


Transitions of Care

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Discussion Points

- “Transitions of Care”
- Challenges to Hi Quality Transitional Care
- Promising Innovations
- Care Transitions in CMS’ 9th SOW
- Discharge Planning/Physician Role
- Successful Interventions

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“Transitions of Care”

No where is the patient more vulnerable,
in our health care system,
than during “transitions of care”,
moving from one care setting to the next.

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Definition – Transitional Care

“A set of actions designed to ensure the coordination & continuity of care as patients transfer between different locations or different levels of care.”

“Transitional care encompasses both the sending & the receiving aspects of the transfer.”

American Geriatrics Society, 2003

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Nature of the Problem

- Older adults with complex care needs frequently require care in multiple settings
- Yet health professionals in these settings often function independently from one another
- As a result, care is often fragmented
- Patient Safety & Quality are compromised

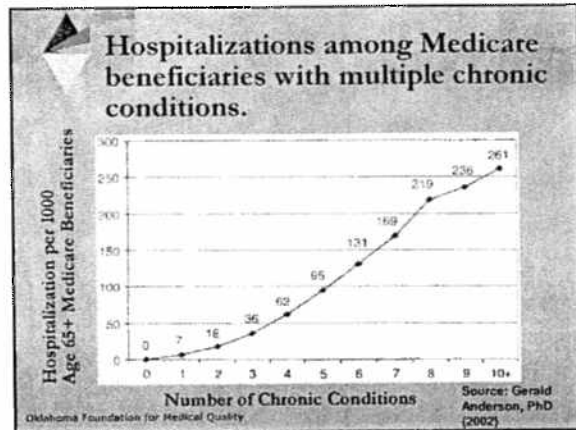
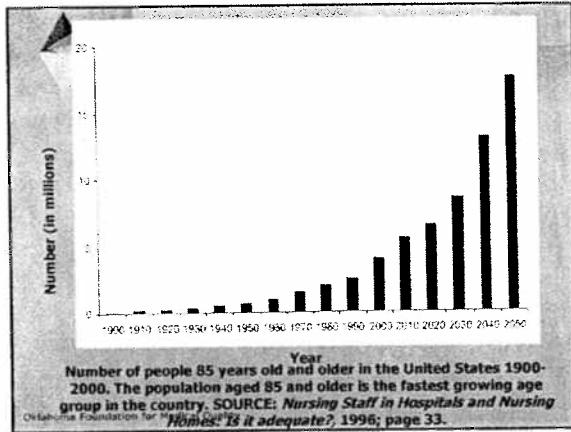
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“Transitions of Care”

The Elderly, with multiple co-morbidities, complex chronic conditions, and, on “Poly-pharmacy”, are at increased risk.

Risks include medical errors, duplication of services, inappropriate care, and critical elements of their care “falling through the cracks”.

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Medicare Current Beneficiary Survey

- Patterns of Care 30 days post hosp ?
- Quality of these care patterns ?
- Can high risk be identified ?

Coleman HSR 2004;37(5):1423-1440

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Medicare Current Beneficiary Survey

- 45 Unique Care Patterns in 30 days
- 1 in 4 "complicated"
- Patients at higher risk for complicated care can be identified at discharge

Coleman HSR 2004;37(5):1423-1440

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High Risk Profile

- Multiple co-existing conditions, therapies
- Functional deficits, Cognitive impairment
- Emotional problems
- Poor general health behaviors
- Personal / environmental threats
- Caregiver health problems
- Fair to poor subjective health rating
- Lack of social support


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Adverse Events After Discharge

- Defined as injury resulting from medical management rather than underlying disease
- 19% had 1+ adverse events < 3 weeks
- Many were preventable
- Adverse drug events most common (66%)

Forster Annals of IM 2003;138:161-7


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Qualitative Studies

- Inadequately prepared for next setting
- Conflicting advice for illness management
- Inability to reach the right practitioner
- Family caregivers repeatedly completing tasks left undone


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“Transitions of Care”

Poorly executed care transitions lead to poor clinical outcomes, patient dissatisfaction, and inappropriate use of hospital, ER, & ambulatory services.


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Challenges to High Quality Transitional Care

- Patient
- Practitioner
- Health Care Institution
- Health Information Technology
- Performance Measurement
- Payment Systems
- Regulatory Requirements & Oversight

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Challenges to High Quality Transitional Care

Patient Level

- Unprepared & uncertain about their role
- Institutions foster dependency & complacency
- This changes abruptly at D/C when expected to assume major role in self-care
- Rising prevalence of cognitive impairment intensifies the challenge

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Challenges to High Quality Transitional Care

Practitioner Level

- Rare for clinicians to orchestrate care across multiple settings; poor communication
- Rise of Hospitalists & “SNFists”
- Many practitioners have never practiced in (much less set foot in) settings to which they transfer patients

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Challenges to High Quality Transitional Care

Health Information Technology

- HIT infrequently extends from hosp or clinic into post-acute care settings (ASPE/UCHSC)
- Lack of connectivity impedes communication, quality measure reporting, & P4P

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Challenges to High Quality Transitional Care

Performance Measurement

- Lack of quality measures for transitional care is a barrier to QI
- Not well represented in national performance/QI efforts
- (Sub-national projects beginning in CMS 9th SOW)

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Challenges to High Quality Transitional Care

Payment Systems

- Current payment gives little incentive for collaboration across care settings, reinforcing “silos” of care
- Similarly, current payment does not penalize poor transitions
 - No CPT code captures OK transfer or D/C
 - No reduced payment for readmissions

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Challenges to High Quality Transitional Care

Regulatory Requirements & Oversight

- Regulatory requirements focus on settings, not patients
- Different assessment tools in different settings, e.g., MDS for NH pts, OASIS for HH pts
- Accreditation programs focus on discharge planning elements *within* the institution


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Promising Innovations

- Patient
- Practitioner
- Health Information Technology
- Performance Measurement


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Promising Innovations- Patients

- Coleman/UCHSC/Hartford Foundation Transition Coaches urged active role of pts & caregivers, reducing re-hospitalization
- National Family Caregivers Association & UCHSC, family care-giving, collaborating towards combined IOM report


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Promising Innovations- Practitioners

- Naylor, U of Penn, APNs post hospital care reduced re-hospitalizations
- Care Management Workgroup/ RWJF Senior pt management positions Skills/tools for practitioners Accountability for sending/receiving teams


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Promising Innovations- Measurement

- The Care Transitions Measure (CTM -3) could help fill the gap
- JCAHO
Tracer methodology
Medication reconciliation


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Promising Innovations- HIT

- PeaceHealth (Or, Wa, Ak)
Electronic shared care plan accessed by pt & clinician
- FHIN, COHIE, statewide RHIOs, HIEs
- Others


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Care Transitions in CMS' 9th SOW

- Sub-national projects focusing on "seamless transition" from hospital to home, SNF, or Home Health.
- Reduce risk, harm, costs
- To address medication management, post D/C follow up, & plans of care across settings
- Required Interventions to be implemented
1. hospital/community wide, 2. disease/condition specific, & 3. readmission reason specific


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"Seamless Transition" Discharge Planning

- Begins at the time of admission
- Best "Anticipator of Needs" is the Physician !
- "Supporting Actors" include:
Nurse, Case Manager, Social Worker, "Discharge Planner", Outpatient Rehab, PT/OT, etc, Home Health, DME Provider, Family/Caregivers, & the Patient
- Includes timely communication to PCP and next setting of care


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Physician' Responsibility at the Time of Discharge

- Patient Evaluation
- "Plan of Care"
- Face to Face Discharge Instructions, diagnosis & patient specific, including meds, diet, activity, wound care, f/u appointment(s), signs/sx of emergent situations, etc, etc, etc.
- Prescriptions/Other needs(DME)
- Contact Information
- Documentation
- Communication to PCP, other Caregivers

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Physician Oversight

"Hospitalization (Readmission) likelihood is reduced with close PCP monitoring & intervention."

Division of Health Care Finance & Policy, 2002

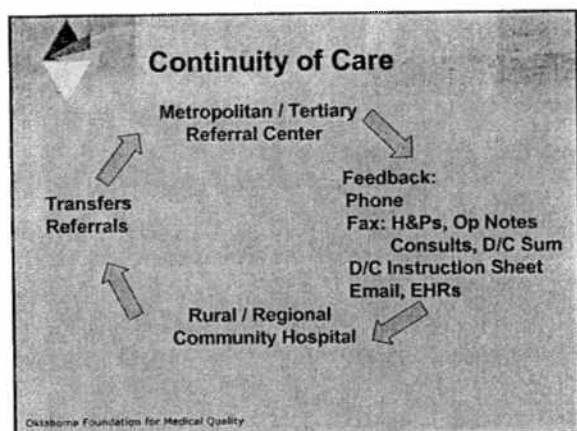
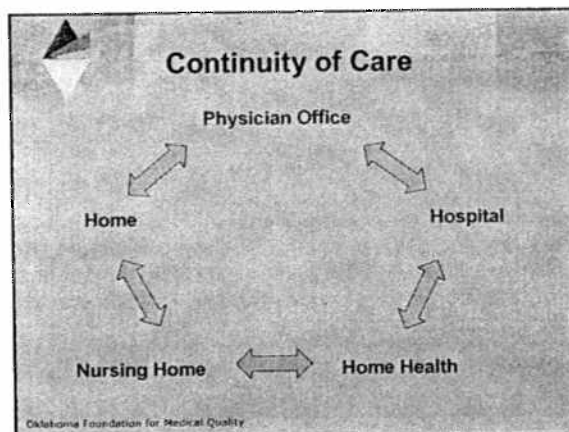
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Successful Interventions Quality Transitional Care

Communication Process Changes :

- HH Liaison at hospital
- Revised HH Referral / DC Form
- Revised Transfer Information Fax Form
- Medication Reconciliation at D/C, transfer
- Timely communication to PCP, other caregivers
- "Auto-Fax"- H/Ps, Op Notes, Consults, D/C Summaries, & D/C Instruction Sheets
- Early phone contact with pt & caregiver

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"Low Hanging Fruit"?

With CMS focusing on "Seamless Transition" at, and after, hospital discharge,

and with the Commonwealth's "States in Action" project focusing on "Medical Homes" and care coordination,

should Oklahoma consider "mandatory" communication with the PCP at the time of hospital discharge?

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