TRANSITIONS of CARE

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5-15-15
Objectives

At the conclusion of the presentation, the participant will be able to:
1. Improve movement of patients between health-care locations and providers.
2. Improve communication of essential patient information to the next patient care setting.
3. Improve medication reconciliation upon transfer from one prescriber to another.
4. Foster reductions in hospital readmissions.
**Definition**

**Transition of care** refers to the movement of patients between health care locations, providers, or different levels of care within the same location as their conditions and care needs change.

Requires actions to ensure coordination and continuity of care based on a comprehensive care plan, available well-trained practitioners who have information about the patient’s treatment goals, preferences and health status.
Poor Transitions Lead To:

- Increased hospital readmissions
- Duplication of services
- Medication errors
- Lack of continuity of care from one practitioner to the other.
Older Adults at Particular Risk

Those with multiple medical problems
Cognitive deficits
Depression
Isolated seniors
Non-English speakers
Immigrants
Those with few financial assets
Stats

Transfers from nursing facilities

8.5% of all Medicare admissions to acute-care hospitals

40% of these hospitalizations occur within 90 days of nursing facility admission.

84% of these patients are discharged from the hospital back to their original care setting.

One-fifth of all Medicare patients discharged from the hospital are readmitted within 30 days.

- 90% of these readmissions are Unplanned.
- Cost Medicare $17.4 billion in 2004.
- Readmissions within 30 days: Heart failure 26.9%, Pneumonia 20.9%
Stats

Analysis of postacute and SNF settings

5 million patients >65 made more than 15 million transitions.

1.1 million (22.4%) had subsequent health care use indicating a transition problem.

• ER visits, hospital stays, return to institutional setting

CMS 2009 estimated 18% of Medicare patients are re-hospitalized within 30 days of discharge and 13% may be avoidable (cost $12 billion)
Stats

Medication changes upon hospital admission and discharge are frequent cause of adverse events.

Regularly used medications discontinued in 46.4% of cases, with 38.6% considered to have potential to cause moderate/severe discomfort or deterioration

20% of patients discharged from a tertiary hospital experienced an adverse event on transition from hospital to home.

66% were adverse medication events
- 1/3 were preventable (caused by an error)
- Adverse drug events due to medication changes occurred in 20% of transfers between nursing homes and hospital.
High prevalence of medical errors when patients transferred from hospital to the community. Patients were 6 times more likely to be re-hospitalized when PCP did not follow-up on work-up recommendations by the inpatient provider.
Communication Deficiencies

Hospital and primary care physicians rarely communicated with each other directly.

Hospital discharge summaries often did not identify:

- The Responsible hospital physician
- Main diagnosis
- Physical findings
- Discharge medications
- Follow-up care plans
- Tests pending at discharge
- Counseling provided to patient and/or family

11% of discharge letters and 25% of discharge summaries never reached the patient’s PCP
Communication Deficiencies

Only 25% of discharge summaries mentioned pending tests.
13% documented all pending tests.
72% of pending test results requiring a treatment change were NOT mentioned in discharge summaries.

Only 67% of discharge summaries identified the health care providers responsible for the patient’s follow-up care.

Were MC. Adequacy of hospital discharge summaries, J Gen Intern Med 2009;24(9):1002-1006
Communication Deficiencies

Yearly 25% of nursing home residents are transferred to ED for evaluation

10% transferred without any documentation
90% essential patient information commonly missing

Terrell KM. Challenges in Transitional Care Between Nursing Homes and Emergency Departments. JAMDA 2006;7(8): 499-505
Communication Deficiencies
Practitioners fail to communicate patient’s care plan developed in one care setting to the next.

- Goals of care
- Follow-up appointments and lab testing
- Review current medication regimen
- Requisite information about the care the patient received

Break down of care processes
- Preparation of patient and caregiver
- Communication of vital elements of care plan
- Transportation
- Completion of follow-up care
- Diagnostic imaging or laboratory testing
- Availability of advance care directives across settings
Segmentation of Primary Medical Services

Many practitioners have not practiced in the settings that they are sending their patients to. Unfamiliar with care-delivery capacity of these settings
May transfer patients inappropriately
Segmentation

Difficult defining what Primary Care comprises

Dwindling supply of PCP’s

Hospitalists-practice only within a hospital
  May be reluctant to write orders for patient moving to the community

Skilled Nursing Facility Specialists (SNFists)
  Difficulty connecting patients with community-based services because they don’t practice in the community
Segmentation

Community PCP asked to resume care, approve multiple services and prescriptions and may have little knowledge of the illness episode or follow-up visit to approve services, medications or treatment.

Treatment may be delayed with a gap during which no practitioner is overseeing the patient’s care.

Discontinuity of care

Hospital → SNF → Home → Hospice

• May take 24-48 hours to obtain pain medication Rx
Barriers to Effective Transitions-Delivery System

Silos- Each care setting functions independently without formal relationships.

Information systems incompatible with each other.

Financial incentives lacking.

Multiple formularies

  Constant medication switches
    • Generic substitutions

  Each hospitalization results in changes in patient’s drug regimen

Insurance coverage drives service delivery

  May require change in doctor
Barriers-Clinician

Single clinician rarely provides continuous care for a patient across care settings.
Clinicians in different care settings DON’T COMMUNICATE information to one another!!
Multiple consults with specialists, multiple additional tests and medications
  May be unnecessary
  May generate multiple follow-up appointments and tests

Care managers and social workers
  Now work in specific settings and don’t work longitudinally across settings
Barriers-Patient (and families)

Presume health care professional will take care of their needs!
Not informed of their disease process and next steps and next setting.
Not empowered to express preferences or provide input to patient’s care plan.
Take-home information may be conflicting results in confusion.
Barriers-Patient

Cultural barriers
   Different expectations
   Language fluency
   Health-care literacy

Cognitive impairment

Advance care directives
   Need to be discussed in advance with primary care
Benefits of Continuity of Care

Care coordination of discharge services
  Arrange follow-up appointments
  Reconcile medications
  Educate patients

Reduced ED visits and readmissions within 30 days of discharge by 30%.

Benefits

Care Transitions Intervention

Transition Coach established

- Provided continuity across settings (Accountability)
- Ensured patient needs met regardless of setting.

Reduced rates of rehospitalization as far as 6 months out in a population of chronically ill community dwelling adults > 65 yo.

Four factors most valuable to patients & caregivers

- Assistance with medication self-management
- Patient centered record owned by the patient to facilitate cross-site information transfer
- Timely follow-up with primary or specialty care
- List of red-flags indicative of a worsening condition and instructions on how to respond to them

Benefits

MSU Nurse care manager and social workers coordinate care across sites and healthcare practitioners for elders and seniors at high risk for hospitalization and readmission.

Michigan Primary Care Transformation Program (MIPCT)
- Funded by CMS
- Medicare, Medicaid and some BCBS
- Strengthen the patient care team relationship with the primary care doctor in the center of care
- Help patients manage their own care
Purpose

Conduct care transitions smoothly. Essential patient information is transmitted to the next care setting. Health care professionals involved in the care of the patient communicate appropriately about the patient’s care needs.

TRANSITION NOT Discharge

Not Discharge which implies the patient is NO longer our responsibility
Contributes to lack of continuity of care
Extend medical providers responsibility into the next level of care!
Accountability

Assign a designated person within each care site for every transition task.

Individual accountability for specific tasks but safe transitions are Everyone’s responsibility.

Relationship centered care focused on patient and family, may be family or support system.

Individuals selected by patient to receive personal medical or social information to assist in decision-making or actually make decisions as desired by the patient (DPOA).

Mix of respect for patient autonomy, privacy (HIPAA) and regulation negotiated in patient’s best interest.
Accountability

Develop relationships with counterparts
   Social workers at SNF/Subacute Rehab
   Home health agencies
   Community service agencies
      • Dialysis centers, Infusion therapy

Review writing orders
Medication reconciliation
Copying records
Contacting patient’s family
Arranging transportation
Inservice training

At all levels of care and all sites

Hospital-based physicians may not be familiar with services provided at LTCC.
  May not have 24 hour diagnostic services, laboratory testing or pharmaceutical services.
  Physicians may not be available on site at all times.

Training the caregiver

  Family or informal caregiver, such as friends or neighbors.
  Family caregivers provide the most long-term care in the U.S.
  Valued at $354 billion in 2006.
Medication Reconciliation

Create the most current list of medications
Compare against orders at each stage of the patient’s stay in the facility.
66% of reconciliation errors occurred during transition to another level of care
   22% during admission
   12% at discharge
Each facility may use a unique formulary
Unintended drug omissions
Medication Reconciliation

Should be performed every time a patient is admitted to a facility or transferred to another setting or level of care.

Joint Commission made medication reconciliation a National Patient Safety Goal

Also a CMS Guideline for nursing facilities the medication review is done monthly by a consultant pharmacist.

Also review OTC and complimentary meds (vitamins, supplements.

Drug allergies
Medication Reconciliation

Nonprescription drug usage
Adherence to the prescription drug program
Electronic Health Records

Sharing a common EHR between health-care entities.
Interoperable, easily accessible, secure EHR
Financial Issues

One-fifth of Medicare patients discharged from the hospital are rehospitalized within 30 days. 90% of these readmissions are unplanned. CMS adopting standardized measure of readmissions for heart failure, heart attack and pneumonia.
Implementation of a Care Transitions Program

May be planned or unplanned
The patient has a recognized status change.
  Deterioration or improvement
  Anticipated: post-surgical and in need for rehabilitation
  Unanticipated: patient falls
System should be in place for the caregiver to communicate the status change to the care-team.
Ideally the point of contact should be the PCP.
  Ask patient to identify who their preferred provider is.
Implementation of Care Transitions

Interdisciplinary team members communicate with each other and with the patient/family unit to determine the most appropriate care transition. Family should be fully involved. Transitions should be guided by advance directives of the patient.

The sending facility communicates with the receiving entity. Patient information should be received by the entity prior to arrival.

ORAL COMMUNICATION IS IDEAL!

Shared EHR
### TABLE 6
**AMDQ Universal Transfer Form**

AMDQ has developed and recommends the use of the Universal Transfer Form (UTF) to facilitate the transfer of necessary patient information from one care setting to another. Patient transfers are fraught with the potential for errors stemming from the inaccurate or incomplete transfer of patient information. Use of the UTF can help to minimize the occurrence of such errors by ensuring that patient information is transmitted fully and in a timely fashion.

<table>
<thead>
<tr>
<th>Patient ID:</th>
<th> </th>
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<tbody>
<tr>
<td>Patient's date of birth:</td>
<td> </td>
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<tr>
<td>Patient's gender: Male</td>
<td>Female</td>
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</tbody>
</table>

**Admitting diagnosis:**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>6</td>
<td>7</td>
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</table>

**Diagnoses prior to admission:**

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<tr>
<th>1</th>
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<th>3</th>
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<th>5</th>
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<tr>
<td>6</td>
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</table>

**Diagnosis during admission (include name physician performed the procedure):**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
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<tbody>
<tr>
<td>4</td>
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</tbody>
</table>

**Laboratory values (please record most recent results, with date):**

- **WBC**
- **Hgb**
- **Na**
- **K**
- **Creatinine**
- **Blood glucose**
- **Other**

**Results and dates of pertinent studies (radiology, CT, MRI, nuclear scans, etc.) (may attach):**

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<tr>
<th>1</th>
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<th>3</th>
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</thead>
<tbody>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
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</tbody>
</table>

**Allergies:**

- Medication: Reaction:
- Medication: Reaction:
- Foods: Reaction:
- Other: Reaction:

**Admission weight:** Discharge weight:
<table>
<thead>
<tr>
<th>TABLE 6 (continued)</th>
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<tbody>
<tr>
<td>AMDA Universal Transfer Form</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>I. Advance directives:</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>CPR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Artificial Nutrition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>J. Has patient had a recent fall?</th>
<th>Yes</th>
<th>No</th>
<th>Did the patient wander unsafe while hospitalized?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>K. Comments on inpatient course (may attach narrative)</th>
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<table>
<thead>
<tr>
<th>L. Is the patient aware of his/her diagnosis(es)?</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>If not, why?</td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>M. Patient's cognitive status for decision-making:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
</tr>
<tr>
<td>Modified independence (some difficulty in new situations)</td>
</tr>
<tr>
<td>Moderately impaired (decisions poor)</td>
</tr>
<tr>
<td>Severely impaired (never makes decisions)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>N. Is the patient a candidate for rehabilitation therapy?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, state goals for rehabilitation:</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>O. Discharge medication orders:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dose</td>
</tr>
<tr>
<td>2. Dose</td>
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<tr>
<td>3. Dose</td>
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<td>5. Dose</td>
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<td>6. Dose</td>
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TRANSITIONS OF CARE IN THE LONG TERM CARE CONTINUUM
<table>
<thead>
<tr>
<th>TABLE 6 (continued)</th>
<th>AMDA Universal Transfer Form</th>
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<tbody>
<tr>
<td>Date</td>
<td>Route</td>
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<td>11</td>
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</table>

P. Date: ___________________________

O. Immunizations:
   Influenza: Date: __________   Pneumococcal: Date: __________
   Varicella: Date: __________   Tetanus: Date: __________
   PPD: Date: __________   Rif: Date: __________

R. Additional orders:
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

S. Follow-up on consultants/procedures recommended:
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

T. Is patient the primary decision maker? Yes ___ No ___
   If no, name of the substitute or surrogate:
   __________________________________________

Name of physician designee completing form:
   __________________________________________
   Contact phone number: ___________________
   Date form completed: __/__/____

Name of Primary Care Physician:
   __________________________________________
   Contact phone number: ___________________
   Extension or Beeper: ____________________
### Table 7

**Recommended Elements of a Discharge or Course-of-Treatment Summary**

- Reason for course of treatment (i.e., disease process)
- Near diagnoses arising during course of treatment
- Surgery or other procedures performed during course of treatment
- Consultants utilized during course of treatment
- Complications encountered during course of treatment (e.g., falls, nosocomial infections, patient harm)
- Changes from pre-admission baseline (e.g., change in ability to communicate, cognitive issues, functional decline)
- Treatment goals and advance directives discussed with patient/family
- Anticipated treatment goals at time of transition
  - Return to previous site of living vs. stay at a level of care different from preadmission status
  - Total recovery vs. partial recovery vs. recovery not likely (i.e., rehabilitation potential)
  - Palliative care/hospice
- Test results pending at time of transition (e.g., biopsies, lab tests, radiology studies)
- Next steps planned in patient’s care plan, with specifics as to why and when and which practitioner(s) need to be involved

### Table 8

**Practitioner Request for Notification of Medication Changes**

Dear Receiving Physician,

I am the practitioner for [name of patient].

Before discontinuing or changing the following medications, please contact me.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Notes</th>
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Dr. ___________________________

Facility _______________________

Phone _________________________

Pager _________________________

Your cooperation is greatly appreciated.
**Resident Transfer Form**

**Name of Nursing Home**

**Address**

**Date of Transfer** to the Emergency Room  

**Print only and answer each question.** Please do not leave any blank. Blank areas may be completed prior to the date of the emergency and hospitalization.

**Resident’s Last Name**

**First Name**

**MI**

**Sex**

**Date of Birth**

**Name of unit/floor resident transferring from**

**Phone No. of unit/floor**

**Unit Fax No.**

**Attending Physician**

**Dr. Orders**

**Advance Directive sent**

**Yes**

**No**

**Name/Resident’s name of kin/Health Care Power of attorney**

**Phone Number**

**Level of kin notified**

**Yes**

**No**

**Check (Present)**

**Physical**

**Intellectual**

**Impairments**

**Mental Status**

**Religion**

**Index**

**A**

**B**

**C**

**D**

**Checking boxes:**

- **Allergies**

- **Chief complaints (noted at the time of the emergency and hospitalization)**

- **Diagnosis**

- **Past Medical History**

**Lab or other tests ordered prior to transfer or within 24 hrs.**

**Yes**

**No**

**Final signs at the time of transfer**

**Transport via**

**Ambulance**

**Other**

**Signature of the Transfer Nurse**

**Print Name**

**Date of transfer**

**Time of transfer**

**EM Dr. Orders fax # (Cover letter required)**

**EM Orders signed**

**Last rev:** 1/1/92

**Resident Transfer Form**

**Note:** This form is required for all residents who are transferred to the ER. The form should be filled out completely.

**Transitions of Care in the Long Term Care Continuum**
References


Transitions of Care in the Long-Term Care Continuum

PRACTICE GUIDELINE

amda
Dedicated To Long Term Care Medicine