



## Transitions of Care: “The National Perspective”

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## Objectives

At the end of this session the participant will have:

- Developed the impact of care transitions to frail elders
- Determined the high risk seniors for difficult care transitions
- Reviewed the concept, and elements, of patient-centered care to improve care transitions

*“The greatest barrier to patient safety and safety culture is the inherent fragmentation of the US system of care.”*

Stephen Shortell, PhD, MBA, MPH & Steve Singer, PhD, MBA  
*JAMA*, January 30, 2008

## The System & the Patient...A Conflict

- Health care
  - Provided by teams of individuals usually narrowly trained to perform specialized tasks
- Health care institutions
  - Organized around specialties & service lines
  - Separated by stage of illness (acute vs. long-term)
- Patients Increasingly
  - Experience chronic, complex co-morbid diseases
  - Utilize various sites of care

*Shortell & Singer, JAMA, Jan 30, 2008*

## One Patient...Many Doctors

- Between 2000-2002 typical Medicare beneficiary saw a median of 2 PCP's & 5 specialists annually
- Patients with several chronic conditions may visit up to 16 physicians annually
- Elders with one or more chronic conditions over the course of one year see an average of 8 physicians

*Pham et al NEJM 2007*

2001 Harris Poll sponsored by RWJ Foundation

## The Curse of Knowledge

- *Made to Stick*
  - Chip Heath & Dan Heath
  - Random House, NY, 2007
- “Tappers and Listeners”

## The Curse of Knowledge

- Once we know something, we find it hard to imagine anyone else not knowing it.
  - Tom Hanks in “Castaway”
  - Jaycee Dugard
- Difficult to share knowledge with others in a logical, linear, comprehensive fashion because we cannot re-create the listener’s state of mind.

## What is “Transition of Care”

- The movement of patients from one health care practitioner or setting to another as their condition and care needs change
- Occurs at multiple levels
  - Within Settings
    - Primary care ↔ Specialty care
    - ICU ↔ Ward
  - Between Settings
    - Hospital ↔ Sub-acute facility
    - Ambulatory clinic ↔ Senior center
    - Hospital ↔ Home
  - Across health states
    - Curative care ↔ Palliative care/Hospice
    - Personal residence ↔ Assisted living

National Transitions of Care Coalition (NTOCC)

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## Care Transitions: Expectations

- **Medicare Conditions of Participation**
  - Address selected areas of transitions, but are loosely monitored and rely on Joint Commission on Accreditation of Healthcare Organizations (JACHO) to enforce
- **The Joint Commission**
  - Site-specific rather than **across** settings of care
  - Should be “safe and adequate”
- **National Quality Forum (NQF)** has identified care coordination as a “priority area.”
- *Crossing the Quality Chasm: A New Health System for the Twenty-first Century* [Institute of Medicine(IOM) 2001]
  - Calls for greater integration across settings to improve quality of care and reduce medical errors

## Care Coordination in the 9<sup>th</sup> SOW

- The aim of QIO work under the Care Coordination Theme is to improve Medicare beneficiary transitions from hospitals to other care settings through a comprehensive community effort.
- Measured by
  - Global Re-Hospitalization Rate
  - Patient Experience on Hospital Performance at Hospital Discharge (HCAHPS)
  - Visit within 30 days of discharge & before readmission

## Continuity Assessment Record & Evaluation – The CARE Tool

- CMS Goal: Develop a uniform assessment instrument to measure and compare Medicare beneficiaries’ health and functional status across provider settings, over time.
- Internet-Based ~ Uniform Assessment Tool to:**
- Standardize data collection.
  - Promote safe transitions.
  - Identify patient characteristics and needs.
  - Rapidly communicate key information.
  - Consistent with IOM’s critical aims: Patient-centered, Safe, Effective, Efficient, Timely, Equitable care

## CARE Tool...cont.

- Items common to all settings (Hospital, SNF, IRF, LTCH, HHA)
  - Administered at:
    - Hospital discharge
    - Across PAC settings (SNFs, IRFs, HHAs, LTCHs)
      - Admission
      - Significant Changes
      - Discharge
- Major areas of assessment include:
  - Administrative
  - Medical
  - Cognitive
  - Functional
  - Prognosis
  - Discharge Status/Continuity of Care

## The Burden of Poor Transitions

- Jencks et al (NEJM 2009)
  - Nearly one-fifth of all M/C beneficiaries discharged for hospital readmitted within 30 days
  - 90% of readmits are unplanned
  - Cost if unplanned readmits in 2004 was \$17.4 billion

## The Burden of Poor Transitions

- CMS in 2008 in the proposed inpatient PPS rule for FY 2009 estimated
  - nearly 18% of M/C beneficiaries re-hospitalized within 30 days
  - 13% of all readmissions were potentially avoidable
  - Cost of \$12 billion

## Problems That Illustrate Inadequacies of Care Transitions

- Medication errors
- Increased health care utilization
- Inefficient/duplicative care
- Inadequate patient/caregiver preparation
- Inadequate follow-up care
- Dissatisfaction
- Litigation/Bad publicity

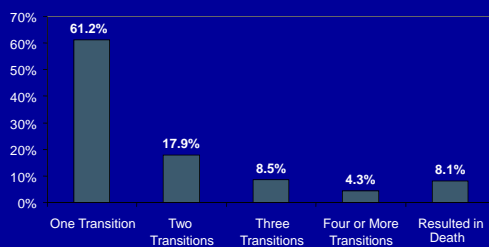
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## Ineffective Transitions Lead to Poor Outcomes - Australia

- Wrong treatment
- Delay in diagnosis
- Severe adverse events
- Patient complaints
- Increased healthcare costs
- Increased length of stay

Australian Council for Safety and Quality in Health Care. Clinical hand-over and Patient Safety Literature Review Report. March 2005. Available [www.safetyandquality.org/internet/safety/publishing.nsf/Content/AA1369AD4AC5FC2ACA2571BF0081CD95/\\$File/clinhowrlitrev.pdf](http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/AA1369AD4AC5FC2ACA2571BF0081CD95/$File/clinhowrlitrev.pdf)

## Post-Hospital Transitions Followed 30-Days Post Discharge



Coleman, M, Chomick & Kramer, HSR: Health Services Research 39:2 (October 2004)

## Elder Discharge Destinations

- Hospital discharges to SNF
  - 19% back to acute care within 30 days *Kramer et al, 2000*
  - 42% within 24 months *Barker et al, 1994*
- Age 65 and older hospital patients *AHCOR HCUPnet, 1999 (online)*
  - 23% discharged to another institution
  - 11.6% discharged with HHC

## Unanswered Questions

1. What is the “right” percentage of readmissions within 30 days of hospital discharge?
2. What is the “right” number of transitions within 30 days of hospital discharge?

## Seniors with Especially High Risk for Transition Problems

- Multiple medical problems
- Dementia
- Depression or other mental health problems
- Isolated seniors – lack of caregivers
- Those in poverty or near poverty
- **Non-English speakers**
- **Racial and ethnic minorities**
- **Recent immigrants and refugees**

Brown-Williams, Neuhauser, Ivey et al. Health Research for Action, UC Berkeley 2006

## The Common Factor in Care Transitions

- Most transitions across care sites are unplanned and due to acute illness or injury.
- Patients transitioned across care sites are quite vulnerable – functional loss, delirium, pain and/or anxiety are common. *Coleman 2003, Kiely et al 2003*
- Typically, the only common factor in the care system as individuals move through different sites of care and various medical care professionals, is the patient.

## Qualitative Studies Have Shown

- Patients and their caregivers are unprepared for their roles in the next setting of care.
- They:
  - Do not understand essential steps in management of their care
  - Cannot contact appropriate health practitioners for guidance
  - Are frustrated by being forced to perform tasks healthcare professionals left undone Coleman

## Safer Transitions

1. Communication
2. Medication Reconciliation
3. Patient-centered Care
4. End-of-Life/Palliative Care

*Communication*

## Expectations for Sending & Receiving Teams

- Shift from the concept of “discharge” to “transfer with continuous management”
- Begin transfer planning upon or before admission
- Incorporate patient/caregivers’ preferences into plan
- Identify a patient’s social support and function (how will this patient care for herself after transfer?)
- Collaborate with practitioners across settings to formulate and execute a common care plan.

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## Expectations for the Sending Team

- The patient is stable for transfer
- The patient and caregiver understand the purpose of the transfer
- The patient and family understand their coverage
- The receiving institution is capable and prepared
- The care plan, orders, and a clinical summary precede the patient’s arrival
- The patient has a timely follow-up appointment

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## Expectations for the Receiving Team

- Review the transfer forms, clinical summary, and orders prior to or upon the patient’s arrival.
- Incorporate the patient/caregiver’s goals and preferences into the care plan.
- Clarify discrepancies regarding the care plan, the patient’s status, or the patient’s medications

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## “It’s All in the Discharge Summary”

- Increasingly, patients [are] discharged with unresolved medical problems. *“Quicker and Sicker”*
- Few PCPs ever receive discharge summaries prior to post-discharge patient visits. *Van Walraven et al 2002*
- 35.9% of recommended evaluations post-hospital discharge [are] not completed. *Moore, McGinn & Halm, AIM 2007*
  - 54.1% of DCS failed to document necessary post-discharge workups clearly documented in the hospital chart.

## Hospital to PCP Communication Gaps

- Meta-analysis
- Direct communication between hospital physicians and primary care physicians occurred infrequently
- Discharge summary
  - Availability at first post-discharge visit low (12%-34%)
  - Remained poor at 4 weeks (51%-77%)
  - Affected quality of care in ~25% of follow-up visits
  - Often lacked important information (e.g., lab results, discharge medications, treatment, follow-up plan)

Kripalani S et al. JAMA 2007; 297:831-41

Table 1. Nurse-to-Nurse Reporting Format

For use as a guide to the nurse when discharging a patient to the nursing home in order to provide continuity of care. THIS FORM DOES NOT BELONG TO THE RESIDENT RECORD

Patient Name: \_\_\_\_\_ Nursing Home: \_\_\_\_\_  
 Date and Time of Report: \_\_\_\_\_ By: \_\_\_\_\_ To: \_\_\_\_\_  
 Diagnosis: (6-MD Check, Summary): \_\_\_\_\_

**CURRENT FUNCTIONAL ABILITY**

Medical status: \_\_\_\_\_

Behavior/mood problem: \_\_\_\_\_

Feeding status: \_\_\_ Independent \_\_\_ Assist/act up \_\_\_ Dependent \_\_\_ TF  
 Bladder continence: \_\_\_ Yes \_\_\_ No \_\_\_ Foley  
 Bowel continence: \_\_\_ Yes \_\_\_ No \_\_\_ Last BM  
 Transfer: \_\_\_ Independent \_\_\_ Assist \_\_\_ Dependent  
 Ambulation: \_\_\_ Independent \_\_\_ Assist \_\_\_ Dependent  
 Assistance device: \_\_\_ None \_\_\_ Walker \_\_\_ Wheelchair  
 Dentures: \_\_\_ Yes \_\_\_ No  
 Hearing aid: \_\_\_ Yes \_\_\_ No  
 Glasses: \_\_\_ Yes \_\_\_ No  
 Skin breakdown: \_\_\_ Yes \_\_\_ No  
 Stage of ulcer: \_\_\_ Stage I \_\_\_ Stage II \_\_\_ Stage III \_\_\_ Stage IV

Location of ulcer(s): \_\_\_\_\_

Current treatment of ulcer: \_\_\_\_\_  
 if diabetic (on sliding scale) \_\_\_ Yes \_\_\_ No \_\_\_ When last covered: \_\_\_\_\_ BS

Other nursing treatments: \_\_\_\_\_

Family issues: \_\_\_ Yes \_\_\_ No Advance directives: \_\_\_ Yes \_\_\_ No  
 Infection control requirements: \_\_\_ HISA \_\_\_ VRE \_\_\_ C. Diff

TF = tube feeding BM = bowel movement BS = blood sugar HISA = medical history atypical organisms VRE = vancomycin-resistant enterococci C. Diff = Clostridium difficile

## Improving Transitional Care

- Forms alone don't change process
- Do not confuse paperwork with communication.
- Make a call to the receiving caregivers.
- Retain responsibility for the patient until care is assumed by the receiving caregiver.

## Medication Reconciliation

*"If the whole materia medica, as now used, could be sunk to the bottom of the sea, it would be all the better for mankind, and all the worse for the fishes."*

- Oliver Wendell Holmes, Sr., MD, 1861

## What is "Medication Reconciliation?"

- Process of comparing a patient's medication orders with previous and present medication regimens
- Should be done at every transition of care
- Process comprises five steps:
  - 1) develop a list of current medications;
  - 2) develop a list of medications to be prescribed;
  - 3) compare the two lists;
  - 4) make clinical decisions based on the comparison; and
  - 5) communicate new list to appropriate caregivers and give to the patient.

The Joint Commission

## Medication Reconciliation ... continued

- Know what medications are taken.
  - Prescription
  - Non-prescription (OTC)
  - The neighbor's
  - The dog's
- Know why they are taken.
- Ensure the need for each medication.
- Determine a good reason not to stop each medication.
- Ensure a final, correct, legible, and understandable, "take only these" list of medications to the next level of care and the patient/caregiver.

## Overuse of Medications - Outpatient

- Use of medications when not indicated
  - Lipton HL et al. Med Care 1992;30:646-58.
    - 59% of outpatients taking drugs without an indication for use
  - Schmader K et al. JAGS 1994;42:1241-7.
    - 55% of outpatients taking drug without an indication for use
    - 16.8% taking drug with another drug of same class (considered a therapeutic duplication)

## Medication Perils - LTC

- 10-30% of hospital admits in elders are drug-related. *Col et al., 1990; Hohl et al, 2001; Passarelli et al, 2005; Grymonpre et al, 2004*
- 20% of readmissions to the hospital in a geriatric population of 706 were drug-related and 75% could have been prevented with proper medication use. *Bero et al.*
- Nearly two-thirds of NH residents had ADRs over a four-year period, with one in seven resulting in hospitalizations. *Cooper JW 1999*

## Hospital Records and Medications

- Medication Error:
  - Failure to record use stated by a patient
  - Recording a medication patient denied using
- All medications – Prescribed & OTC
  - 83% of patients had at least one error
  - 46% had three or more
- Prescription medications only
  - 60% had at least one error
  - 18% had three or more
- Failure to record the more common error

Beers, Murakata & Sorrie 1990

## Post-hospital Medication Discrepancies

- Post-hospital medication review to compare what hospital told patient to take versus what patient was actually taking
- Results
  - Of the 375 patients, 14.1% experienced one or more medication discrepancies
  - 14.3% with discrepancies readmitted within 30 days versus 6.1% in those with none
  - Patients who experienced a discrepancy averaged 9 medications compared to 7 for those without a discrepancy ( $p < .001$ )

## Adverse Events after Hospital Discharge

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

## PATIENT-CENTERED CARE

## Emerging Force in Safe Transfers

- “Patient-centered” concept
  1. **Patient/family ownership** in the process and empowerment
    - Institutions foster dependency and acceptance.
    - Abruptly changes upon discharge
      - Check own blood sugars
      - Self-administer medications
  2. **Information transitions with the patient** rather than residing at the care site only.



## Personal Medication Organizer: USP

## PHR: Coleman

<http://www.caretransitions.org/documents/pdf/>

## PHR: Coleman

The Personal Health Record of:

### Personal Information

Address:  
Home Phone#: \_\_\_\_\_  
Alternate Phone #: \_\_\_\_\_  
Birth Date: \_\_\_\_\_  
Hospital ID #: \_\_\_\_\_  
PCP Name: \_\_\_\_\_  
Advance Directives?: \_\_\_\_\_

### Hospitalization Information

Admitted: \_\_\_/\_\_\_/\_\_\_ Discharged: \_\_\_/\_\_\_/\_\_\_  
Reason for Hospitalization: \_\_\_\_\_

### Caregiver Information

Name: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_  
Alternate Phone #: \_\_\_\_\_  
Relation to Patient: \_\_\_\_\_

### Medical History

- Arthritis
- Abnormal Heart Rhythm
- Cancer
- Diabetes
- Hardening of the Arteries
- Heart Disease
- Heart Failure
- High Blood Pressure
- Hip Fracture
- Lung Disease
- Medical/Surgical Back conditions
- Pneumonia
- Stroke
- Other Diagnoses: \_\_\_\_\_

## End-of-Life/Palliative Care

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## POLST Form

## Summary

- The transition in which you are involved is only one step in the patient journey.
- Every change in the site of care, level of care at the same site, practitioner, and caregiver is a transition of care and must be attended to with the same intensity of hand-off as airplane landings.
- **Communication**, not paperwork, is the key to patient safety.
- **Medication reconciliation** during transitions is *the* crucial step for patient safety.
- This is a **patient-centered activity**: information must follow the patient.