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.
"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”

Source: Position Statement from the American Geriatrics Society, 2003
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?

Coleman et al. HSR 2004;37(5):1423-1440
## 45 Unique Care Patterns

<table>
<thead>
<tr>
<th>Transfer Type</th>
<th>Episodes</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Single transfer</td>
<td>444 episodes</td>
<td>61.2 %</td>
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<tr>
<td>Two transfers</td>
<td>130 episodes</td>
<td>17.9 %</td>
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<tr>
<td>Three transfers</td>
<td>62 episodes</td>
<td>8.5 %</td>
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<tr>
<td>≥ Four transfers</td>
<td>31 episodes</td>
<td>4.3 %</td>
</tr>
<tr>
<td>Deaths</td>
<td>59 episodes</td>
<td>8.1 %</td>
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“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”
<table>
<thead>
<tr>
<th>Sample</th>
<th>“Complicated”</th>
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<tr>
<td>1997 MCBS</td>
<td>22 %</td>
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<tr>
<td>1998 MCBS</td>
<td>25 %</td>
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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
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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Date</th>
<th>Instructions (Do not use Med. Abbrev)</th>
<th>Times</th>
<th>Purpose</th>
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<tbody>
<tr>
<td>1. Tylox</td>
<td></td>
<td>1-2 x 4 HR or q.d.</td>
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<td>Pain</td>
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<td>2. Colace</td>
<td>100y</td>
<td>1 tab 2 x 1 p.r.n.</td>
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<td>Stool Softener</td>
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Additional instructions per physician (e.g. home oxygen, dressing changes, etc.): Ear, leg, by care

Additional instructions per nurse: J.P. line

Take to shower (no bathing, swim, soak)

Chart Copy = White  Patient Copy = Yellow  Agency Copy = Pink

Please bring this form with you to return appointments.

Signature:  ____________________________  ____________________________
Patient's Name:  ____________________________  Patient's Signature:  ____________________________

N320.1034-3/2 (899)
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
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 steel), 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