Transitional Care: Bridging the Gaps of a Fragmented Health System

Amy J H Kind, MD, PhD

Assistant Professor, Division of Geriatrics

University of Wisconsin School of Medicine and Public Health

Madison VA GRECC

Ms. B's Story

- 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

[*] Jencks et al, *NEJM*, 2009. 360: 1418-28.

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

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

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

* Coleman. JAGS. 2003;51: 549-555; Ma et. Al. J Am Geriatr Soc 2002; 49(4):S35.

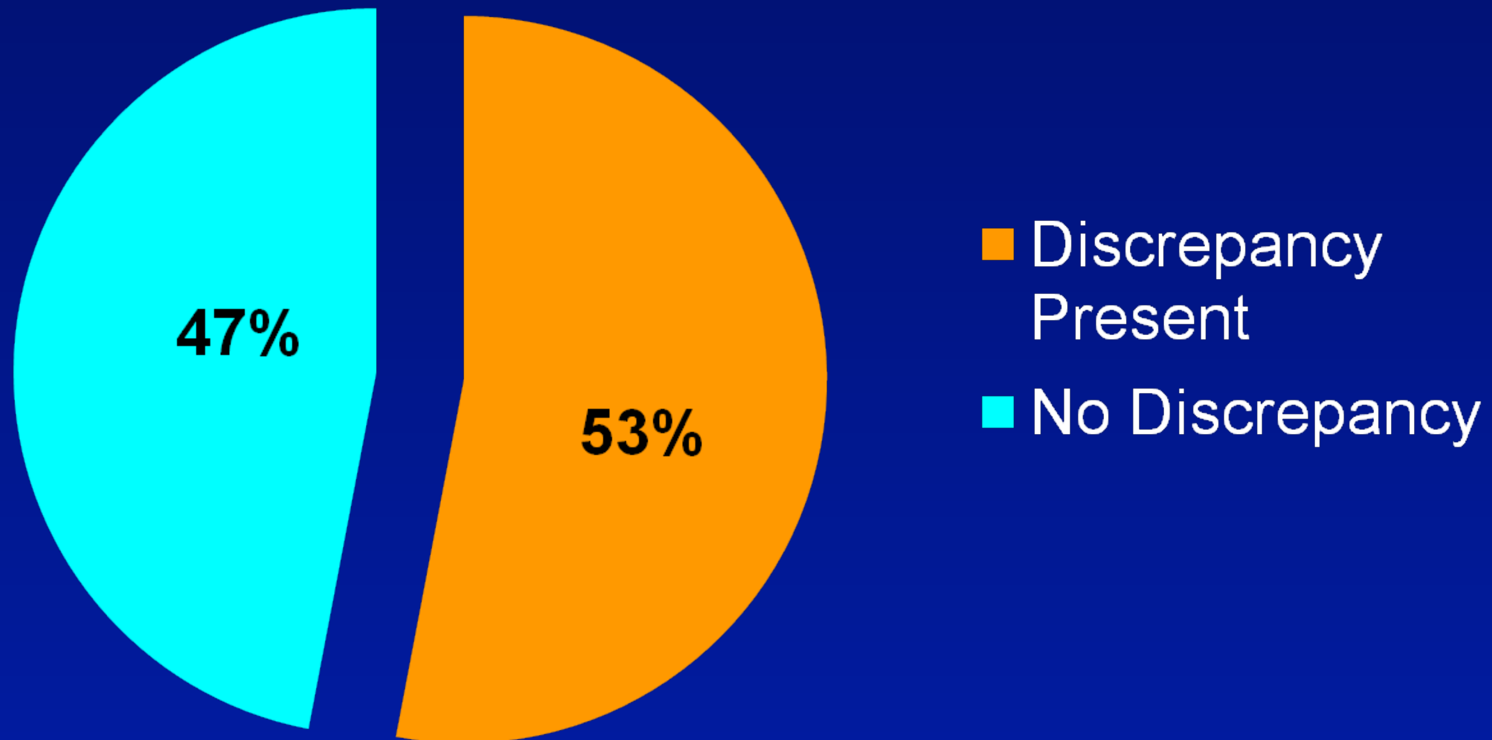
Difficult for Patients to Overcome Health System Fragmentation

- 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)

* Kind, AGS Abstract, 2012.

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

*Roy et.al, Ann Int Med, 2005; Moore et al, Arch Int Med, 2007.; Jencks, NEJM, 2009.

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

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 <u>both</u> 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'

* Deutsch, Am J PMR, 2002; Hickey, Int J Geri Psych, 1997

Major Points

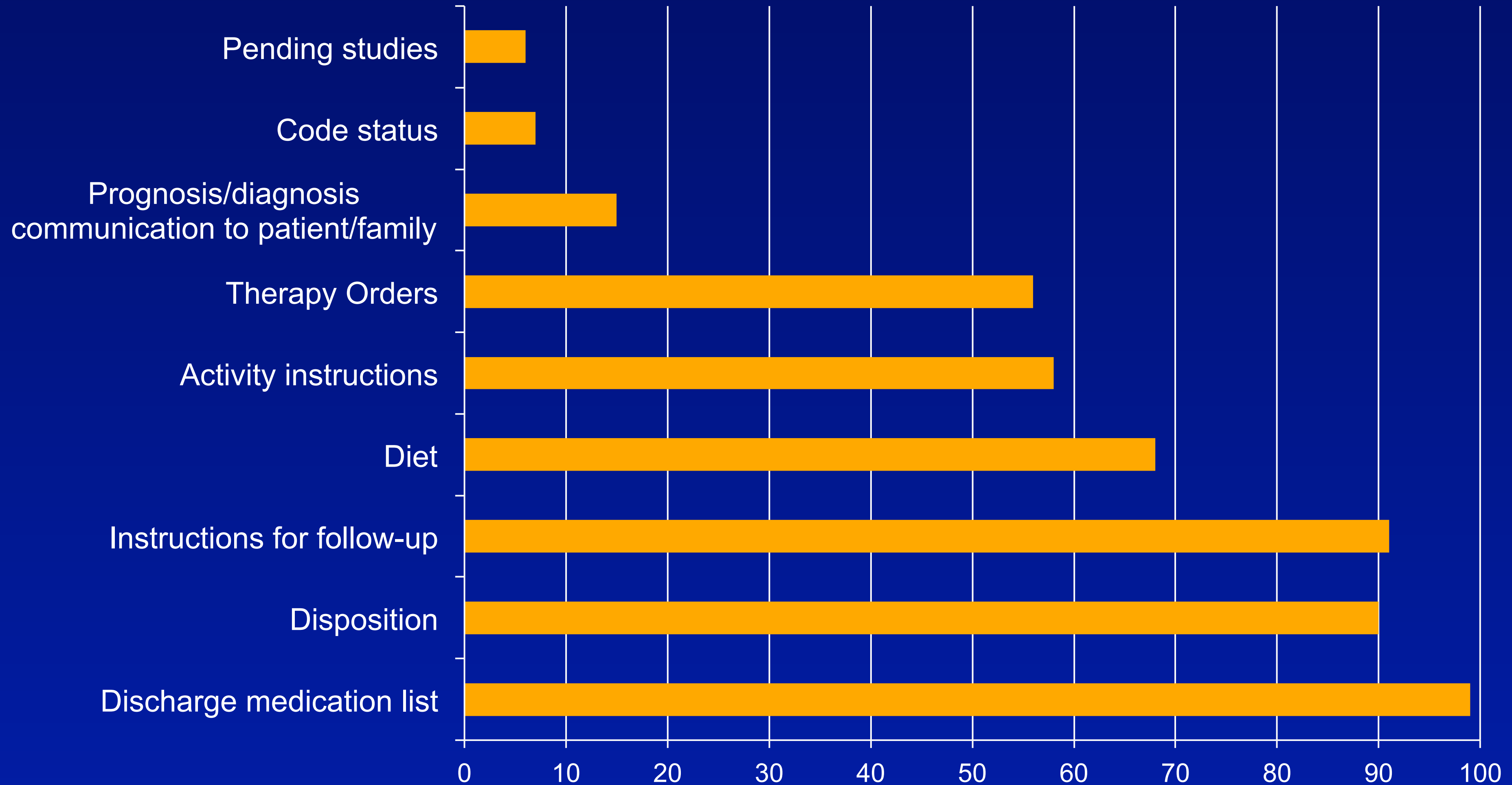
- Health system fragmentation contributes to rehospitalizations
- Education-based transitional care services decrease rehospitalizations in those going home
- Effective communication lies at the core of safe transitions, especially those to nursing homes

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

Nursing Home Nurses Want Better Quality Discharge Communication

- 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

Acknowledgements

Collaborators/Mentors

Maureen Smith
Barb Bowers
Stacy Walz
Laury Jensen
Alan Bridges
Andrea Gilmore

Sanjay Asthana
Barb King
Justin Sattin
Steve Barczi
Becky Kordahl
Rachel Roiland

Staff

Sandy Wright, Peggy Munson, Katie Ronk, Patrick Ferguson, Brock Polnaszek, Kathleen Madden, Melissa Hovanes

Funding

- NIA Beeson Career Development Award (1K23AG034551)
- NIH UW CTSA KL-2 1KL2RR025012-01
- UW Health Innovation Program
- Madison VA GRECC
- UW Hartford Center of Excellence in Geriatrics Medicine and Education
- VA Older Women's Health Fellowship/UW Center for Women's Health Research
- UWHC Quality Through Safety Grant
- VA T-21 Funding: Innovative Patient Centered Alternatives to Institutional Care