Transitional Care

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Disclosure

I have no potential conflicts of interests to report pertaining to this lecture.

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Objectives

- Understand concepts of transitional care
- Identify reasons behind suboptimal TOC
- Describe examples of successful models

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Transitional Care

"care involved when a patient/client leaves one care setting...and moves to another."

"encompasses a broad range of services and environments designed to promote the safe and timely transfer of patients from levels of care or across settings, has emerged to bridge the gap between and among a diverse range of providers, services and settings"

"a set of actions designed to ensure the coordination and continuity of care received by patients as they transfer between different locations or levels of care."

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Transitions of Care

Hospital → Home

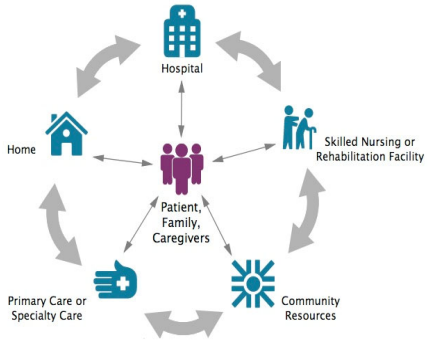
Hospital →SNF

SNF →Hospital

SNF → Home

ER → Med Surg

ICU → Med Surg



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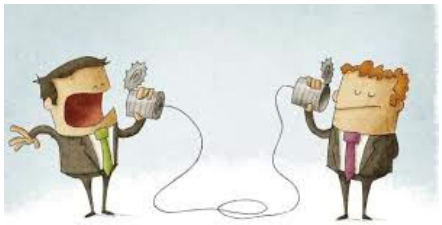
https://www.pcori.org/topics/transitional-care/about-transitional-care

Communication



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Risk

- Incomplete knowledge of patient's baseline function
- Poor communication across sites
- Incomplete transfer of information

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Risk

- Inadequate preparation of patients and their caregivers
- Limited access to essential services, financial/insurance coverage
- Absence of a single point person to ensure continuity

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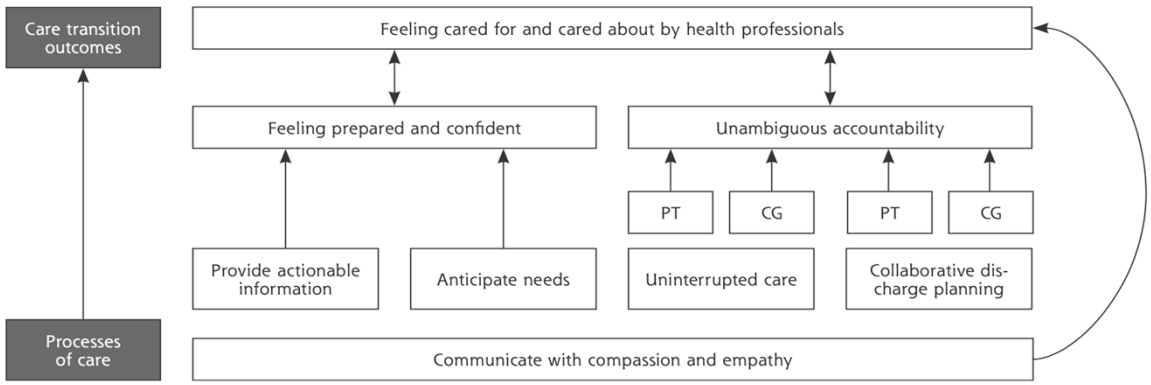
Care Transitions from the other side

Figure 1. Conceptual model of relationship between care transition outcomes desired by patients and caregivers and care transition services and provider behaviors across the care continuum.



PT = patient; CG = caregiver

(Mitchell, 2018)

A Vulnerable Time

- 2003 Forster et al: 20% of recently d/c'd medical pts had adverse event during first several weeks at home- 66% involved meds
- 2012 Foust et al: 71% of hospital d/c records of older adults with HF had at least one med reconciliation problem

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A Vulnerable Time

- 2010 Corbett et al: 94% of patients having at least one discrepancy with an average of 3.3 per patient during hospital to home

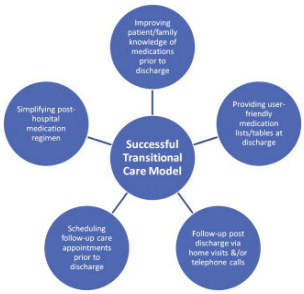

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Table 3.
Percent of Participants in the Intervention Group with Differing Medication Discrepancy Causes and Contributing Factors

Patient Level Medication Discrepancy Causes and Contributing Factors	Percent of Participants
Adverse drug reactions or side effects	17.8%
Intolerance	3%
Did not fill prescription	28.7%
Did not need prescription	7.9%
Money/financial barriers	1%
Intentional nonadherence	39.6%
Unintentional nonadherence	29.7%
Performance deficit	5.9%
System Level Medication Discrepancy Causes and Contributing Factors	
Prescribed with known allergies/intolerances	0%
Conflicting information from different informational sources	35.6%
Confusion between brand and generic names	5.9%
Discharge instructions incomplete/inaccurate/illegible	46.5%
Duplication	15.8%
Incorrect dosage	14.9%
Incorrect quantity	0%
Incorrect label	6.9%
Cognitive impairment not recognized	6.9%
No caregiver/need for assistance not recognized	4%
Sight/dexterity limitations not recognized	2%

Transitions of Care – Key Issues

- Inpatient-outpatient physician discontinuity
- Changes and discrepancies in medication regimen
- Self-care responsibilities and social support
- Ineffective physician-patient communication

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(Kripalani, 2007)

Post Acute Care – Readmit

Risk Factors for Readmission:

- Minority race/ethnicity
- Higher comorbidity score
- Recent admit (within 6 months)
- Cognitively/functionally impaired
- Primary dx of heart failure

- **12% within 4 days**
- **27.5% within 7 days**
- **49.5% within 2 weeks**

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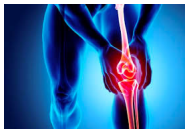
Burke, 2016

Takeaways:

High stress situation involving:

- Patient
- Family/Caregiver
- Providers



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Poor quality discharge leads to:

- Hospital readmissions
- Injury
- Poor patient and family satisfaction
- Undue Stress

Core Features of Transitional Care

- Comprehensive assessment of an individual's health goals and preferences
- Implementation of an evidenced based plan of transitional care
- Transitional care needs to be initiated at hospital admission…but extends beyond discharge through home visits and telephone follow-up

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Core Features of Transitional Care

- Mechanisms to gather and appropriately share information across sites of care
- Engagement of patient and family/caregivers in planning and executing the plan of care
- Coordinated services during and following the hospitalization by a health care professional with special preparation in care of the chronically ill

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FIGURE 1.
TRANSITIONAL CARE CORE COMPONENTS

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(Naylor, 2017)

In The Literature – TOC Clinic

$17 Billion per year

Fig. 1. TOC Intervention protocol flow chart. This flow chart is included to highlight the multidisciplinary nature of this TOC protocol.

Inpatient medication reconciliation and data compilation by the inpatient team

Table 2. This table compares the 30 day readmission and 90 day mortality rates for between patients following up in a hospitalist-led TOC clinic with those that did not follow up in a hospitalist-led TOC clinic.

	Readm 30D	No Readm 30D	Total	Percent 30 day readmission rate
TOC	33	340	373	8.85%
Non-TOC	153	847	1000	15.30%
Total	186	1187	1373	
	90D Mortality	**No 90D Mortality**	**Total**	**Percent 90 day mortality**
TOC	9	364	373	2.41%
No TOC	31	969	1000	3.10%
Total	40	1333	1373	

TOC face to face clinic visit was held within 14 days of discharge

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(Baldino, 2020)

The Ideal Transition in Care Framework

1.) Discharge planning
2.) Complete communication if information
3.) Availability , timeliness, clarity and organization of information
4.) Medication safety
5.) Educating patients to promote self management
6.) Enlisting help of social and community supports
7.) Advanced care planning
8.) Coordination care among team members
9.) Monitoring and managing symptoms after discharge
10.) Outpatient follow-up

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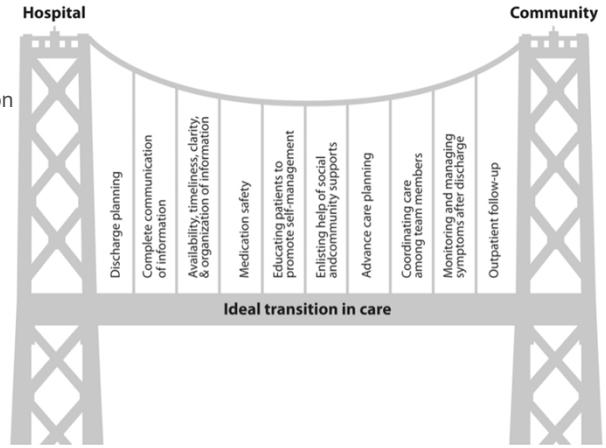
Figure



(Kripalani, 2014)

Model – Care Transitions Intervention (CTI)

20-50%
REDUCTION IN HOSPITAL READMISSIONS

$365K
NET SAVING PER TRANSITIONS COACH®

52%
PATIENTS MEETING OR EXCEEDING SELF-IDENTIFIED PERSONAL CARE GOALS

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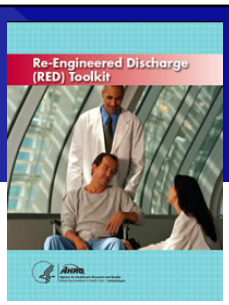
https://caretransitions.org/about-the-care-transitions-intervention/

AHRQ tool kit



Components of the RED

1. Ascertain need for and obtain language assistance.
2. Make appointments for followup care (e.g., medical appointments, postdischarge tests/labs).
3. Plan for the followup of results from tests or labs that are pending at discharge.
4. Organize postdischarge outpatient services and medical equipment.
5. Identify the correct medicines and a plan for the patient to obtain them.
6. Reconcile the discharge plan with national guidelines.
7. Teach a written discharge plan the patient can understand.
8. Educate the patient about his or her diagnosis and medicines.
9. Review with the patient what to do if a problem arises.
10. Assess the degree of the patient's understanding of the discharge plan.
11. Expedite transmission of the discharge summary to clinicians accepting care of the patient.
12. Provide telephone reinforcement of the discharge plan.

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https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html

Predictors

Table 1. HOSPITAL Score

Attribute	Points if Positive
Low hemoglobin at discharge (<12 g/dL)	1
Discharge from an Oncology service	2
Low sodium level at discharge (<135 mEq/L)	1
Procedure during hospital stay (ICD10 Coded)	1
Index admission type urgent or emergent	1
Number of hospital admissions during the previous year	
0-1	0
2-5	2
>5	5
Length of stay ≥ 5 days	2

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Table 2. LACE index

Attribute	Points if Positive
Length of stay	
Less than 1 day	0
1 day	1
2 days	2
3 days	3
4-6 days	4
7-13 days	5
≥ 14 days	7
Acute or emergent admission	3
Charlson comorbidity index score	
0	0
1	1
2	2
3	3
≥4	5
Visits to the emergency department in the previous 6 months	
0	0
1	1
2	2
3	3
≥4	4

T.F

Patient T.F
78 year old male living in the community, independently

He has 7 Physicians caring for him

- **1 PCP**
- **6 consulting**

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T.F

- **Problem list has 19 items**
- **PShx has 8 items**
- **Medications 33**
- **22 standing and 11 prn**

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The Good, The Bad, The Ugly

GOOD

BAD

UGLY

www.ntocc.org

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What can we do?

- Share
- Investigate
- Innovate
- Make transitional care better

Institute for Healthcare Improvement

http://www.ihi.org/Topics/Readmissions/Pages/default.aspx

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	LTAC	Acute Rehab (IRF)	Subacute	SNF	Home Health Care (HHC)	Hospice
Which Patients	Technology dependent: trach, vent, TPN, dialysis	Mostly CNS or neuro-muscular	Complex med or surg	Med or Surg	Homebound. PT or skilled nursing to open	MD referral for life expectancy ~ <6 mo. Any setting except rehab
Hospital Stay	Required	Not required	3 midnight unless waived by Medicare advantage plan. Excludes ED observation		Not required (can order from the office)	Not required. Forgo hospitalization while enrolled
Therapy	Not specified	3 hr 5d/wk	1.5 hr 5-6 d/wk	1 hr 5-6 d/wk	PT/OT 2-3/wk. SN 1/wk	None
Length of Stay	Aggregate > 25d	1-4 wks	Aggregate < 2wk	Avg 30d	Usually 1-8 wks	Varies by diagnosis
Medicare Part A	100%	100% (if show progress)	100% d1-20, then 80% d21 – 100 plus copay		No co-pay	100% (up to a cap amount) for team services, meds, DME
Physician Visits	Daily (hospitalists, pulmonologists)	Daily (mainly PM&R physicians)	Every 30d or as required by facility (usually 2-3 days) (primary care clinicians)		As outpatient, Face-to-face encounter w/in 90d prior to or 30d after start HHC	Can keep PCP. Office or home visits. Hospice MD also available.
Usually Excludes		Complex wounds	In-house dialysis, TPN, Vent, PCAs, continuous infusions		Unsafe environment	Not terminally ill
Approx cost range	$1500-3000/d	$1000-2000/d	$600-700/d	$150-400/d	$100-300/d	$100-800/d
Comment	Can have complex wounds		Unusual: Medicaid	Medicaid can provide copay	HHA 6 hr/wk. Can add SW, ST. Can have SN daily early.	Team approach; pain and symptom control. Does not cover facility room and board

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Additional Resources

Pod cast – Transitions of Care

https://www.jointcommission.org/resources/news-and-multimedia/podcasts/take-5-understanding-transitions-of-care/

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CARE TRANSITIONS MEASURE (CTM-3)

Patient Name: _____ Date: _____

1. The hospital staff took my preferences and those of my family or caregiver into account in deciding ***what*** my health care needs would be when I left the hospital.

Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know/ Don't Remember/ Not Applicable

2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know/ Don't Remember/ Not Applicable

3. When I left the hospital, I clearly understood the purpose for taking each of my medications.

Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know/ Don't Remember/ Not Applicable

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