

Transitional Care: Focus on Clinical Care and Quality

Eric A. Coleman, MD, MPH

Associate Professor

Divisions of Health Care Policy and Research
and Geriatric Medicine

University of Colorado Health Sciences Center

Nature of the Problem

- Older adults with complex care needs frequently require care in multiple settings
- Yet health professionals in these settings often function independent from one another
- As a result, care is often fragmented
- Patient safety and quality are compromised

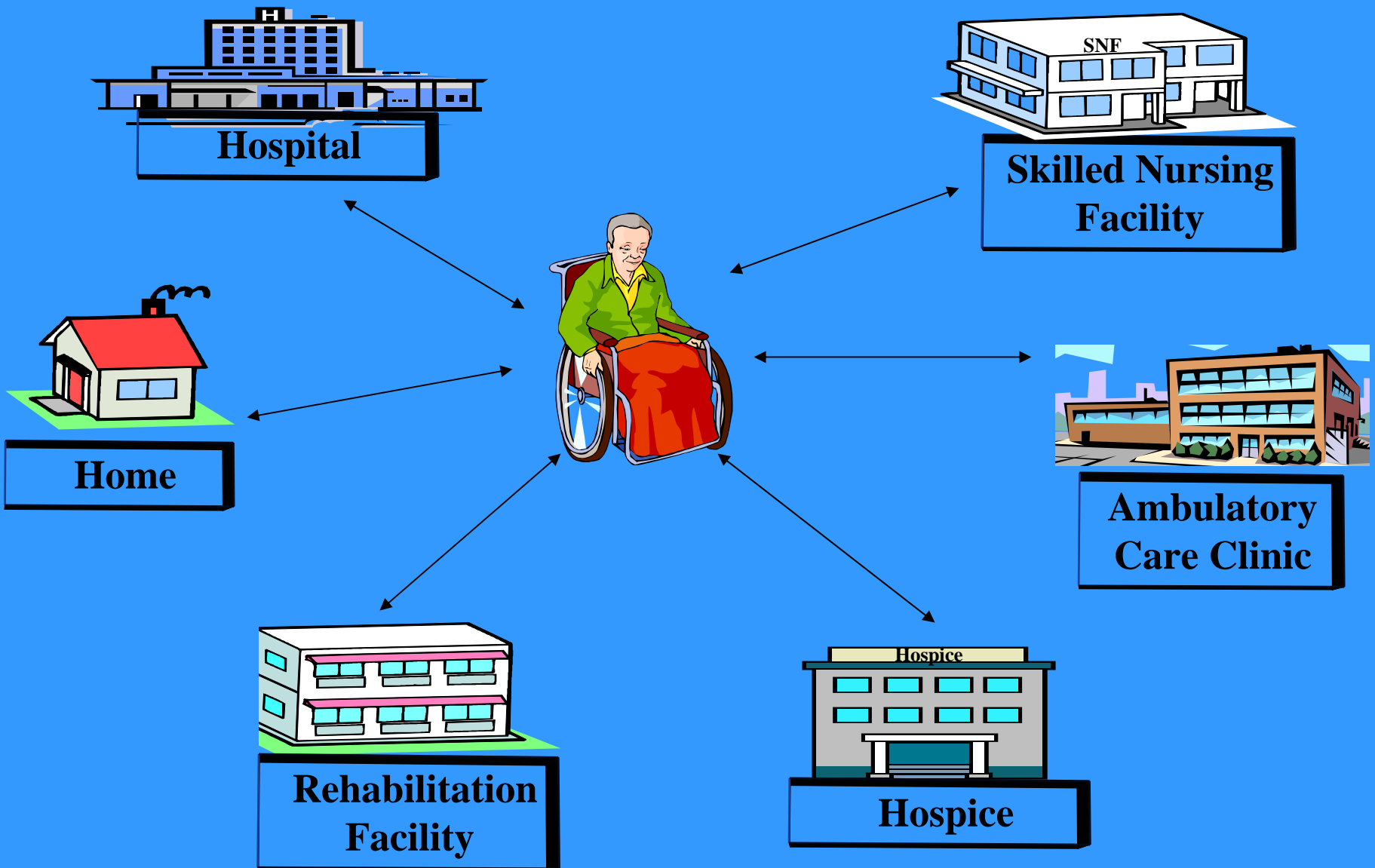
Illustrative Cases

“They overmedicated me like you wouldn’t believe. All they had to do was make one call to my primary care doctor”

“The nurse did not know that there was no way that my wife could take care of me ”

“We can’t get hold of anybody--all we have is a quick question”

Fundamental Disconnect...



Definition—Transitional Care

“A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. Transitional care encompasses both the sending and the receiving aspects of the transfer”

Isn't This Just Case Management?

- Focus of transitional care is on the time interval that begins with preparing a patient to leave one setting and be received in the next
- Many transitions are unplanned and occur in “real time” during nights and on weekends
- Case management/disease management approaches are not structured to respond in a timely manner
- As a result, transitional care involves clinicians who do not have an ongoing relationship with the patient

Care Transitions Are Common...

Policy-Relevant Questions: Medicare Current Beneficiary Survey

1. What are the patterns of during the 30-day period following hospitalization
2. How can the quality of these care patterns be characterized?
3. Can those at greatest risk for poor quality transfers be identified?

45 Unique Care Patterns

Single transfer	444 episodes	61.2 %
Two transfers	130 episodes	17.9 %
Three transfers	62 episodes	8.5 %
\geq Four transfers	31 episodes	4.3 %
Deaths	59 episodes	8.1 %

Complicated Vs. Uncomplicated

- “Uncomplicated” care transitions: sequence of transfers from high intensity care environments to lower intensity ones without recidivism
- Care patterns with 1+ transitions occurring in the reverse order were defined as “complicated”

Prevalence of Complicated Transfers

Sample	“Complicated”
1997 MCBS	22 %
1998 MCBS	25 %

Summary

- 45 Unique Care Patterns in 30 days
- 1 in 4 episodes determined to be “complicated”
- Older patients at risk for complicated care patterns can be identified using information routinely available at the time of discharge

Evidence of Serious Quality Problems

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

California Health Care Foundation

- Patients rated experiences at 200 California hospitals
- Effort to move towards performance reporting
- Three areas uniformly poor
 - Transition to home
 - Involvement of family and friends
 - Emotional support

Adverse Events after 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%)

Information Transfer

- Discharge/transfer information inadequate or not conveyed to next setting (many)
- Hospital => NH Transfer, documentation was not legible 28% of time (Foley et al.)

10. Diet: Regular Other _____
 11. Activity: No Restrictions As Tolerated
 Other No heavy lifting

To Be Filled Out by Nurse:
 12. Seek medical attention for: _____
 13. Instruction sheets given: _____

Medication	Dose	Instructions (Do not use Med Abbrev)	Times	Purpose
1. Tylox		1-2 tabs every 4 hours as needed		Pain
2. Colace	100mg	1 tab 2x per day		Stool Softener
3.				
4.				
5.				
6.				
7.				
8.				
9.				

Additional instructions per physician (i.e., home oxygen, dressing changes, etc.):
 Foley leg bag care
 JP care
 OK to shower (no bathing, swims, soaks)
 Change dressing over suprapubic site as

Additional instructions per nurse:

Sign below if you understand the above instructions and have been given a copy of these instructions:
 Patient's/Significant Other's Signature: _____ Patient's Phone #: _____

Please bring this form with you to return appointments.
 Chart Copy = White Patient Copy = Yellow Agency Copy = Pink

Medication Errors



Medication Errors

- 20% of patients discharged from hospital had at least one medication discrepancy (UCHSC)
- 1/3 of all medications prescribed at hospital discharge not taken (Beers et al.)
- Transfers NH=> hospital, average 3 medications changes; 20% lead to ADE (Boockvar et al.)
- ACOVE—New medication at discharge not noted in outpatient record approximately half the time

Ultimately Higher Health Care Costs

- Inefficiencies/duplication of services
- Greater use of hospital and emergency services when care needs are not met

Challenges to Improving Quality

Challenges Occur at Multiple Levels

- Patient
- Practitioner
- Health care institution
- Health Information Technology
- Performance measurement

Patient Level



- Unprepared and uncertain about their role
- Institutions fosters dependency and complacency
- This changes abruptly on transfer when expected to assume major role in self-care
- Rising prevalence of cognitive impairment intensifies this challenge

PIRARO.

SORRY. THIS ISN'T
MY TABLE.



Practitioner Level

- Rare for one clinician to orchestrate care across multiple settings
- Rise of hospitalists and SNFists
- Many practitioners have never practiced in (*much less set foot in*) settings to which they transfer patients

Health Care Institution Level Barriers

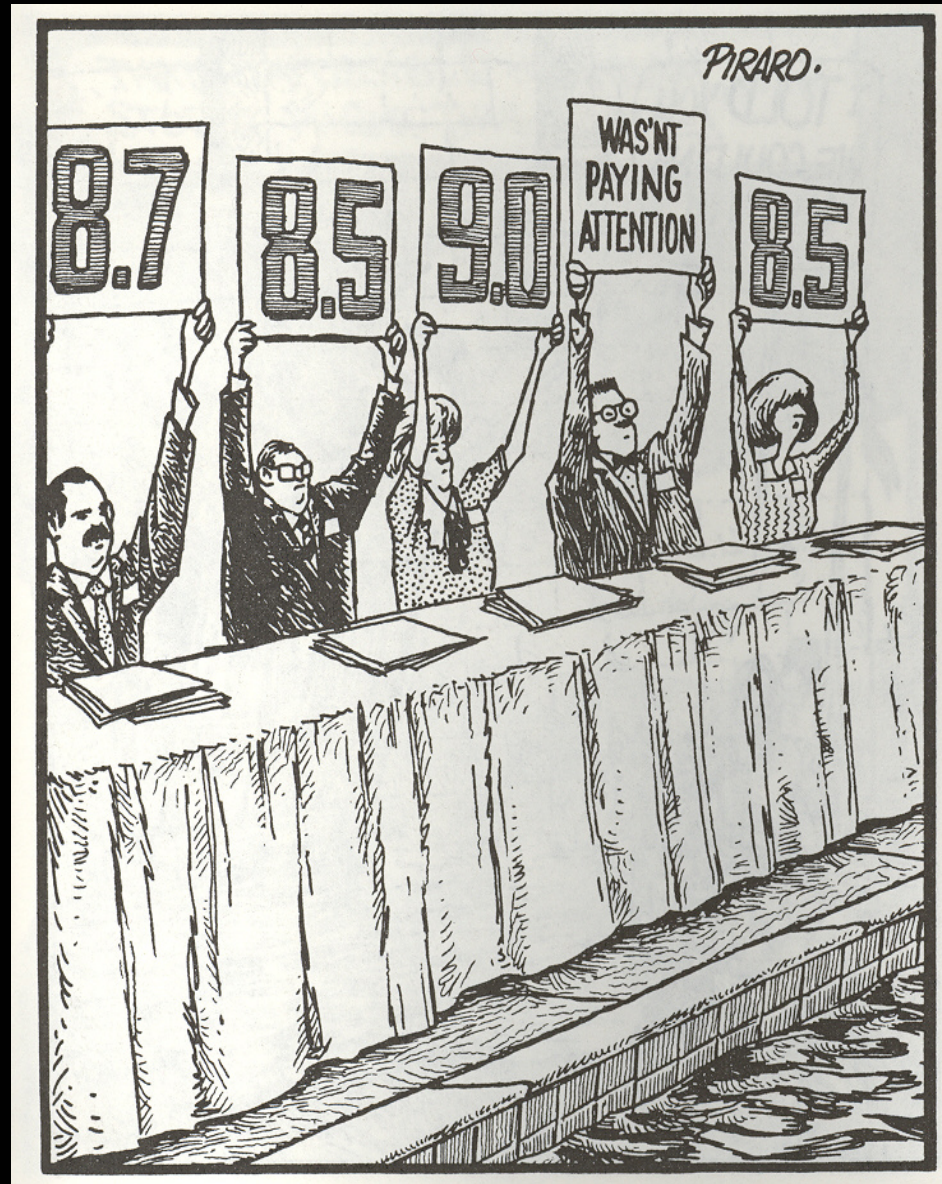


Figure 2. Tower silos may be either conventional open-top (usually concrete, cast-in-place or pre-cast stave), or oxygen limiting (usually concrete or glass-lined steel).

Health Information Technology

- Health Information Technology infrequently extends from hospital or clinic into post-acute care settings (ASPE/UCHSC)
- Lack of connectivity impedes collection of quality measures that could be used for public reporting or rewarding performance

Performance Measurement



Performance Measurement

- Lack of quality measures for transitional care is a significant barrier to quality improvement
- Not well represented in national performance measurement/quality improvement efforts

Promising Innovations

- Practitioner
- Patient
- Health Information Technology
- Performance measurement

Promising Innovations-Practitioners

- Naylor et al./University Pennsylvania
 - APNs managed care 4 weeks post-hospital.
 - Reduced re-hospitalizations
- Care Management Workgroup/RWJF
 - Senior medical and patient management positions
 - Essential skills and tools for practitioners
 - Accountability for sending/receiving care teams

Promising Innovations-Patients

- Coleman et al./UCHSC/Hartford Foundation
 - Transition Coaches encourage patients and caregivers to assert a more active role during care transitions.
 - Significantly reduced re-hospitalization
- National Family Caregivers Association/UCHSC
 - Family caregiving ↔ Transitional care
 - Collaborating towards a combined IOM report

Promising Innovations-Measurement

- The Care Transitions Measure (CTM) could help to fill this important gap
- JCAHO
 - Tracer methodology
 - Medication reconciliation

Promising Innovations-HIT

- PeaceHealth (OR, WA, AK)
 - Electronic shared care plan accessed by patient and clinicians

www.caretransitions.org

- Care Transitions Measure (CTM)
- Care Transitions Intervention
 - Manual
 - Video clips
 - Tools for patients and caregivers
- Medication Discrepancy Tool (MDT)
- Patient Educational Forum