours to care for someone 50 years or older (Family Caregiver Alliance, 2012). The 10 million caregivers over the age of 50 who care for their parents lose an estimated $3 trillion in wages, pensions, retirement funds, and benefits. Costs are higher for women, who lose an estimated $324,044 due to caregiving, compared to men at $283,716 (Family Caregiver Alliance, 2012). Caregiver depression, stress, or burnout can affect the quality of care experienced by chronically ill older adults, resulting in heightened risk for health complications that may lead to re-hospitalization (Giosa et al., 2014; Lopez-Hartmann et al., 2012).

5. Evidence Gaps:
Research on care coordination strategies tailored to individuals transitioning home from SNFs is limited. Care coordination for this population can be institution- or community-based, which implies that different operational approaches are applicable (Golden et al., 2011). A rich body of evidence demonstrating the effectiveness of transitional care strategies exists, much of which includes care coordination elements. While these strategies primarily focus on transitions from the hospital to home or between hospitals and SNFs, it is expected that aspects of transitional care models translate to the SNF to home transition (AMDA, 2010). There is a need for more research on longer-term care coordination strategies and outcomes beyond 30 days, given the frailty of the population involved in...
such transitions and associated impact on patients’ functioning and quality of life, as well as the role and burden placed on caregivers to coordinate care and public policy structured to promote individuals living at home in the community with adequate supports. The following sections highlight existing research relevant to care coordination for SNF residents post-discharge and evidence gaps. They are organized by care coordination as part of a transitional care intervention, care coordination specifically for chronically ill elderly, the role of caregivers in care coordination, availability and role of community resources in support of care coordination, and home health care.

**Care Coordination in Transitional Care**

Systematic reviews of care transition interventions provide insight into key care coordination strategies. While they focus mostly on hospital transitions, they have the potential to support aging in place and the SNF transition, specifically. Hansen et al.’s (2011) review of 43 reports of interventions focused on reducing hospital readmissions within 30 days of discharge identified 12 intervention categories in three domains: 1) pre-discharge (patient education, discharge planning, medication reconciliation, appointment scheduled before discharge); 2) post-discharge (timely follow up, timely primary care provider follow up, follow-up telephone call, patient hotline, home visit); and 3) bridging the transition (transition coach, patient-centered discharge instructions, provider continuity). However, due to variation in the components constituting each study’s intervention and potential interactions among components within bundles of interventions that could modify the effectiveness of individual pieces, the authors did not identify a single intervention or bundle of interventions that reliably reduced risk for 30-day re-hospitalization. Nonetheless, evidence shows the potential effectiveness of some of these transition interventions; for example, interventions focused on bridging the transition from hospital to home, such as patient-centered discharge instructions (PCDI) and transition coaches, engage the patient in the discharge process and transform the process into an activity done with a patient rather than to a patient (Hansen et al., 2011).

There are several evidence-based hospital-to-home care transitions programs that support chronically ill older adult patients in the home after their transition, such as Better Outcomes for Older Adults through Safe Transitions (Project BOOST), which provides clinical tools for a team approach to hospital transitions (Society of Hospital Medicine, 2015), and the Transitional Care Model (TCM), a care management intervention focused on continuity of health care between hospital, post-acute, and primary care clinicians facilitated by a transitional care nurse (Transitional Care Model, 2015). Project Re-Engineered Discharge (Project RED) is an evidence-based comprehensive discharge intervention focused on hospital-to-home transitions that has successfully been adapted to the SNF setting by reducing 30-day readmission rates (Berkowitz et al. 2013). Key care coordination elements found in Project RED and elsewhere include:

- **Activities prior to discharge.** Project RED includes a family meeting one week prior to discharge to ensure the family and patients agree on goals of care for the post-discharge phase of life (Jack et al., 2009). The Project RED intervention also involves transmitting a discharge summary to community-based providers who are responsible for the patient’s care post-discharge (Jack et al., 2009).

- **Complete medication reconciliation and ongoing management.** Many follow-up protocols for after discharge emphasize conversations about evidence-based medication regimes (AHRQ, 2012).

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Project RED calls for medication management and reconciliation; discharge advocates are responsible for confirming patients’ medication plans, reconciling the discharge medication regimen, explaining what medications to take and when, reviewing each medication’s purpose and side effects, and making sure that patients have realistic plans for obtaining their medications (Jack et al., 2009). In addition to medication reconciliation following hospital discharge, care plans under Project RED must all consider a patient-centered approach to medication management in the community. As another example of medication management interventions, a nurse care management intervention involving technological devices for medication administration highlights how medication management, with the assistance of a medplanner device, is a crucial component of chronic disease management for the frail elderly and has been proven effective in supporting participants to achieve better clinical health status outcomes (Marek et al., 2013).

**Development and continuous monitoring of care plans.** SNFs often struggle to meet care planning and discharge requirements (OIG, 2013), resulting in recommendations that CMS strengthen care planning in this setting. The main care planning and discharge requirement related to quality of care is that care plans must specify how services will be provided and must include discharge planning. Specifically, care plans must describe patients’ medical, nursing, and psychosocial needs and how the SNF will meet these needs, must include measurable objectives and timetables and be customized to the patient, and must be developed by an interdisciplinary team that includes at least the attending physician and a registered nurse with responsibility for the patient (OIG, 2013). Extending to the home setting, Project RED includes development of a care plan that is coordinated with visiting nursing assistants who manage the plan post-discharge (Jack et al., 2009).

Little research focuses on which care coordination activities are crucial for promoting discharge of SNF patients in communities in ways that would facilitate successful aging in place as well as improvements in health-related quality of life, symptom relief, and caregiver burden. Because there is typically more time leading up to discharge from a SNF than there is leading up to discharge from a hospital, there is room for more planning and coordination of support and services for the transitioning SNF population, but there is little information on how best to take advantage of this time in order to plan for the most reliable and effective care coordination strategies in the post-transition time period.

**Care Coordination for Chronically Ill Elderly**

Peikes et al. (2009) conducted an evaluation of ten programs focused on Medicare beneficiaries at the time of transition from the hospital or emergency department to home. Peikes et al. concluded that two of the ten programs with care coordinators were effective at reducing short-term readmissions through several mechanisms: 1) more in-person contact; 2) teaching patients how to take their medications; 3) working closely with local hospitals; and 4) more frequent opportunities for care coordinators to interact informally with physicians. Long-term impact of these programs were not measured.

**Caregivers’ Role and Burden**

Care coordination strategies that account for the caregivers’ role and measure caregiver burden are limited, despite the challenges faced by caregivers during the post-discharge period, including impacts on physical and mental health, ability to work, and finances. Examples of caregiver supports include
respite services, group and individual psychosocial support, and information and communication
technology support, and such supports have been shown to reduce depression, burden, and anger, and
have shown to improve coping ability and knowledge about caregiving and care processes (Lopez-
Hartmann, 2012).

Literature suggests that, despite the availability of caregiver supports, many caregivers feel ill-prepared
to manage the caregiving role (Bull, Hansen, & Gross, 2015) and that family caregivers are frequently
dissatisfied with the amount of information they receive during the discharge process (vom Eigen et al.,
2015). Family caregivers perform medical and nursing tasks for their chronically ill care recipients,
including medication management, administering IVs and injections, wound care, and operating
specialized medical equipment and monitors; and although family caregivers recognize the importance
of these medical tasks, 40% of caregivers have reported feeling stressed and worried about making a
mistake (AARP & UHF, 2012). Research on the role of caregivers in care coordination for transitions
between SNFs and the community and how to proactively support those caregivers is lacking. Since
caregiver stress can exacerbate the risk of health complications for the care recipient (Giosa et al.,
2014), health care professionals and providers should be encouraged to reassess the way they interact
with caregivers, ensuring that caregivers are well trained and prepared to perform difficult tasks (AARP
& UHF, 2012). Giosa et al. (2014) found that assessing a caregiver’s unique situation and needs and
tailoring the relevant information, education, and training supports they receive allows caregivers to feel
better prepared to confidently provide care in the home environment with ongoing support.

Availability and Role of Community Resources
Community-based resources, such as Aging and Disability Resource Centers (ADRCs), aim to support
older adults living in the community. However, availability in certain areas, funding structures, and
partnerships across settings are often a barrier to successful implementation of these services (Sundar,
Fox, & Phillips, 2014). ADRCs, which often include Area Agencies on Aging, provide services such as
referrals, options counseling, eligibility determination for public programs, and person-centered
transition support, and can promote long-term stays in the community (Administration on Aging, 2011).
Evaluations of ADRCs have shown positive results in terms of how these resources assist consumers.
High levels of consumer satisfaction with ADRC services (specifically related to services received, ease of
access, and staff responsiveness to unique individual needs and preferences) have been found in several
states (O’Shaughnessy, 2010). An analysis in Wisconsin found that its ADRCs had developed policies and
procedures that support consumer access. The analysis also pointed to some best practices to best
support patients, such as co-locating staff who perform functional and financial assessment of
consumers needing LTSS (O’Shaughnessy, 2010). However, ADRCs vary in their size, structure, and
capacity, thus potentially limiting their facility in providing services to support patients transitioning out
of SNFs back into the community and their caregivers.

Home Health Care
Since home health providers have teams of skilled health professionals who are ready and able to work
closely with providers, patients, and their families and caregivers to facilitate transitions, home health
providers are in the position of coordinating care and successfully transitioning chronically ill older adult
patients from SNF to home (AHHQI, 2014). However, there is limited information on how best to
incorporate home health providers into the transition, as well as the efficacy of the approach. The Alliance for Home Health Quality and Innovation (AHHQI) (2014) has developed an evidence-based care transition model for patients moving from hospital to home; this model calls for care coordination strategies similar to other care coordination interventions, including medication management, timely follow-up, and patient-activated education and coaching, and focuses on the outcomes of high patient satisfaction and reduction in 30-day avoidable re-hospitalizations, looking specifically at the 60-day home health episode following a patient’s discharge from an acute care hospital. Further research on this model and the general role of home health care is necessary to shed light on how home health providers can help to ensure successful aging in place of chronically ill older adults discharged from SNFs, as well as improvements in other outcomes such as health-related quality of life and symptom relief.

6. Ongoing Research

Clinical Trials

Searching for studies on ClinicalTrials.Gov in September 2015 with the search term “care coordination frail elderly” yielded 12 search results. Topics of these studies include home care, medication management, integrated care for reducing hospitalization and nursing home placement in community-dwelling frail elderly, use of care managers, and high-tech interventions to assist in guiding care between a care manager and primary care physicians.

One study titled “Home Care Medication Management Program for the Frail Elderly” addresses the importance of medication management for the general frail elderly population. In this study, a team of advanced practice nurses and registered nurses coordinated care for 12 months to two intervention groups who also received either an MD.2 medication-dispensing machine or a medplanner. The focus on medication management connected nurse coordinators with participants via planned weekly phone calls and every other week visits to the home (Marek et al., 2013). Results of this study provide evidence that nurse care coordination has a beneficial effect on cognitive functioning, depressive symptoms, functional status, and quality of life in both mental and physical functioning, but the results do not provide evidence that the addition of the MD.2 medication-dispensing machine to the nurse care coordination resulted in better health status outcomes (Marek et al., 2013).

An additional search on ClinicalTrials.gov with the search term “care coordination SNF” yielded a study titled “Using Health Information Technology (HIT) to Improve Transitions of Complex Elderly Patients from Skilled Nursing Facility (SNF) to Home.” Investigators test the use of an electronic health record (EHR)-based transitional care intervention for complex elderly patients transitioning from subacute care in a SNF to the ambulatory setting to assure that physicians in the ambulatory setting receive key health information and alerts. This study was designed with single group assignment, and primary outcome measures for this study include rate of follow-up to outpatient provider within 21 days of SNF discharge, prevalence of appropriate monitoring for selected high-risk medications at 30 days from time of SNF discharge, incidence of adverse drug events 45 days after discharge, and rate of SNF readmission and ED visits within 30 days of discharge (ClinicalTrials.gov, 2014).
Searching on ClinicalTrials.Gov for “care transitions” to find context and background for the care coordination strategies surrounding care transitions yielded several results, one of which was titled “Improving Veteran Transitions from VA Community Living Centers (CLC) to the Community.” This was the only study that is clearly focused on the transition from SNF to community and that assessed longer-term outcomes beyond 30 days post-discharge. This study of the efficacy of the Everyday Competence Assessment and Planning for Community Transitions (ECAP-CT) intervention is a single group assignment with a target enrollment of 60 participants. The ECAP-CT toolkit will allow CLC interdisciplinary team members to 1) assess veterans’ everyday competence for safe and independent living; 2) develop personally meaningful rehabilitation goals that facilitate successful transition; and 3) conduct structured treatment planning to support resident goals around transitioning back into the community. The primary outcome of interest will be transition outcome; transitions will be “successful” if the resident leaves the CLC with a community destination and is not readmitted to the CLC within 90 days (ClinicalTrials.gov, 2015).

Ongoing Initiatives

There are many ongoing initiatives and funding sources to support transitions of patients from hospitals into their communities and the subsequent care coordination, and some of these transitions include SNFs. Many of these initiatives involve evidence-based care transition models. Some current initiatives funded by PCORI and the Centers for Medicare and Medicaid Services (CMS) include the following:

- Project ACHIEVE, funded by PCORI, is focused on evaluating the comparative effectiveness of ongoing multi-component efforts at improving care transitions and developing recommendations on best practices for the design, implementation, and large-scale national spread of highly effective, patient-centered care transition programs (PCORI, 2015).
- The PCORI-funded project, “Improving Care Transitions for Acute Stroke Patients Through a Patient-Centered Home-Based Case Management Program,” aims to improve the experience of stroke patients after they return home through the development of a patient- and caregiver-centered case management program delivered by Social Work Bridge Coordinators (SWBC). This is a randomized control trial that will examine outcomes for participants with the SWBC case management program and participants with the SWBC plus an online patient-centered support resource called the Virtual Stroke Support Portal (VSSP) as compared to those with usual care (PCORI, 2015).
- The Community-based Care Transitions Program (CCTP), funded by CMS, is a demonstration program testing models for improving care transitions from the hospital to other settings in coordination with community-based organizations, with the goal of improving quality of care and documenting measurable savings to Medicare (CMS, 2015). Some of these organizations work with SNFs through this program; 43% of the community-based organizations involved partnered with SNFs serving post-discharge short-term rehabilitation clients (Econometrica, 2014).

PCORI also funds various other projects related to improving health care transitions and care coordination, such as Patient Navigator to Reduce Readmissions (PArTNER) and Improving Post-Discharge Outcomes by Facilitating Family-Centered Transitions from Hospital to Home. However, it is noteworthy that none of these PCORI-funded projects focus on the transition from SNF to home, or on longer-term outcomes.

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7. Likelihood of Implementation of Research Results in Practice:
Many evidence-based interventions focus on hospital transitions rather than SNFs; however, their lessons are broadly applicable to SNFs. One specific example is Project RED. Berkowitz et al. (2013) found that the intervention could be successfully adapted and implemented in a SNF to reduce re-hospitalization rates.

In addition, changes in Medicare SNF payment policy, quality reporting requirements, and general movement toward value-based and risk-based payment strategies in Medicare, incentivize providers to adopt practices that affect outcomes such as re-hospitalization. For example, CMS’ proposed fiscal year 2016 policy changes require SNFs to report quality data to CMS; those that fail to submit will have their annual payment updates reduced by two percentage points (CMS, 2015). The US Department of Health and Human Services has set a goal to have 30% of Medicare payments in alternative payment models (e.g., Medicare Advantage, Medicare Accountable Care Organizations [ACOs], and advanced primary care medical home models) by the end of 2016 and 50% by the end of 2018 (CMS, 2015). Changes to nursing home certification and survey processes have enhanced the focus on identifying errors and deficiencies related to nursing home resident care including transitions to the community (CMS Center for Clinical Standards & Quality, 2014). These developments collectively provide impetus to prevent hospitalizations and readmissions, which are critical performance metrics in these delivery systems.

8. Durability of Information:
The percentage of the US population over the age of 85 is expected to grow to over 6.5 million by 2020 and to over 19 million by 2050, thus increasing the proportion of those individuals who will need access to more intensive and more costly care (Administration on Aging, 2010). Providing a variety of supportive services that meet the diverse needs of chronically ill older individuals is crucial to enabling them to remain healthy and independent in their homes and communities and to avoid unnecessary, expensive nursing home care (Administration on Aging, 2010). A number of post-acute care coordination strategies are still in their infancy (Ackerly & Grabowski, 2014), but as new payment models proliferate to encourage providers’ accountability for outcomes beyond a single service encounter, providers and care coordinators will be seeking out best practices in care coordination that improve patient safety, outcomes, and efficiency.

9. Potential Research Questions:
Based on our reviews of the relevant literature, we have identified several opportunities for comparative effectiveness research addressing transitions from post-acute, short-term SNFs to the community and care coordination during the period after transition and for the longer term. Questions that could aid future comparative effectiveness research include:

- What is the relative effectiveness of different transitional care models (e.g., Project RED, BOOST) in avoiding re-hospitalizations and supporting long-term (i.e., longer than 30 days), patient-centered outcomes after discharge from SNFs?
- What combinations or bundles of care coordination services (e.g., coaching, medication education and reconciliation, predischarge planning with family, care coordinators) can reduce re-hospitalizations and other acute care utilization for individuals that have transitioned from a SNF
back to the community? How do discrete components of these service bundles compare to one another in improving patient-centered outcomes such as reduced symptom burden and improved health-related quality of life?

- What is the comparative effectiveness of different care strategies for involving caregivers in the care transition and care coordination process for individuals moving from SNFs into the community? Which strategies are most effective in terms of reducing caregiver burden during and after the transition?
- What is the relative effectiveness of different combinations of community resources and types of providers (e.g., ADRCs, home health providers) for supporting the population of older adults transitioning from SNFs into the community? Are such community resources and combinations of resources effective in ensuring positive outcomes beyond the immediate transition period, extending their utility into the longer term health and safety of these individuals?

10. Conclusion:
The evidence base on strategies for care coordination as chronically ill older adult patients move from short-term SNFs to community settings is emerging. Reviews of literature and ongoing initiatives for care transitions and care coordination yield information focused on the care transition period and the 30 days following, but do not provide insight into care coordination strategies that focus on longer-term outcomes. There is therefore opportunity for comparative effectiveness research on the specific care coordination activities required for chronically ill older adults transitioning from SNFs to the community, and on where and how these activities should take place. There is also need for comparative effectiveness research on how to better integrate and direct resources at caregivers and to understand the relationship between community resources and effectiveness of transitions.
References for Topic: Effectiveness of different care coordination strategies to move from post-acute, short-term skilled nursing facility stays back into the community


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Appendix

Methods

Literature Search
In August 2015, we conducted a targeted literature review to identify evidence-based research around the effectiveness of different care coordination strategies designed to move from post-acute, short-term skilled nursing facility stays back into the community in terms of reducing patient hospital readmissions and reducing caregiver burden. We conducted our review by searching through scholarly databases and other web-based tools including PubMed, Google Scholar, Cochrane Database of Systematic Reviews, JSTOR, and more in order to access relevant sources including peer-reviewed literature, systematic reviews, meta-analyses, reports published by the federal government, and other literature on this topic. We also searched for resources on specific websites likely to provide pertinent information, including government agencies and relevant professional associations and societies; for example, we reviewed resources directly from PCORI’s website, as well as from the Medicare Payment Advisory Commission.

We used specific search terms to identify the most relevant literature for this topic. Some of the search terms that we employed include but are not limited to: “skilled nursing facility”; “care coordination”; “care coordination frail elderly”; “readmission”; “re-hospitalization”; “caregiver”; “care transitions”; and “skilled nursing facility discharge.” We focused the majority of our search on literature published in the last five years (i.e., 2010-2015) in order to help ensure that the information in this brief will remain current for several years. Due to the lack of research targeted specifically about SNF-to-community transitions and care coordination for the post-transition period, we broadened our search to include literature on hospital and inpatient settings in order to capture what information is currently available and thereby identify gaps and opportunities.

Clinical Trials
In August and September 2015, we conducted a search on ClinicalTrials.Gov for open clinical trials related to the topic. We focused our search on the search terms “care transitions” AND “community” to identify more trials (including both open and completed trials) that could be relevant to this topic. We reviewed the studies that came up in our searches and have provided in this brief an overview of the landscape of relevant clinical trials in the area of SNF-to-community transitions.

We also searched for other clinical trials related more specifically to care coordination by using search terms including “care coordination frail elderly,” “care coordination SNF,” and “care transitions.” These searches were more targeted and specific, and thus yielded only a small number of search results. We reviewed these results and presented the relevant information in the brief above.

Input from Research Experts
We had email communication and telephone calls with two research experts on this topic. We communicated via email with Cindy Brach of the Center for Delivery, Organization, and Markets within the Agency for Healthcare Research and Quality (AHRQ). Cindy Brach has done work with Project Re-Engineered Discharge, which we have discussed throughout this brief. Brach also referred us to Dr.

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Michael Paasche-Orlow of the Boston School of Medicine, and we then held a telephone call with this additional expert. Paasche-Orlow is an investigator for Project RED and one of the senior authors for the article titled “Project Re-Engineered Discharge (RED) Lowers Hospital Readmissions of Patients Discharged from a Skilled Nursing Facility,” which has been cited in this brief.