TRANSITIONS OF CARE

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OBJECTIVES

Know and understand:

- Why care transitions are frequently suboptimal
- Why older adults are particularly vulnerable during transitions
- Risk factors for experiencing an unsafe transition
- How to improve transitional care

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TOPICS COVERED

- The Treachery of Suboptimal Care Transitions
- Barriers to Safe Transitions
- Strategies to Improve Transitional Care and Outcomes of Specific Care Models
- Discharge Destinations and Care Venues
- Discharge Medication Regimen
- Communicating with Patient, Caregivers, and Receiving Team
- Steps to Improve Care Transitions

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INTRO TO CARE TRANSITIONS

- Defined as the movement of a patient from one set of providers, level of care, or health care setting to another
- Other terms: “handoffs,” “handovers,” and “transfers”
- Can occur *within* the hospital setting or *across* health care settings

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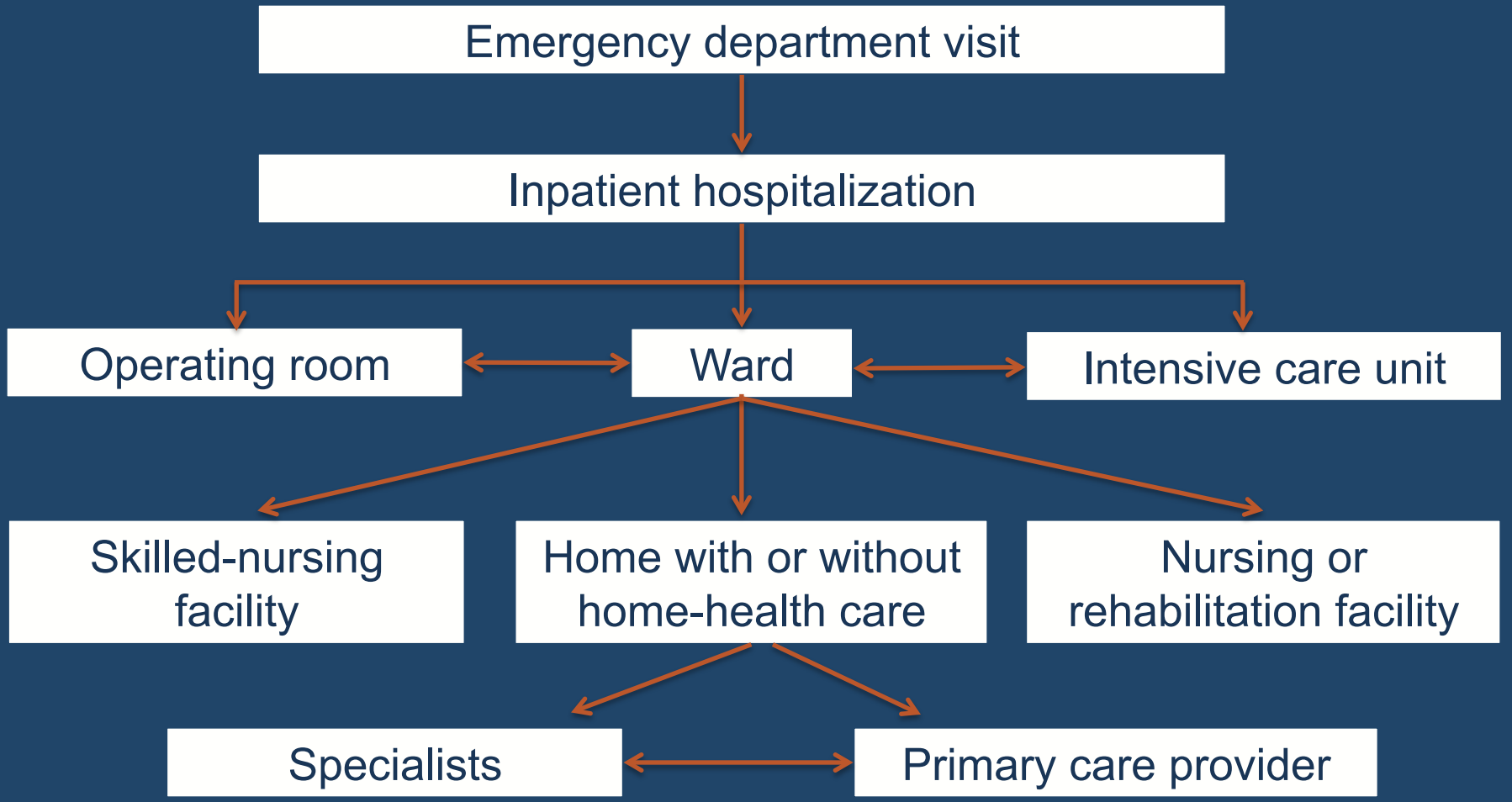
COMMON CARE TRANSITIONS



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TRANSITIONS ARE COMMON AND COMPLICATED

- Almost 40% of older adults experience ≥2 transitions within 30 days of hospital discharge
- National study: 22% of Medicare beneficiaries experienced care transitions of some kind
  - 50% — single hospitalization, then return to original residence
  - 50% — complex sequence of other transitions
  - Few predominant transition patterns were present, which makes planning difficult

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SUBOPTIMAL TRANSITIONS ARE COSTLY

- One in 5 older adults discharged from the hospital is rehospitalized within 30 days
- One third are rehospitalized within 90 days
- Cost of unplanned rehospitalizations to Medicare: Estimated $15 billion/year

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SUBOPTIMAL TRANSITIONS THREATEN SAFETY

- Can result in adverse events, medication errors, inaccurate or incomplete information transfer
- Almost half of all medication errors occur during hospital admission or discharge
- Inaccurate or incomplete information can result in:
  - Delayed diagnosis
  - Duplicative medical services
  - Hospital readmission
  - Reduced patient and provider satisfaction

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OLDER ADULTS ARE ESPECIALLY VULNERABLE

Older adults are more likely than other groups to:

- Transition frequently across health care settings
- Be readmitted to the hospital, with longer lengths of stay
- Have higher rates of iatrogenic complications
- Have multiple chronic conditions
- Follow complex therapeutic regimens
- Be vulnerable to the hazards of hospitalization: Functional decline, delirium, adverse drug events, pressure ulcers, bowel and bladder dysfunction, malnutrition, and dehydration

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PATIENT-LEVEL RISK FACTORS FOR SUBOPTIMAL TRANSITIONS

- Education less than high school
- No help with ≥1 deficit in an activity of daily living
- Limited self-management ability
- Worse self-rating of health
- Living alone
- Transition to home with home-care services
- Prior hospitalization
- Long hospital length of stay
- Low income or Medicaid-eligible, including homelessness
- Older age
- Five or more comorbidities
- Depression, CVD, diabetes mellitus, cancer, substance abuse

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SYSTEM-LEVEL RISK FACTORS FOR SUBOPTIMAL TRANSITIONS

- Communities with high hospital admission rate
- Lack of discharge education
- Insufficient communication across care settings
- Failure in implementation of plan of care (durable medical equipment, home health care, follow-up appointments, mediations, tests)

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INCENTIVES TO IMPROVE TRANSITIONS

- Interventions to improve care transitions are a high priority under the Affordable Care Act to attempt to realign financial incentives to improve care transitions and reduce hospital readmission rates
- Medicolegal concerns
  - Hospital health care providers have a duty to the patient to assure care until the transition is complete, including follow-up of pending tests, incidental findings, and medical treatments started in the hospital
  - The primary care provider has a duty to the patient to obtain hospital records, if not received, and ensure proper follow-up once the care transition is complete

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COMMON BARRIERS TO SAFE TRANSITIONS

- Diverse needs depending on illness, social situation, and type of transition
- Lack of provider education and feedback, for example:
  - No timely, effective discharge summary
  - Lack of knowledge of the capabilities of various postacute care settings
- Difficulty communicating with colleagues at the previous or next site of care
- Lack of time or financial resources; lack of reimbursement in the current US system

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OPTIMAL TRANSITIONAL CARE

- Entails a broad range of time-limited services designed to ensure the coordination and continuity of health care as patients transfer between:
  - Different locations
  - Different levels of care
- Contains elements of care coordination, discharge planning, and disease or case management
- Focuses on highly vulnerable and chronically ill populations

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COMPONENTS OF OPTIMAL TRANSITIONAL CARE (1 of 2)

- Accurate and timely transfer of information to the next set of providers
- Empowerment of the older adult to assert his or her preferences
- Comprehensive assessments of older adult and caregiver needs
- Comprehensive medication review and management
- Logistical arrangements related to executing the transition

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COMPONENTS OF OPTIMAL TRANSITIONAL CARE (2 of 2)

- Education to prepare older adults and caregivers for what to expect at the next site of care
- Support for self-management of medical conditions
- Coordination among medical and community resources
- Follow-up and support after discharge

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CARE TRANSITIONS: MAJOR INTERVENTIONS (1 of 6)

Intervention	Goal of Intervention	Key Component Interventions	Demonstrated Outcome Improvements
Care Transitions Intervention (www.caretransitions.org)	Minimize rehospitalization of older patients with complex care needs	Post-discharge: follow-up call; home visit Transition: patient-centered discharge instructions	Reduction in readmissions Improvement in care transition quality score
Re-Engineered Discharge ("Project RED") (www.bu.edu/fammed/projectred/)	Minimize rehospitalization of diverse inpatient populations	Pre-discharge: patient education, discharge planning, medication reconciliation Post-discharge: timely communication with primary care provider, follow-up call Transition: patient-centered discharge instructions	Reduction in ED and hospital utilization within 30 days

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CARE TRANSITIONS: MAJOR INTERVENTIONS (2 of 6)

Intervention	Goal of Intervention	Key Component Interventions	Demonstrated Outcome Improvements
Transitional Care Model (www.transitionalcare.info/)	Minimize rehospitalization of older patients with complex care needs	Pre-discharge: patient education, discharge planning Post-discharge: follow-up call, hotline Transition: transition coach, patient-centered discharge instructions	Reduced readmissions, increased time between discharge and readmission, decreased cost of providing health care
Better Outcomes by Optimizing Safe Transitions (BOOST) (www.hospitalmedicine.org/Web/Quality_Innovation/Implementation_Toolkits/Project_BOOST/Web/Quality___Innovation/Implementation_Toolkit/Boost/Overview.aspx)	Minimize rehospitalization of patients at high risk of readmission	Approach not stated; rather, each site receives a mentor to develop its own strategies based on local needs assessment and existing best practices	Reduction in 30 day readmission

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CARE TRANSITIONS: MAJOR INTERVENTIONS (3 of 6)

Intervention	Goal of Intervention	Key Component Interventions	Demonstrated Outcome Improvements
Guided Care (www.guidedcare.org/)	Managing complex older adults in ambulatory care or home care, and through transitions	Pre-discharge: patient education, discharge planning, medication reconciliation Post-discharge: timely communication, timely clinic follow-up, follow-up call, post-discharge hotline, home visit Transition: coach, patient-centered discharge instructions, provider continuity	Tended to use less home health services Reduced costly health care utilization in integrated health care systems

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CARE TRANSITIONS: MAJOR INTERVENTIONS (4 of 6)

Intervention	Goal of Intervention	Key Component Interventions	Demonstrated Outcome Improvements
Interventions to Reduce Acute Care Transfers (INTERACT) (http://interact2.net/)	Minimize rehospitalization of nursing-home residents	Post-discharge/ Transition: • Timely staff communication of change in clinical status • Evidence-based clinical care pathways triggered by changes in clinical status • Advance care planning	Reduction in readmissions

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CARE TRANSITIONS: MAJOR INTERVENTIONS (5 of 6)

Intervention	Goal of Intervention	Key Component Interventions	Demonstrated Outcome Improvements
Discharge of Elderly from the Emergency Department (DEED) (www.ncbi.nlm.nih.gov/pubmed/10408663)	Reducing risk of older adults' return to the ED	Pre-discharge: comprehensive geriatric assessment Post-discharge/ Transition: • Timely communication with primary care provider • Home visit • Formulation of care plan by interprofessional team • Transition patient to use community services	Reduced rate of hospitalization within the first 30 days Reduced rate of ED admission for 18-months after index ED visit Longer time to the first repeat ED visit Maintained greater degree of physical and mental function

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CARE TRANSITIONS: MAJOR INTERVENTIONS (6 of 6)

Intervention	Goal of Intervention	Key Component Interventions	Demonstrated Outcome Improvements
Geriatric Resources for Assessment and Care of Elders (GRACE) (http://graceteamcare.indiana.edu/case-for-grace.html)	Reducing ED visits, hospital admissions and readmissions, and nursing-home admissions for frail older adults with complex needs	Post-discharge / Transition: • Home-based care management by nurse practitioner and social worker • Collaborations with primary care provider and geriatric interprofessional team • Care protocols for geriatric conditions	Improved patient-centered care transitions, reduced hospital readmissions and nursing-home placement

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POLICY APPROACHES TO IMPROVE TRANSITIONAL CARE

- In transitional care models of care, CMS has placed emphasis on patient-specific goals, quality, safety, and the avoidance of cost shifting to other components of the healthcare system

- Community-based Care Transitions Program (CCTP) is the federal government's program to improve transitions of care of Medicare beneficiaries
  - Since its implementation in 2011, CCTP has shown declines in all-cause 30-day rehospitalizations and all-cause hospitalizations

- In 2013, CMS introduced transitional care management payment codes that allow ambulatory care providers to bill for services they perform to assist with transitions of care in the first 30 days of discharge from an inpatient hospital setting

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DISCHARGE DESTINATIONS (1 of 3)

- Home with family support
- Home with home-health care
  - Works well for older adults requiring only intermittent skilled services (nursing, PT, or speech therapy)
  - Older adults with one of these needs may also receive assistance under Medicare from OT, medical social work, or home-health aides
  - Medicare requires that older adults receiving home-health care be homebound

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DISCHARGE DESTINATIONS (2 of 3)

- Custodial care (eg, assisted living or “nursing home”)
- Skilled-nursing facility (SNF)
  - Under Medicare, older adults in SNFs must need a skilled service such as IV therapy, artificial nutrition and hydration, complex wound care, ostomy care, or rehabilitation
  - Medicare covers all or part of SNF care for up to 100 days after a qualifying hospital stay
  - Coverage stops earlier if treatment goals are met or the older adult no longer demonstrates improvement

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DISCHARGE DESTINATIONS (3 of 3)

- Acute rehabilitation hospital
  - For older adults with substantial rehabilitation needs and considerable rehabilitation potential
  - Many older adults are ineligible because they cannot participate in 3 hours/day of intense therapy
- Long-term acute care
  - For the rare patient who requires prolonged hospital-level care such as long-term mechanical ventilation, multiple IV medications, parenteral nutrition, or complex wound care
- Inpatient hospice

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THE DISCHARGE MEDICATION REGIMEN (1 of 2)

- Include:
  - An indication for each medication
  - Stop dates (eg, antibiotics) or tapering schedules (eg, for systemic corticosteroids), as appropriate
  - Clear behavioral triggers for as-needed psychiatric medications

- Medications added during the hospital stay for use as needed or for prophylaxis, such as analgesics, proton-pump inhibitors, or laxatives, can be tapered or discontinued

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THE DISCHARGE MEDICATION REGIMEN (2 of 2)

- Formally reconcile with the preadmission medication regimen
- Imperative to clearly document which:
  - Medications that are new since admission
  - Preadmission medications that have been stopped
  - Dosages of continued medications that have been changed

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INFORMATION TO COMMUNICATE TO PATIENTS AND CAREGIVERS

- When discharge is directly to home:
  - Follow-up appointments
  - Warning symptoms or signs to watch for, with instructions on whom to contact
  - Clinical disciplines (eg, nursing, PT) contracted to provide services in the home
  - Reconciled medication list
- When discharge is to another care setting:
  - Nature of the new institution
  - Identity of the new attending physician (if known)
  - Expected frequency of provider visits
- Helpful tools for patients and caregivers: www.caretransitions.org

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INFORMATION TO COMMUNICATE TO NEW CLINICIAN(S)

- Directly communicate about:
  - Critical but pending study results
  - Nuances of goals of care
  - Family dynamics

- Otherwise, a brief, prompt discharge summary suffices:
  - Summary of hospital course with care provided and results of important tests
  - List of problems and diagnoses
  - Functional and cognitive status at baseline and at discharge
  - Reconciled medication list
  - Allergies
  - Test results still outstanding
  - Follow-up appointments
  - Goals, preferences, and advance directives
  - Best contact information for the discharging clinician in case any questions arise

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THREE STEPS TO IMPROVE TRANSITIONS

1. Set expectations for both the sending and receiving provider teams
   - The National Transitions of Care Coalition recommends shifting from the concept of “discharge” to that of “transfer with continuous management”
2. Tailor communication strategies to the type of information being communicated and the type of transition
3. Target specific processes or outcomes for improvement, using established QI methods
   - Begin by focusing on 1 or 2 measures, then expand once initial goals are achieved

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STEP 1. SET EXPECTATIONS

- Based on the information available at admission, what needs will this older adult have after transfer?
- What are the patient's and caregiver's preferences?
- How will the patient care for himself or herself after transfer?
- What other clinicians need to evaluate the older adult to formulate an effective care plan?
- Do the older adult and caregiver understand the purpose of the transfer and what to expect at the next site of care?
- Has the next site of care received, understood, and clarified discrepancies about the care plan?

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STEP 2. TAILOR COMMUNICATION

- Based on this patient's current episode of illness, what is the most relevant information to communicate to the next site of care?
- Should the information also be given directly to the older adult and caregiver?
- How should this information be communicated?
  - Electronically — for notification of admission, discharge, or nonurgent issues
  - Verbally — for situations of urgency or uncertainty, or those with complex social dynamics
  - In writing — for information that must be a part of the medical record or used as a reference by the older adult, caregiver, or clinician

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STEP 3. SELECT QI MEASURE

Examples:

- Communication with PCP before older adult's transfer
- Medication reconciliation at the time of transfer
- Older adult's, caregiver's, or receiving clinician's satisfaction with the quality of the transition
- Timeliness of arrival of transfer summaries
- Inclusion of various components in transfer summaries (eg, documentation of cognitive and functional status)
- Ease of scheduling follow-up appointments
- Frequency of health care usage after transfer

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SUMMARY (1 of 2)

- Older adults transitioning between or across health care settings are at risk of suboptimal care and adverse events
- Successful transitions can result in more effective implementation of care plans, reduced adverse events, faster restoration of older adults' functioning, and improved patient and caregiver satisfaction
- Optimal transitional care contains elements of care coordination, discharge planning, and disease or case management

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SUMMARY (2 of 2)

- The discharge medication list should be formally reconciled with the preadmission regimen
- The 3 steps in improving transitional care are to:
  1. Set expectations for both the sending and receiving provider teams
  2. Tailor communication strategies to the type of information being communicated and the type of transition
  3. Target specific processes or outcomes for improvement, using established QI methods

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QUESTION (1 of 2)

Which one of following interventions has been found to reduce in-hospital deaths in patients at the end of life?

A. Use of teams comprising specialists from oncology, palliative care, social work, and office-based nursing

B. Increased home nursing care

C. Enhanced access to patient-centered medical home model of primary care

D. Enhanced access to team of specialists in palliative, nursing, and primary care

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QUESTION (2 of 2)

Which one of following interventions has been found to reduce in-hospital deaths in patients at the end of life?

A. Use of teams comprising specialists from oncology, palliative care, social work, and office-based nursing

B. Increased home nursing care

C. Enhanced access to patient-centered medical home model of primary care

D. Enhanced access to team of specialists in palliative, nursing, and primary care

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AGS
75 YEARS OF CARING FOR OLDER ADULTS

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GNRS5 Teaching Slides modified from GRS9 Teaching Slides

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