This month, Lutheran Services in America and the University of North Carolina are partnering to launch Phase 2 of the Connect-Home Collaborative. Connect-Home is an evidence-based transitional care process that empowers patients and their caregivers to manage patients’ serious illness at home, improve function, and prevent avoidable re-hospitalizations. Developed by Dr. Mark Toles at the University of North Carolina School of Nursing, Connect-Home guides post-acute care providers through a process that prepares patients for the transition to home from skilled nursing facilities. Generous support for this 12-month project is provided by the Harry & Jeanette Weinberg Foundation.

1.7 million older adults transfer from hospitals to skilled nursing facilities in the U.S. each year. These patients are a frail population with multiple medical conditions and are in need of assistance for activities of daily living. When they return home, they often misunderstand medication orders and self-management advice, and their family caregivers may have limited understanding of how to provide assistance. As a result, more than half of skilled nursing patients are re-hospitalized, use emergency services, or die within 90 days of returning home. Connect-Home is a solution designed to help providers deliver excellent transitional care in the nursing home setting. The goals of the Connect-Home intervention are:

- Improve patient and caregiver preparedness for discharge
- Improve patient quality of life and health
- Improve caregiver burden and distress
- Prevent avoidable acute care use and health care costs
- Improve market, compliance, and financial outcomes in nursing homes

The recently-completed Phase 1 project was successful in several ways. 325 low-income adults, with an average age was 83.2 years, and their caregivers received the Connect-Home intervention at no charge. Fidelity to the Connect-Home model, a primary evaluation measure, was strong - site compliance was 85.5% for the steps defined as essential to ensuring improved post-discharge outcomes and quality of life for patients. Representatives from the participating acute care sites reported that Connect-Home improved patient care and, in particular, the way they educate patients and caregivers about continuing care at home. Evaluation findings suggest both a relative advantage of the Connect-Home model and acceptability by skilled nursing staff. Phase 1 White Paper

The Phase 2 project was launched this month at a meeting of the Connect-Home Collaborative in Washington, DC. The Collaborative includes three new implementation sites: Lutheran SeniorLife in Pittsburgh, Pennsylvania; Niagara Lutheran Health System in Buffalo, New York; and Luther Manor in Milwaukee, Wisconsin. Skilled nursing facility staff representatives met with the University of North Carolina and Lutheran Services in America teams to receive training in the Connect-Home intervention. Phase 2 Group Photo The primary objective of this meeting was to teach Collaborative members how to use a quality improvement process to implement Connect-Home in a nursing home as a means to enhance transitional care.
This training meeting also afforded Collaborative members an introduction to implementation science. They learned that interventions like Connect-Home not only need to be effective, but they also must reach the intended populations, be adopted by providers, be implemented with fidelity, and be maintained over time. Participants reviewed the Connect-Home evaluation model and its target outcomes, and were instructed in the use of Plan/Do/Study/Act (PDSA) cycles. PDSA is a quality improvement model that tests a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act). The questions a PDSA cycle asks are:

a) What are we trying to accomplish?
b) How will we know that a change is an improvement?
c) What changes can we make that will result in an improvement?

As they implement Connect-Home, Collaborative members will use this model in their three quality improvement cycles as a means to measure progress over time.