Transitional Care: Bridging the Gaps of a Fragmented Health System

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80yo nursing home patient hospitalized for pneumonia. Found to have trouble swallowing -- placed on special diet.

Discharged back to nursing home.

Hospital discharge communication did not include any dietary information, so Ms. B was placed on a regular diet.

Ms. B rehospitalized 5 days later after choking, developing pneumonia.
30 Day Rehospitalizations: A Major Health System Problem

- Affect 1 in 5 hospitalized Medicare patients
- Account for over $17.4 billion annually
- Major target in health reform

Major Points

- Health system fragmentation contributes to rehospitalizations
- Education-based transitional care services decrease rehospitalizations in those going home
- Effective communication lies at the core of safe transitions, especially those to nursing homes
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The Problem:
Health System Fragmentation

- Hospital
- Primary Care
- Nursing Home
Contributors to Health System Fragmentation

- Organization of the health system into distinct, independent institutions ("silos")
- Lack of formal relationships/information systems between care settings
- Communication between settings is often poor
- Nursing home patients move frequently between care settings
- Transitional care given little emphasis in traditional clinical training programs

Difficult for Patients to Overcome Health System Fragmentation

- Patients are often not prepared for next setting
- Little patient empowerment in hospital
- Lack of patient education

* Coleman. JAGS. 2003;51: 549-555.*
Medication Discrepancy within 72 Hours of Hospital Discharge

- 18 Medications/patient, average (range 0-46)
- 2 Discrepancies/patient, average (range 0-9)

Care Transitions Can Be Dangerous

- 41% of patients have laboratory tests pending at time hospital discharge; primary care providers are unaware of 61% of these.

- Poor communication of care plans to primary care provider can lead to inappropriate, delayed care.

- Over half of rehospitalized patients do not see their outpatient provider between the time of discharge and rehospitalization.

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Mr. A’s Story

- 89yo hospitalized with allergic reaction to an antibiotic
- Original antibiotic stopped and discharged home on different antibiotic
- Rehospitalized after allergic reaction recurred
- Mr. A reported taking both antibiotics after discharge because staff told him to “be sure to finish your antibiotics”
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 in the same location.

* Coleman. JAGS. 2003*
Transitional Care Services Combat System Fragmentation

- Health care staff bridge the hospital and home
- Post-hospital home visits to teach patients about their care and conditions
- Decrease rehospitalizations by 30%
- Not for nursing home patients

*Naylor, JAMA, 1996; Coleman, Archives, 2005.*
Ms. B’s Story

- 80yo nursing home patient hospitalized for pneumonia. Rehospitalized after being placed on the wrong diet.
- Dementia
- Not a candidate for educational programs like transitional care services
Nursing Home Transitions: A System Solution Is Needed

- Nursing home patients can rarely advocate for themselves
- Often no family or caregiver to advocate for the patient during the transition
- Patient becomes completely reliant upon the system to ‘get it right’

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Hospital Discharge Summary

- Primary post-hospital communication tool
- Can dictate patient’s care for up to 30 days
- Care plans for nursing home patients are copied directly from the discharge summary
  - Medications
  - Diet
  - Activity
- Accreditation groups set minimal standards which most transitional care experts feel are inadequate
- Discharge summaries are often inadequate, slow to arrive at next setting of care

* Kripalani, JAMA, 2007; Dimant, JAMDA, 2003
Inclusion of Care Plans in Hospital Discharge Summaries

*Kind et al, JGIM, 2011
Focus groups of nursing home nurses:

- How do they transition care?

Themes:

- Information/communication from hospital is virtually always inadequate, inaccurate or incomplete
- Hospital providers are difficult to contact for clarification
- Makes it difficult for nursing home staff to adequately plan for the patient’s arrival
- Forces staff to take precious time away from patient care
- Leads to care delays, medication errors, rehospitalizations, staff/patient/family dissatisfaction – all perpetuating a negative image of nursing homes

* King, AGS Abstract, 2012.*
Efforts to Improve Discharge Communication

- The promise of information technology
- Advent of accountable care organizations
- Medicare penalties for rehospitalizations
 Overall Conclusions

- Health system fragmentation contributes to rehospitalizations.
- Education-based transitional care services decrease rehospitalizations in those going home.
- Effective communication lies at the core of safe transitions, especially those to nursing homes.
Policy Implications: What Should You Do?

- Ask your constituents about their care transitions experiences/stories
- Encourage patients to always have an advocate (family member/caregiver) accompany them before, during and after a care transition
- Have ADRCs actively reach out to support, educate families/patients trying to navigate our fragmented health system, especially after hospital discharge
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