TMF Health Quality Institute

QI Snapshot

Brief #9

Development of a Community Church Caregiver Advocate Program

Project Overview

The TMF Quality Innovation Network Quality Improvement Organization (QIN-QIO), under contract with the Centers for Medicare & Medicaid Services, subcontracting with the Arkansas Foundation for Medical Care, collaborated with local providers to develop the Community Church Caregiver Advocate Program (CAP) to reduce 30-day hospital readmissions among vulnerable elderly. The Community Church CAP is an innovative model specifically designed to use organized church outreach ministry volunteers to address patient and caregiver support, or lack thereof, for those vulnerable elderly discharged to home who are high risk for 30-day readmissions. This population includes Medicare beneficiaries released to home with no follow-up services, those with co-morbidities, those with little or no support in the home environment and those with cognitive impairment.

Intervention Methodology

The TMF QIN-QIO's Arkansas Care Transition (ACT) South Central Coalition conducted a root cause analysis to identify the problems causing their community seniors to return to the hospital within the first 30 days after being discharged to home. The coalition used church outreach ministries to identify barriers that might result in avoidable readmissions and/or poor health outcomes in this vulnerable elderly population. Upon feedback from the church ministry, the coalition members created a subcommittee to develop a new CAP. The purpose of this program is to facilitate the use of common community resources to help vulnerable patients transition from acute care to the home setting safely and effectively. To implement the CAP, the coalition developed a model to connect hospitalized seniors from a community church to fellow congregants trained to provide needed support in facilitating the safe transition to home after discharge.

CAP Model

The CAP model identifies churches, acute care hospitals and patients in a community that would benefit from its use. The target patient population includes high-risk Medicare beneficiaries with high admission rates, higher than expected emergency department (ED) use and/or high avoidable 30-day readmission rates. Within the geographic area, two hospitals were interested in the CAP and churches with preexisting aging adult outreach programs and pastoral buy-in to CAP were identified. The coalition developed a standardized script and approach used to facilitate the recruitment of churches.

CAP Process

Caregiver Advocate Volunteers (CAs) were identified among congregational members interested in completing the training as well as caregivers and patients themselves. CAs were then matched to patients by pastor, zip code, gender matching and other criteria. The CA's responsibilities include providing support to their designated patient during and

after hospitalization. When the patient is admitted, the CA connects with the case manager, caregiver and patient to identify any needs during the hospital stay. During discharge planning, the CA asks questions, takes notes and facilitates the discussion for clarity and understanding. When the patient is discharged home, the CA accompanies the caregiver and patient and provides a home evaluation for safety and basic needs. Once the patient has transitioned home, the CA ensures that the patient has access to needed follow-up services and scheduled appointments, and the CA will assist with the facilitation of the identified services.

CAP Training

As part of the CAP, a training curriculum for the CAs was developed based on the University of Arkansas for Medical Sciences (UAMS) Schmieding Method of Training. The UAMS Schmieding Method of Training is a formal caregiver training program designed to prepare individuals to care for older adults in the home setting. The Schmieding curriculum is evidence-based and focuses on the needs of the elderly population, including activities of daily living and instrumental activities of daily living, cognitive impairment, and other common disabilities or limitations. Two local resources, the Oaklawn Center on Aging (OCOA) and the OCOA Schmieding Center, modified the existing caregiver training curriculum to fit the needs of the CAP model and provided the trainings for potential CAs.

As a result of this work, the team identified many key resources that were common to all communities, both urban and rural, across Arkansas, including churches, Centers on Aging and Schmieding caregiver programs.

Assessment

The assessment of the pilot is ongoing, using both qualitative and quantitative sources of data to determine efficacy. The following process measures were initially developed to better understand the population in need and further refine the curriculum:

Table 1: Measures for the CAP

Measure	Measure Description
#1: Volunteer Recruitment and Retention	Number and percentage of volunteers recruited and retained who completed level 1 and level 2 of the program.
#2: Training Efficacy	CA post-training evaluation to determine efficacy of curriculum.
#3: Consumer Demographics and Perception of CAP	Assessment of the target population's perception of the needs of patients and the program, both before and after an educational event on the program to incorporate the patient's voice in the intervention.
#4: Caregiver Advocate Satisfaction Questionnaire	Qualitative data gathered from the CAs on the services provided through the CAP, whether it was a positive experience and what would have been helpful in improving the experience.

#1: Volunteer Recruitment and Retention: Of 60 initial volunteers who expressed interest in participating, 58 percent (35) completed level 1 training, and 43 percent (26) completed both level 1 and 2 training.

#2: Training Efficacy: CA participants were assessed to better understand their level of confidence, knowledge and skill in working with the older population both pre- and post-training. A majority of the CAs reported very high or high confidence in each of the categories after the training, including knowledge, confidence and skill in working with an older adult population and confidence and skill in assisting with patient transition and setting follow-up appointments.

#3: Consumer Demographics and Perceptions of CAP: The age range of respondents was 54 to 87 years of age, with 80 percent of CAs being female. One hundred percent reported being involved with their church. Forty percent of respondents reported they were likely to use a CA, 33 percent reported they were unsure and 25

percent reported they would not use the program. In contrast, 100 percent reported they would recommend the CA program to a family or friends. Approximately 67 percent reported they would volunteer to be an advocate. Qualitative responses to open-ended questions indicated respondents believed this was a "needed program" and a "wonderful" program. Specific needs with which the respondents believed the CA could assist included food preparation, transportation, access to pharmacy and relieving a caregiver of a homebound patient.

#4: Caregiver Advocate Satisfaction Questionnaire: One hundred percent of CAs reported that functioning as a CA was a "positive" experience. The CAs described the assistance provided to the patient/caregiver in the following areas: 1) helped with making arrangements during transition, 2) helped with activities of daily living, 3) helped with food, 4) served as a "spokesperson," as the patient had difficulty speaking and 5) was a "good listener" and offered company to a patient who appeared depressed.

Future Outcomes

Future plans for measurement include CAs reporting the types of intervention(s) implemented, both the type and frequency, and documenting patient status during the 30-day post-discharge timeframe to indicate additional services required and/or re-hospitalization. A standardized list of CAP model components will be utilized for this intervention (see Table 2).

Table 2: Care Model – CAP Model Components

COMPONENTS	CARE MODEL	CAP MODEL
Community	Self-Management Support	Utilization/promotion of evidence-based community programs to help seniors better control their chronic disease(s), help them remain in their own homes and reduce the likelihood of a 30-day readmission to the hospital. The community resources include: free Diabetes Self-Management Education, Chronic Disease Self-Management Education and Chronic Pain Self-Management Education workshops and prevention programs for seniors such as Tai Chi, a Matter of Balance, Aging Gracefully and Healthy Cooking. These resources are introduced as part of the CA training curriculum.
Community	Resources/Policies	Church outreach ministry programs Volunteers (church and health care professionals) Higher education programs Centers on aging Hospitals
Health Systems Organization	Decision Support	Facility-level reporting Risk scoring Diagnosis Church affiliation Other demographics (e.g., gender/ZIP codes)
Health Systems Organization	Delivery System Design	Planned and timely interactions Coordinated care Uses evidence-based tools Culturally appropriate
Health Systems Organization	Clinical Information Systems	Facility-level admissions/readmissions monitoring Process improvement workflows for communication/support at time of discharge
Improved Outcome	Productive Interaction	Proactive support system Better equipped patient and caregiver during transitions

To measure outcomes, the CAP team will use a concurrent mixed-method approach to monitoring the efficacy of the intervention. Concurrent data will include: 1) CAP participating facility (hospital)-level data to track total numbers of beneficiaries opting to use a CA and percent of those recipients who had a 30-day readmission; 2) CAP recipient follow-up data to be captured during the 30-day period post-transition to home; and 3) patient, caregiver and CA interviews.

Discussion

Developing a model utilizing pre-existing groups of volunteers to provide additional support to the vulnerable elderly expands the scope of the health care delivery model to accommodate the growing needs of the at-risk senior population. This CAP model, using primarily pre-existing volunteer groups, is relatively sustainable with little funding. Additionally, many states across the country have the common community assets, including hospitals, churches, higher education and organized care transition coalitions, to replicate a similar program.

Based on CA training and community feedback, ACT South Central Coalition's consensus is that the CAP model can provide immediate, timely and effective support to seniors and their caregivers during transitions from hospital to home. The next phase of this project will be to collaborate with community hospitals to evaluate the impact the CAP has on outcomes such as reducing readmissions to the hospital.

A potential expansion of this model could include collaboration with primary care physicians or accountable care organizations to identify vulnerable patients and caregivers. Incorporating this intervention into the population-based health model may further prevent avoidable ED visits and hospital admissions.

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