Transition Across the Continuum of Care

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Why is it important?

Who should be involved?

What do you need to make it seamless and positive for the resident?
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.

Hospital, Outpatient, Skilled, Hospice, Senior Day Care, ALF, Providers, ...
Why is this important?
Impact of Transitions

Hospital Readmissions, Medication Errors, and Adverse Events

- Transfers from nursing facilities constitute 8.5% of all Medicare admissions to acute-care hospitals; about 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.

- 1/5 of all Medicare beneficiaries discharged from the hospital are readmitted within 30 days,

- 90% of these readmissions are unplanned, and that the cost to Medicare of unplanned hospitalizations amounted to $17.4 billion in 2004.

- Patients with heart failure accounted for 26.9% of all readmissions within 30 days; patients with pneumonia, 20.9%.
The Centers for Medicare and Medicaid Services (CMS), in its proposed inpatient prospective payment system rule for fiscal year 2009, estimated that nearly 18% of Medicare patients are re-hospitalized within 30 days of discharge and that 13% of all readmissions—costing approximately $12 billion—are potentially avoidable.
“Triple Aim” of Health Care
Don Berwick, CMS 2008

1. Better care for individuals
   • Enhancing Quality
   • Enhancing the Patient Experience

2. Better health for populations
   • Systems
   • Data

3. Reducing costs
Focus on Quality of Care

- Hospital Pressures
  - Re-hospitalizations
  - Quality Measures

- NH Compare website
  - 5 star program
  - Post Acute Care (POC) is the second most costly site of health care

- PQRS for Physicians
  - Pay for Performance based on quality and cost measures

- We are being measured!
IMPACT Act

- Requires standardized patient assessment data for assessment and quality measures [QMs], quality of care, improved outcomes, discharge planning, interoperability, and care coordination
  - Use of standardized data across programs for SNF’s, Inpatient Rehab Facilities, LTAC, Home Health
  - Facilities to report data via the MDS by Oct. 1, 2018
  - HHAs have until Jan. 1, 2019
IMPACT Act

- Reporting on the following data categories:
  - Functional status;
  - Cognitive function and mental status;
  - Special services, treatments, and interventions;
  - Medical conditions and comorbidities;
  - Impairments; and
  - Other categories required by the Secretary of the U.S. Department of Health and Human Services.
Added Challenge

• Our residents are aging in place!
  • This is what residents desire

• Avoiding the “Institutional Transfers”
  • “Money Follows Person” Initiatives
Bundled Payments for Care Improvement (BPCI)

- Initiative from CMS
- Organizations enter into payment arrangements that include financial and performance accountability for episodes of care.
- These models may lead to higher quality, more coordinated care at a lower cost to Medicare.
Bundling Programs

4 Models of Care

1. Retrospective Hospital
2. Retrospective Hospital + PAC
3. Retrospective PAC
4. Prospective Hospital
BPCI Program

• Establish a target price
• Follow episodes of care
  – There are 48 different “episodes”
  – Triggered by hospital stay
• Followed for 30, 60, or 90 day period
  – All care during this time will be attributed to the convener
Bundled Services Include

- Physicians’ services
- Care by post-acute providers
- Related readmissions
- Other related Medicare Part B services included in the episode definition such as...
  - clinical laboratory services
  - durable medical equipment
  - prosthetics, orthotics and supplies
  - Part B drugs
Transitions of Care — Hospital Discharge

• A 2012 systematic review found that many types of interventions (including medication reconciliation, structured electronic discharge summaries, discharge planning, and facilitated communication between hospital and community providers) impacted favorably on outcomes including readmission rates

• What data do we have for other settings?
Risk Factors of Poor Transitions

• There is a “transition in place” … a trajectory of aging
  – Can only manage

• Several factors that increase the likelihood of readmission may be modifiable, especially those that relate to clinician or system level issues.

• Such factors include:
  – Premature discharge or inadequate post-discharge support
  – Insufficient follow-up
  – Therapeutic errors
  – Adverse drug events and other medication related issues
  – Failed handoffs
  – Complications following procedures
  – Nosocomial infections, pressure ulcers, and patient falls.
We each have wonderful opportunity to make changes and improve quality and the patient experience!
Two Sided Conversation

Quality of Care vs Cost of Care
  – PAC Length of Stay
  – Hospitalizations
  – Other costs
  – Follow up/Transitions

• Similar goals to Accountable Care Organizations (ACOs)
Where do we go from here?
Who leads the initiatives in your organization
Who Should Be Involved?

Leadership
Management
In Addition... Identify those who will manage the transitions in your organization

- Admissions Coordinators
- Social Workers
- Nursing
- Therapy Providers
- Medical Directors
- Administration – billing
- Insurance companies (Case managers, Bundling programs, etc)
How do we pull it all together?
Process
Focused Initiatives

Main initiatives:

• Medication management and reconciliation
  • Make it easy to follow
  • Legible
  • CORRECT!!

• A patient-centered record owned and maintained by the patient to facilitate cross-site information transfer

• Advanced Care Directives
  • MOST Forms
  • Golden Rods

• Timely follow-up with primary or specialty care

• A list of “red flags” indicative of a worsening condition and instructions on how to respond to them.
If a nursing home resident is transferred to an ED, the nursing home should provide the following written information in the transfer paperwork:

- Reason for transfer
- Resuscitation status
- Medication allergies
- Contact information for the nursing home, primary care or on-call physician, and the resident’s legal health care representative or closest family member
- Medication list.
- If a nursing home provider requests that specific tests be performed in the ED, the emergency physician should document performance of the requested tests (or document in the medical record why the tests were not performed).
Facility Post-Transition Checklists

Planned Patient Transfer to Another Facility or Level of Care

1. Ensure that patient’s PCP or other medical point of contact has been notified of the following:
   - That the patient has been discharged
   - Name and contact information of attending practitioner in the LTCC facility who may be contacted if the PCP considers this appropriate
   - Name and contact information for a facility staff member that the PCP may contact for further information

2. Advise the patient/family and receiving facility that the facility is willing and able to send information to the patient’s new caregivers

3. Provide contact information for the person at the sending facility who can provide this information

4. Call both the receiving facility and the patient/family 24 hours after transfer to confirm the patient’s arrival at the new facility and obtain closure of any unresolved questions or issues.

Document the call to the medical point of contact in the patient record, noting the date, time, and a summary of the information exchanged.
Discharges
What do we need to do while they are here?

Day 1-3 of stay
• Evaluate what knowledge and resources that patients and primary caregivers will need to continue care at home.

Day 4-5 of stay
• Plan and evaluate community service needs and prepare patients and/or primary caregivers to return home.

Day 6-8+ of stay
• Create a Transition Plan: Discover knowledge and resources that patients and/or primary caregivers will need to safely continue care at home.

Post Discharge
• Call the Patient at Home: Follow-up call to reinforce the transition plan with the patient and/or primary caregiver.
Discharge Planning Process

Resident Name: __________________________________________ Phone: ______________
Family/Caregiver: _______________________________________ Phone: ______________
Follow-up MD/ NP/PA: _____________________________________ Phone: ______________
Community Provider(s): ___________________________________ Phone: ______________

Care Team:
Physician __________________________________________________
Nurse(s) ___________________________________________________
SW _________________________________________________________
PT(s) _______________________________________________________
OT(s) _______________________________________________________
Other(s) ___________________________________________________

Dates:
Estimated Day of Discharge ___/___/____
Scheduled Family/Caregiver Meeting ___/___/____
Home Health or other community provider arranged ___/___/____
Provider of services: _________________________________ Services needed: PT, OT, RN, CNA, SW
DME needs arranged ___/___/____
DME Supplier: __________________________________________
PCP follow-up scheduled ___/___/____ Appt Date: _____________________________
Patient Discharged ___/___/____
24 hour post discharge call ___/___/____
72 hour post discharge call ___/___/____
Essential Information That Should Accompany Every Transitioning Patient

- Patient name
- Primary diagnosis for admission to sending facility
- Accurate medication list with prescription and non-prescription drugs, with doses and frequency
  - The patient’s medication administration record could serve as the medication list.
- Allergies and medication intolerances
- Vital signs
- Copies of advance directives including MOST/CODE status and desired interventions

Name and specific contact information for:
- Sending facility (including phone number of facility/wing of facility and nurse name)
  - Responsible practitioner at sending and receiving sites of care
  - Responsible family member/decision-maker
- Cognitive issues that impair decision-making; who should be contacted for decision-making
- Reason for transfer (i.e., the acute change in condition or problem precipitating the transfer) along with any acute changes from baseline associated with this transfer (e.g., confusion, unable to walk, unresponsive)
- Medical devices, lines (e.g., central line, dialysis site, pacemaker) or wounds
- Significant test results
- Tests with results pending, consults or procedures ordered but not yet performed
- Prognosis and goals of care
- Follow-up information with outside providers that have been arranged
Medication review, is the process of verifying patient medication lists at a point-of-care transition, such as hospital discharge

- Identify which medications have been added, discontinued, or changed relative to pre-admission medication lists.

- Performing an accurate medication reconciliation is a critical element of a successful discharge transition.
  - Opportunity to ensure that patients understand what medications they are taking, how to take them, and why they are taking them.
  - Make it legible and easy to follow and understand
Facility Post-Transition Checklists

Planned Patient Transfer to a Community Home

1. Ensure that patient’s PCP or other medical point of contact has been notified of the following:
   • That the patient has been discharged
   • When the patient has been advised to arrange a follow-up appointment
   • What information about the patient has been sent to the PCP, when, and how
   • Name and contact information for a facility staff member that the PCP may contact for further information

2. Call the patient/family 24-48 h after discharge for follow-up with the following:
   • Confirm that previously arranged support services (e.g., home health care, Meals on Wheels) have made contact and initiated services. If not, provide contact information for these services to the patient/family
   • Verify that the patient/family has kept previously made appointments
   • Verify that the patient/family understands the next steps in the patient’s care

3. Document all of the above contacts in the patient’s record, noting the date, time, and a summary of the information exchanged.
Telephone Calls

• These calls have been initiated by various members of the care team, including:
  – The discharging clinician or facility
  – A clinical pharmacist
  – A clinician from the patient's primary care clinic
  – Therapists

• Such calls have been effective at reducing emergency department visits and improving follow-up with ambulatory providers.
Telephone Call — Take Home Message

• From Discharging Facility
  – Same day as discharge
  – Repeat call in 48-72 hours
  – Ask specific questions

• Goals…
  – Prompt follow up with PCP
  – Identification of worsening or new conditions
  – Medication reconciliation
  – Caregiver ability evaluation
  – Reducing re-hospitalization
Quality Improvement

What do you do when a discharge doesn’t go as planned??

• Collect and Report Quality Measures
  – Part of a QA Process
    • Results of Discharges
    • Diabetic Management
    • Medication Errors
    • Root Cause Analysis
Emerging strategies
Home Visits

• Home visits made by a number of different types of providers have been shown to reduce readmission.

• One trial illustrated that a single home visit by a nurse and pharmacist to patients discharged with a diagnosis of heart failure, with a goal of optimizing medication management, showed a trend towards almost a 50 percent reduced risk of unplanned readmission.
Home Visits – Take Home Message

• More effective than telephone call alone
• Who should do the visit, RN/LPN/APN?

• Goals…
  – Ensuring prompt follow up with PCP attended
  – Identification of worsening or new conditions
  – Medication reconciliation
  – Caregiver assessment
Telemonitoring

• Use of telemonitoring devices have also been studied as a means for reducing readmissions.
  – As an example, using an integrated telephonic stethoscope in conjunction with follow-up nursing calls in patients with heart failure reduced emergency department visits in one small study, and demonstrated a trend toward reduced readmissions and overall costs.

• Devices for remotely monitoring various physiologic variables, including blood pressure, heart rate, weight, and oxygen saturation have been repeatedly studied, mostly among heart failure patients, and have demonstrated effectiveness in reducing need for readmission.
Effectiveness likely limited to particular diagnoses (ex. CHF, COPD)

 Likely requires home visit to manage technology in older adults
Transition Coach

• A study evaluated the Care Transitions Intervention (CTI) program in which older patients were paired with a discharge nurse transition coach.

• The coach encouraged the patient to maintain a personal health record, obtain timely follow-up appointments, provide self-care, and understand what to do if problems arise.

• The transition coach saw the patient before discharge and at home two to three days after discharge, followed by three telephone calls over the first 28 days post discharge.
  
  – This intervention reduced 30 and 90 day readmission rates (8.3 versus 11.9 percent and 16.7 versus 22.5 percent, respectively) with a cost savings of approximately $500/case.
Focus on self management/self care
  “What would you do if...?”
    Access to prompt assistance
  Maintain records
    Community Clinic in a CCRC
  Challenge for cognitively impaired residents that are aging in place.

Encourage Prompt follow up with PCP

Medication Reconciliation
A randomized trial in 239 elderly patients with heart failure compared assigned advanced practice nurses with usual care.

The designated transitional care partner met with the patient daily during the index visit, made a home visit the day after discharge and at least weekly thereafter over the first three months.

At one year, there were 104 readmissions among intervention patients, compared with 162 readmissions for control patients, resulting in a cost savings of $4845 per patient.
Advanced Practice Nurses
— Take Home Message

- Create a visit schedule post transition
- Involved Home Visit within 24 hours of discharge
- Determine regular follow up
“Virtual Care”

• Care Coordination plus Usual Care
  – Limited efficacy in a recent study
• It is what residents expect…
  – Telephone Calls
  – Nurse Visits
  – On site clinic
  – Prompt access to PCP
Conclusions

• Importance of accountability within team members

• Need process and procedures to maintain consistency
  – Adopt a systematic approach for each assessment
  – A standardized checklist should be used during each visit to ensure no areas of concern are missed.

• Improved communication

• Collect your own data
Conclusions

• Creating a good process with follow-up
• Telephone contact post discharge
• Home Visits within 24 hours
• Prompt follow up with PCP
• Medication Reconciliation
• Identifying patient desires for care
  – MOST forms, Advanced Directives
• Team Approach
Evidence-Based Models of Transitional Care

Care Transitions Intervention
http://www.caretransitions.org

Guided Care
http://www.guidedcare.org/

Project RED (Re-Engineered Discharge)
http://www.bu.edu/fammed/projectred/index.html

INTERACT
www.interact2.net

AMDA
www.amda.com

National Patient Safety Goals
http://www.jointcommission.org/patientsafety/nationalpatientsafetygoals/

Project BOOST (Better Outcomes for Older adults through Safe Transitions)
Society of Hospital Medicine
http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm
Family and Resident Resources

National Family Caregivers Association
http://www.nfcacares.org

Next Step in Care
http://www.nextstepincare.org/

National Transitions of Care Coalition
http://www.ntocc.org/

Taking Care of MY Health Care
http://www.ntocc.org/Portals/0/Taking_Care_Of_My_Health_Care.pdf

My Medicine List
http://www.ntocc.org/Home/Consumers/WWS_C_Tools.aspx
References


Impact Act -
The IMPACT Act is available online at: www.gpo.gov/fdsys/pkg/BILLS-113hr4994enr/pdf/BILLS-113hr4994enr.pdf


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Speakers

Dr. Herman received his medical degree from the Medical College of Georgia in 1993 and completed his Internal Medicine Residency in 1996 and later a Fellowship in Geriatric Medicine at Wake Forest University in 1997. Dr. Herman is Board Certified in Hospice and Palliative Care Medicine, and holds a Certificate of Added Qualification in Geriatric Medicine, and is a Certified Medical Director. He has served as the President of the North Carolina Medical Directors’ Association and is currently the President of Physicians Eldercare. Dr. Herman has a specific interest in long term care, post-acute care medicine, and hospice and palliative care. He also enjoys many outdoor activities. Dr. Herman, his wife, and three children reside in the Triad area.

Background: Bachelor’s Degree in Business Management, Wingate University (1999); Registered Nurse, Stanly Community College (2004); Masters in Nursing (Family Nurse Practitioner), University of North Carolina at Charlotte (2010)

My goal is to provide compassionate care to the geriatric population in the long term care environment. I have a personal interest in long term care, acute rehabilitation, and patient education.

In healthcare management, I work to assist facilities with process development, performance improvement, and evaluating the financial decisions to optimize patient care and maximize facility reimbursement. With a history in acute care, long-term care, and hospice, I am able to assist my clients in development of care needs across the continuum and transitions of care. I currently serve as a Family Nurse Practitioner and Strategic Account Manager for Physicians Eldercare.

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