Medical Xpress

Caregiver engagement enhances health outcomes of chronically ill adults

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Led by Regenstrief Institute Research Scientist Kristin Levoy, Ph.D., MSN, R.N., a meta-analysis of findings from 54 studies (involving more than 31,000 individuals) confirms that caregiver engagement across

health care transitions (for example from hospital to home) of chronically ill adults is instrumental in preventing rehospitalizations, and holds potential for enhancing other patient outcomes.

The work adds compelling empirical evidence of the value of caregivers in facilitating care transitions when the health care team actively partners with them to support the patient's health care following discharge. This not only included engaging caregivers in needs assessments and education (e.g., disease and medication management, red flag recognition) prior to discharge, but also telemedicine follow-up post-discharge to support caregivers in care coordination with other health care providers or supportive services.

"In my own clinical practice, I have had multiple experiences of caregivers coming to me after a health care crisis of their loved ones to reflect on how they didn't feel adequately prepared to support their loved ones' care," said Dr. Levoy, who is also an assistant professor at Indiana University School of Nursing. "These caregivers felt blindsided by how much care they had to provide and ill-equipped for the weighty health care decisions they were involved in.

"Caregivers play a critical role in enhancing patient outcomes and we can do a better job of supporting these unrecognized members of the health care team," she added. "Caregivers often feel abandoned, particularly in times of health care crises, like an unexpected hospitalization, and we need to set them up for success, which includes addressing their unique needs. And these needs only grow greater as the chronic illness advances and the patient's disease and treatment complexity increases."

As adults age with chronic illness, negative changes in health status may result in frequent and often sudden transitions across health care settings, such as from home to hospital and back to home or to a skilled nursing facility. On average, older adults will experience between two and five

health care transitions in the year following a hospitalization.

Dr. Levoy calls for further study of health care delivery models that make caregivers actual partners in the health care process by supporting the care they provide to keep a chronically ill loved one from boomeranging back to the hospital.

The research is published in *Medical Care*.

The authors write that "increasing support for caregiver engagement during care transitions may require the development of value-based reimbursement models that reward health care systems for the adoption of caregiver-engaged principles, creating an environment for systemic change in the way health care systems conduct business, which may also increase the capability of caregivers to provide care in the home over time, thus, delaying institutionalization."

They conclude that "whether in research or clinical practice, transitional care should not be conducted without careful consideration of where and how caregivers will be incorporated and supported as active partners in optimizing patient care across health care transitions."

More information: Kristin Levoy et al, Caregiver Engagement Enhances Outcomes Among Randomized Control Trials of Transitional Care Interventions, *Medical Care* (2022). DOI: 10.1097/MLR.0000000000001728

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