

# Transitions in Care in Older Adults

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May 11, 2018

# Objective

Upon completion of this presentation, attendees will be able to:

- Explain the true cost of poor transitions
- Describe elements of a successful transition in care
- Relate outcomes associated with transitional care models
- Identify steps in medication reconciliation that may be conducted in the primary care setting to reduce the risk of medication associated adverse events

# What are care transitions?

Transitions of Care encompass...

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

The National Transitions of Care Coalition (2008)

# Unique Transition Patterns

Approximately 40% of older adults experience  $\geq 2$  transitions within 30 days of hospital discharge

In a national study: 22% of Medicare beneficiaries experienced a transition in care

- 50% — single hospitalization, with return to original residence
- 50% — complex sequence of multiple transitions
- Few predominant transition patterns were present

(GNRS<sub>5</sub>, AGS, 2016)

Preventable transitions back to hospitals within 30 days

A target for improvement by CMS

- May indicate poor quality of care (within the discharging hospital or post acute care setting)
- Unnecessarily burden patients and their families (AHRQ, 2012; NCQA, 2012)
- Costly!

# Unnecessary Hospital 30-Day Readmission Rates

## *Financial Costs of Unplanned Rehospitalizations*

- Medicare estimates \$15 billion/year
- Increased out-of-pocket costs to patients and families (e.g., co-pays, deductibles, co-insurance)

## *Patient Costs*

- Increased burden to patient and family
- Emotional stress
- Increased risk of iatrogenic complications
- Loss of function
- Increased morbidity and mortality in the elderly

(AHRQ, 2012; NCQA, 2012)

# Transitions and Patient Safety

## *Poor care transitions can result in:*

- Medication errors
- Delayed diagnoses
- Undesired duplication of services
- Low patient (and provider) satisfaction

(GNRS<sub>5</sub>, AGS, 2016)

# Root Causes of Poor Transitions in Care

According to the Joint Commission (n.d.), common issues are noted to be at the core of poor transitions in care

## ***1. Communication Breakdown***

Information may not be effectively or completely given or received by the patient or team in a timely manner

### Risk factors for poor communication:

- Variable expectations between persons involved
- A culture that does not support/promote successful communication (or hand-offs)
- Time constraints
- Lack of a standardized communication procedure



## ***2. Patient Education Breakdown***

Patients and/or family/caregivers unclear on instructions, recommendations, or absent from relevant conversations

Patients unable to understand or retain information in order to share with supportive family/caregivers

Lack of buy-in into a plan of care

## ***3. Accountability Breakdown***

Responsibility unclear, especially if multiple providers

(The Joint Commission, n.d.)

# Patient Risk Factors for Poor Transitions

- $\leq$  High school education
- $\geq 1$  ADL deficit without assistance
- Limited self-management ability
- Low health self-rating
- Living alone
- Transition to home with home-care services
- Prior hospitalizations
- Long hospital length of stay
- Low income, homeless, or Medicaid-eligible
- Older age ( $>80$ )
- Five or more comorbidities
- History of depression, CVD, diabetes mellitus, cancer, or substance abuse

(GNRS5, AGS, 2016)

## Core Components of Transition of Care Models

1. Multidisciplinary communication, collaboration and coordination – including patient/caregiver education – from admission through transition
2. Clinician involvement and shared accountability during all points of transition
3. Comprehensive planning and risk assessment throughout hospital stay
4. Standardized transition plans, procedures and forms
5. Standardized training
6. Timely follow-up, support and coordination after the patient leaves a care setting
7. If a patient is readmitted within 30 days, plans to gain an understanding of why
8. Methods to evaluate and track readmissions

The Joint Commission (n.d.)

# Incentives to Improve Transitions

A high priority under the Affordable Care Act

Medicolegal concerns

- Hospital health care providers have a duty to the patient to assure care until the transition is complete, including follow-up of pending tests, incidental findings, and medical treatments started in the hospital
- The primary care provider has a duty to the patient to obtain hospital records, if not received, and ensure proper follow-up once the care transition is complete

(GNRS<sub>5</sub>, AGS, 2016)

# Penalties

## Hospital Readmission Reduction Program (CMS, 2012)

- Reduced payments to hospitals with 30-day readmission rates above a calculated readmission ratio for select conditions

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html>

# Penalties

Value-based purchasing program (skilled nursing facilities)

- Reduced Medicare reimbursement starting in 2018 if all-cause 30-day hospital readmission rate exceeds a benchmark
- The Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measure (SNFPPR) estimates risk-standardized rate of unexpected, potentially preventable readmissions (PPRs) within 30 days

(CMS, n.d.)

# Transitional Care Models Examples

## 1. Re-Engineered Discharge (RED)

A hospital to home program developed by the Boston University Medical Center

<https://www.bu.edu/fammed/projectred/>

- Decrease 30-day hospital readmissions rates 25%
- Decrease ED use to 16% (from 24%)
- Improve “readiness for discharge”
- Improve follow-up in primary care
- Reduce patient care costs
- Improve patient and family satisfaction scores

(AHRQ, n.d.)

## 2. Interventions to Reduce Acute Care Transfers (INTERACT®)

A long-term-care facility (and recently ALF) to hospital program developed through a CMS Innovations grant at Florida Atlantic University

<http://www.pathway-interact.com>

- Average 17% reduction in readmission rates
- Average Medicare cost savings of \$125,00/year/100 bed facility
- Missouri Quality Initiative (MOQI) demonstrated a sustained 30% reduction in all-cause readmission rates over 3 years with a FT embedded ARNP and INTERACT® program
- Reduced readmission rates in PAC 35.2% in 6 weeks using INTERACT® and an interprofessional transfer triage protocol

(Patel, Wright & Hay, 2017; Rantz, et al., 2017 Ouslander, et al., 2011)



### 3. Better Outcomes by Optimizing Safe Transitions (BOOST)

Society of Hospital Medicine mentors hospital team members to improve processes and action plans to improve transitions from hospital to home

[http://www.hospitalmedicine.org/Web/Quality\\_Innovation/SHM\\_Signature\\_Programs/Mentored\\_Implementation/Web/Quality\\_Innovation/Mentored\\_Implementation/Project\\_BOOST/Project\\_BOOST.aspx](http://www.hospitalmedicine.org/Web/Quality_Innovation/SHM_Signature_Programs/Mentored_Implementation/Web/Quality_Innovation/Mentored_Implementation/Project_BOOST/Project_BOOST.aspx)

- 11-hospitals in semi-controlled pre-post study with 12.7% readmission rate after 12 months (decrease from 14.7%); 2% mean absolute reduction in readmission rates compared to control

(Hansen, Greenwald, et al., 2015)

#### 4. Care Transitions Intervention (CTI)

Program focus on older patients living in the community admitted to hospitals with complex needs

Utilizes a transitions coach and advanced practice RN (APRN)

- Reduces 30-day readmissions rates from 11.9% to 8.3%
- Reduces 90-day readmission rates from 22.5% to 16.7%
- Lowers mean hospital costs at 180 days

(Coleman, Parry, Chalmers & Min, 2006)

## 5. **Guided Care Model (GCM)**

Program for the care of older adults (age 65 or older) with complex care; Utilizes a guided care nurse (RN) to assist with coordination

- 29% reduction in home health care utilization rates
- No change in hospital readmission rates

(Boult et al., 2013)

## 6. Geriatric Resources for Assessment and Care of Elders (GRACE)

Program for older ambulatory adults with complex care needs. Utilizes a support team including APRN and LCSW

- Lower 2-year cumulative ED visit rate (14445 from 1748 per 10000)
- No differences in hospitalization rates
- High-risk group with lower mean 3<sup>rd</sup> year costs (\$5,088 compared to \$6,575); higher mean 2-year costs

(Counsel, et al., 2007; Counsell, et al., 2009)

# Naylor's Transitional Care Model (TCM)

## **7 . *The Transitional Care Model (TCM)***

Developed by Dr. Mary Naylor and colleagues at the University of Pennsylvania in 1994

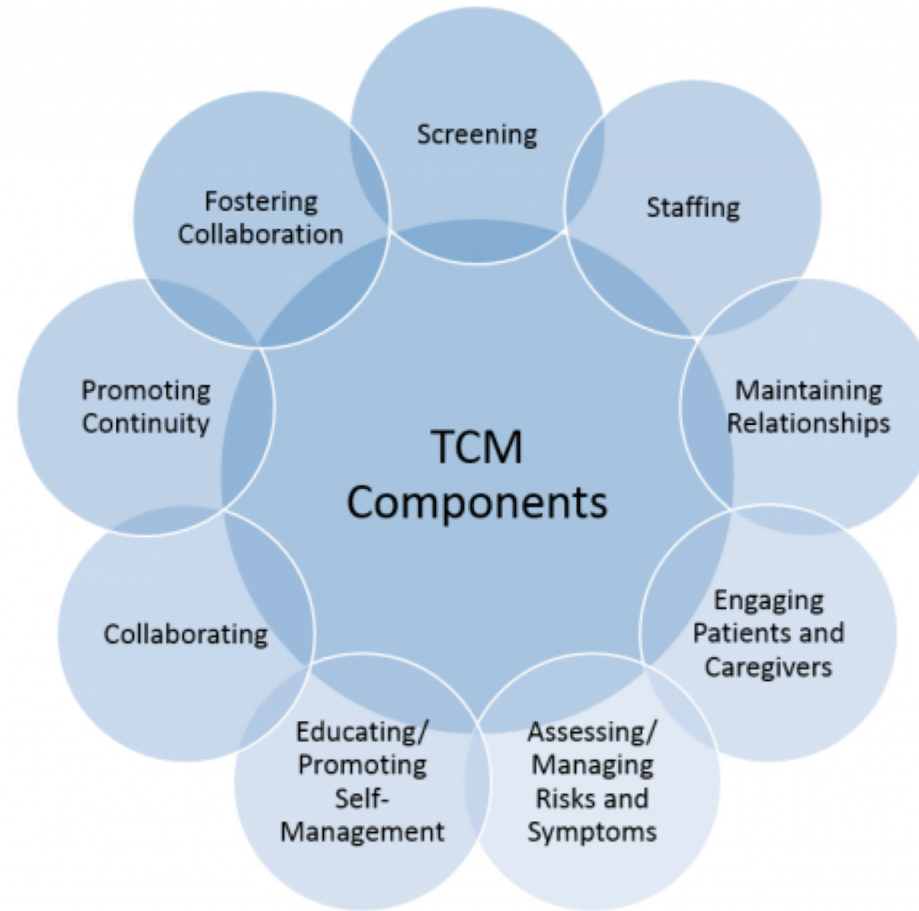
### ***Primary goal***

- Break cycles of repeated, avoidable hospitalizations

## *Elements*

- APRN evaluates patient in the hospital to develop a transition plan
- APRN directs services through home visits and telephone contact
- Initial visit within 24 hours of discharge, then weekly x1 month, then semi-monthly for the duration of the service
- Phone support upon discharge, weekly when not seen for home visit, and ongoing availability including nights and weekends
- APRN attends first post-hospital office visit with patient at PCP office and maintains regular contact and updates

# 9 Components of the TCM



Learn more at NewCourtland Center for Transitions and Health

<https://www.nursing.upenn.edu/ncth/transitional-care-model/about-the-tcm/>

TCM studies often focus on patients with  $\geq 2$  risk factors for readmission

- recent hospital admissions
- multiple chronic conditions
- multiple medications (polypharmacy)
- poor self-health ratings



# TCM Outcomes

1. Reduction in all-cause hospital readmissions through 1 year; increased length of time between readmissions when they do occur
2. Improved health outcomes (physical health, functional status, and quality of life) after discharge
3. Increased patient and caregiver satisfaction with care and possible lower burden of care
4. Mean savings for an HMO was \$2,170-4,000 per member annually
5. Patients in a PCMH plus TCM intervention demonstrated a longer time to first rehospitalization or death than those receiving PCMH only.

Downside: Costly, therefore, best employed with high risk patients.

(Naylor & Sochalski, 2010; Hirschman, et al. 2015)

## Other considerations

### *Where Do Transitions in Care Begin?*

#### High-risk Patient Identification

- Financially Focused Predictive Models
- External Models with interoperability
- Proprietary Predictive Models
  
- Clinically focused predictive models
  - Charlson comorbidity index and readmission-prediction model
  - Risk-adjustment model for hospital length of stay
  - LACE Score
  - HOSPITAL score

(Association of American Medical Colleges & National Association of Accountable Care Organizations, 2016)

## *HOSPITAL Score*

Focuses on potentially avoidable readmissions; not all-cause

- Validated in 4 countries with over 117,00 patients
- A computerized algorithm evaluates 7 variables:
  1. Low Hgb at discharge (<12 g/dL)
  2. Discharge from an Oncology service
  3. Low sodium at discharge (<135 mEq/dL)
  4. Procedure during hospital stay
  5. Urgent/emergent admission
  6. Number of hospital admissions
  7. Length of stay ( $\geq 5$  days)

(Donzé, Williams, Robinson, et al., 2016)

# Medication Reconciliation

## ***Medication errors***

- A major contributor to sentinel events reported to the Joint Commission
- Include errors of omission or commission
- Poor communication during care transitions can negatively impact medication adherence and safe administration, contributing to both types of errors

## ***Medication Reconciliation***

- A formal, standardized process for compiling, recording, and communicating medication information between patients and providers

(Joint Commission, 2010).

# A Quality Measure

## *Medication Reconciliation*

A measure within Meaningful Use, and NCQA's Health Information Data Information Set (HEDIS)

Requires:

- Review of an accurate list of all medications including: name, dosage, frequency, and route
- Compare of medical record to external list of medications (from patient, hospital, or other provider)

Expected to be completed at transitions in care, following the addition of a new medication, or upon return after long gaps between visits

# Conducting Medication Reconciliation

## *3 Steps to Conducting Medication Reconciliation*

1. Verify an accurate medication history
2. Clarify the right medications are prescribed for the right conditions at the right dose by the right route
3. Reconcile by squaring lists

Institute for Healthcare Improvement (n.d.)

## Tips for Medication Reconciliation in Primary Care

- Request hospital records prior to patient visit
- Ask ALL patients to carry a list of medications
- Ask select patients to bring in ALL medications to EVERY appointment
- Check medication bottles
- Update records
- Simplify
- De-prescribe
- Use teach back

# Provider Considerations

## *Considerations for Physicians, APRNs and PAs to improve transitions in care from hospital settings*

1. Determine the appropriateness of discharge
2. Determine the site of care post-discharge  
If discharge to home, consider if the patient can:
  - Obtain/self-administer medications
  - Perform self-care
  - Manage nutritional needs
  - Follow-up with providers

### If discharge to a facility

- Consider appropriateness relevant to each setting (In-Patient Rehabilitation, Long-term Acute Care Hospital, Skilled-Nursing Facility, Home Care)



3. Discharge planning with team
4. Provide a timely discharge summary
  - Outcomes of hospitalization with diagnostic results
  - Disposition
  - Follow-up within 3 days of discharge  
(Out-patient provider/ Primary Care Provider)
5. Complete patient, family/caregiver education
  - Teach back
  - Medications
  - What to do, who to contact if issues arise
6. Consider personally connecting with the receiving facility/provider
7. Complete discharge checklist

(Alper, O'Malley & Greenwald, 2017)

# Summary

- Care transitions are inevitable
- A time of increased risk for medical errors
- Improvement prioritized by CMS and the Joint Commission
- Incentives and penalties are currently in place to promote improvement of relevant care processes

Interprofessional teams (esp. with APRNs) are in key position to improve patient outcomes during transitions

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