

Transitions of Care:
How to Hand Off Without Fumbling

***Transitions of Care: How to
Hand Off Without Fumbling***

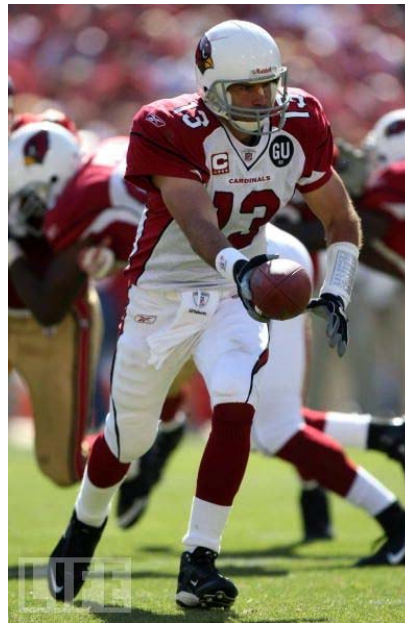
**HSAG Physical Restraints Collaborative-
Learning Session 6
February 23, 2010**

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Transitions of Care: How to Hand Off Without Fumbling

Objectives

- Understand the concepts of transitions of care as they impact multiple care settings.
- Learn how transitions of care will influence future health care reform.
- Realize the clinical and economic impact related to transitions of care.
- Become informed of innovative care transitional models to improve outcomes.

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What Is “Care Transitions?”

- **The movement of the patient** who transitions from one health care practitioner or setting to another (as condition and care needs change).
- Occurs at multiple levels
 - Within settings
 - Primary care ⇔ specialty care; ED to floor or ICU; ICU ⇔ ward
 - Between settings
 - Hospital ⇔ sub-acute facility
 - Ambulatory clinic ⇔ senior center
 - Hospital ⇔ home
 - Across health states
 - Curative care (hospital) ⇔ palliative care (hospice)
 - Personal residence ⇔ assisted living

Source: <http://caretransitions.org> Accessed on August 13, 2009. (c) Eric A. Coleman, MD, MPH

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What Is “Transitional Care?”

- **The actions of the providers** designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location.
- Based on a comprehensive care plan and availability of well-trained practitioners who have current information about the patient’s goals, preferences, and clinical status.
- Includes:
 - Logistical arrangements
 - Education of the patient and family
 - Coordination among the health professionals involved in the transition

Source: Coleman E A, Boulton C, The American Geriatrics Society Health Care Systems Committee. J Am Geriatr Soc 2003;51:556-7.

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Why Are Good Transitions So Important?

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Ineffective Transitions Lead to Poor Outcomes (Clinical and Otherwise)

- Wrong treatment
- Delay in diagnosis
- Severe adverse events
- Patient complaints
 - Decreased patient satisfaction
- Increased length of stay
- Unplanned hospital readmissions

Source: Australian Council for Safety and Quality in Health Care. *Clinical Hand-over and Patient Safety Literature Review Report*. March 2005.
[http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/AA1369AD4AC5FC2ACA2571BF0081CD95/\\$File/clinhovrlitrev.pdf](http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/AA1369AD4AC5FC2ACA2571BF0081CD95/$File/clinhovrlitrev.pdf)

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Clues That “Handoff” May Have Been Poorly Managed

- Medication errors
- Increased health care utilization/readmissions
- Inefficient care—duplicative tests/services
- Inadequate patient/caregiver preparation
- Inadequate follow-up care
- Dissatisfaction
- Litigation/bad publicity

Source: <http://caretransitions.org> Accessed on August 13, 2009. (c) Eric A. Coleman, MD, MPH

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Barriers to Care Coordination

- System-level barriers
- Practitioner-level barriers
- Patient-level barriers

Source: <http://caretransitions.org> Accessed on August 13, 2009. (c) Eric A. Coleman, MD, MPH

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System-Level Barriers



SILOS: where information in one silo (system) is incapable of reciprocal (co)operation with other, related silos (systems).

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Practitioner-Level Barriers

- Practitioners often have not practiced in the settings to which they transfer patients.
 - They lack knowledge of critical information needs.
- Sending practitioners may not communicate critical information to receiving practitioners.
- Receiving practitioners may not know the patient and his or her preferences for care.

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Patient-Level Barriers

- Patients assume that someone is in charge of coordinating care.
- Patients (and caregivers) are often the only common thread woven between care sites . . .
- Yet they navigate the system with few tools and no training to manage in this role.

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Where The Ball Is Fumbled

- On hospital admission, more than 50 percent of patients have at least one medication discrepancy and approximately 40 percent of the discrepancies have the potential to cause harm.
- Upon hospital discharge, 30 percent of patients have at least one medication discrepancy with the potential to cause possible or probable harm.
- After transition from hospital to home, 40 percent of patients experienced at least one medical error.

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Where The Ball Is Fumbled (continued)

- Direct communication between hospital physicians and PCPs occurs infrequently.
- Discharge summaries at first post-discharge visits were available only 12–34 percent of the time and often lacked important information.
 - (e.g., lab results, discharge medications, treatment, follow-up plan).
(Kripalani S, et al. JAMA 2007;297:831-41)
- In hospital-to-nursing home transfers, 32 percent of nursing homes indicated they did not receive all information needed to care for residents transferred from the hospital and 14 percent reported patient harm caused by inadequate information from hospital to nursing home.
(Boockvar KS, Burack OR. J am Geriatr soc 2007; 55:1078-84)

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Rehospitalizations Among Patients in the Medicare Fee-for-Service Program

Study background:

- Reducing rates of rehospitalization has attracted attention from policymakers as a way to improve quality of care and reduce costs.
- There is limited information on the frequency and patterns of rehospitalization in the United States.

Source: S. F. Jencks, M. V. Williams, and E. A. Coleman, "Rehospitalizations Among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine*, Apr. 2, 2009 360(14):1418–28.

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Rehospitalizations Among Patients in the Medicare Fee-for-Service Program (continued)

Methods:

- Study analyzed Medicare claims data from 2003–2004 to describe the patterns of rehospitalization and the relation of rehospitalization to demographic characteristics of the patients and to characteristics of the hospitals.

Source: S. F. Jencks, M. V. Williams, and E. A. Coleman, "Rehospitalizations Among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine*, Apr. 2, 2009 360(14):1418–28.

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Rehospitalizations Among Patients in the Medicare Fee-for-Service Program (continued)

Results:

- Almost one-fifth (19.6 percent) of the 11,855,702 Medicare beneficiaries who had been discharged from a hospital were rehospitalized within 30 days.
- 34.0 percent were rehospitalized within 90 days.
- 67.1 percent of patients who had been discharged with medical conditions and 51.5 percent of those who had been discharged after surgical procedures were rehospitalized or died within the first year after discharge.

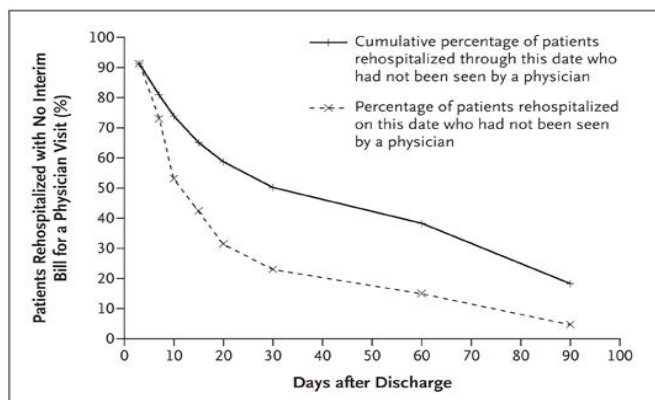
Source: S. F. Jencks, M. V. Williams, and E. A. Coleman, "Rehospitalizations Among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine*, Apr. 2, 2009 360(14):1418-28.

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Rehospitalizations Among Patients in the Medicare Fee-for-Service Program (continued)



Source: S. F. Jencks, M. V. Williams, and E. A. Coleman, "Rehospitalizations Among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine*, Apr. 2, 2009 360(14):1418-28.

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Rehospitalizations Among Patients in the Medicare Fee-for-Service Program
(continued)

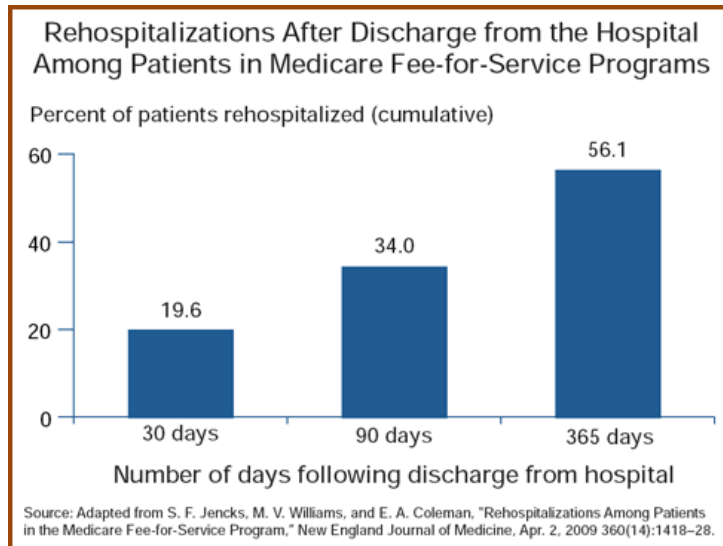
Results:

- Of the 50.2 percent of the patients rehospitalized, within 30 days after discharge, there was no bill for a visit to a physician's office between the time of discharge and rehospitalization.
- Among patients who were rehospitalized within 30 days after a surgical discharge, 70.5 percent were rehospitalized for a medical condition.
- Estimated cost to Medicare of unplanned rehospitalizations in 2004 was \$17.4 billion.

Source: S. F. Jencks, M. V. Williams, and E. A. Coleman, "Rehospitalizations Among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine*, Apr. 2, 2009 360(14):1418-28.

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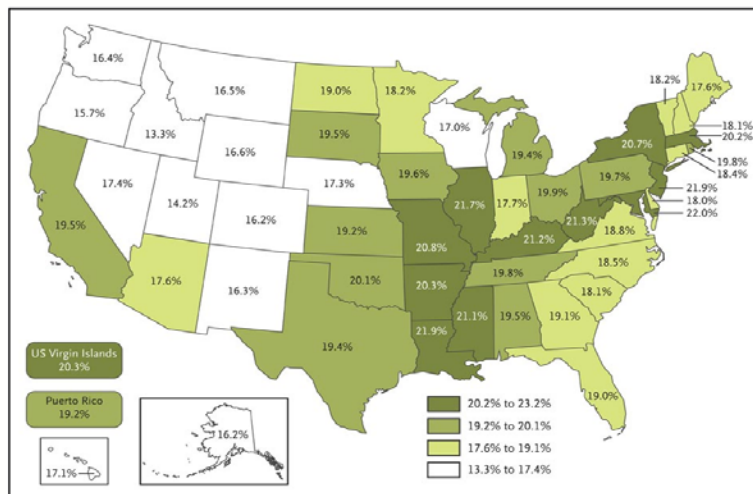
Rehospitalizations Among Patients in the Medicare Fee-for-Service Program
(continued)



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Rehospitalizations Among Patients in the Medicare Fee-for-Service Program (continued)



Source: S. F. Jencks, M. V. Williams, and E. A. Coleman, "Rehospitalizations Among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine*, Apr. 2, 2009 360(14):1418-28.

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Recommendations for Informational Needs Across Settings

- Define the essential information needed to provide high-quality care to patients in transition.
- Ensure that the essential information is accurately and thoroughly conveyed to the receiving practitioners.
- Develop information systems that facilitate practitioners' access to essential data elements and ability to communicate across the care continuum.

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Preventing Fumbles



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The National Transitions of Care Coalition (NTOCC)

- NTOCC is a group of concerned organizations and individuals joining together to address problems associated with transitions of care.
- Founded in 2006 by:
 - Case Management Society of America (CMSA)
 - sanofi-aventis, U.S., LLC
- Goal is to define solutions addressing gaps that impact safety and quality of care for transitioning patients.

Source: <http://www.ntocc.org/> Accessed on August 13, 2009.

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NTOCC Resources

Tools include:

- My Medicine List
- Taking Care of My Healthcare
- Transitions Of Care Checklist
- Cultural Competence

Papers:

- *Improving Transitions of Care: The Vision of The National Transitions of Care Coalition, May 2008*
- *Transition of Care Measures: Paper by the NTOCC Measures Workgroup, 2008*

Source: <http://www.ntocc.org/> Accessed on January 6, 2010.

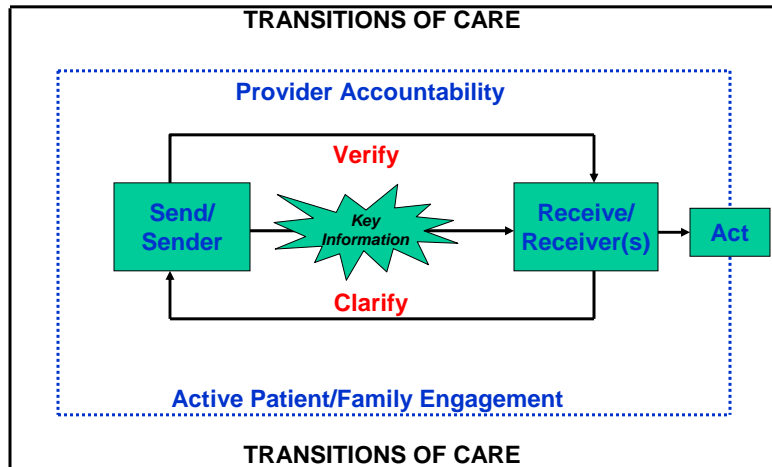
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NTOCC Conceptual Model



Source: <http://www.ntocc.org/> Accessed on August 13, 2009.

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Transitions-of-Care Models

- BOOST: Better Outcomes for Older adults through Safe Transitions
- Transitional Care Model (TCM)
- Care Transitions Intervention
- Project RED (Re-Engineered Discharge)

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BOOST: Better Outcomes for Older adults through Safe Transitions

Funded by: John A. Hartford Foundation *and*
Society of Hospital Medicine (SHM)

Project BOOST's advisory board includes:

- The Agency for Healthcare Research and Quality (AHRQ)
- The Joint Commission
- Centers for Medicare & Medicaid Services (CMS)
- Blue Cross and Blue Shield Association
- Pharmacists, nurses, geriatricians, patient advocates, etc.

Source: http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/project_boost_background.cfm
Accessed on August 13, 2009

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Project BOOST

Outcomes:

By improving discharge processes, Project BOOST aims to:

- Reduce 30-day readmission rates.
- Improve facility patient satisfaction scores.
- Improve the institution's HCAHPS scores related to discharge.
- Improve the flow of information between hospital and outpatient physicians.
- Ensure high-risk patients are identified and specific interventions are offered to mitigate risk.
- Improve patient and family education practices to encourage use of the teach-back process around risk-specific issues.

Source: http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/project_boost_background.cfm
Accessed on August 13, 2009

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Project BOOST's Pilot Mentoring Program

Cohort One

- Started in September 2008
- Six hospitals participating

Cohort Two

- Started in March 2009
- Twenty-four hospitals participating
- Includes Banner Good Samaritan Medical Center—
Phoenix, Arizona

Source: http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/project_boost_background.cfm
Accessed on August 13, 2009

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Transitional Care Model (TCM)

Developed by:

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Marian S. Ware, Professor in Gerontology

Director of the NewCourtland Center for Transitions and Health

University of Pennsylvania, School of Nursing

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TCM *(continued)*

At admission, eligible patients are assigned a transitional care nurse.

A transitional care nurse:

- Conducts a comprehensive assessment of patient/family needs.
- Coordinates the patient's discharge plan with the family and hospital provider team.
- Implements the plan in the patient's home.

Source: http://www.innovativecaremodels.com/care_models/21 Accessed on August 13, 2009.

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TCM *(continued)*

A transitional care nurse:

- Assists the patient with management of his or her care needs.
- Facilitates communication and the transition to community providers and services.

Transitional care nurse is available to the patient seven days per week through home visits and telephone access for one to three months of home follow-up. (two-month average).

Source: http://www.innovativecaremodels.com/care_models/21 Accessed on August 13, 2009.

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TCM *(continued)*

Targets cognitively intact older adults with two or more risk factors:

- Poor self-health ratings
- Multiple chronic conditions
- History of recent hospitalizations

Intended setting(s):

- Successfully transition cognitively intact older adults from acute care into other less-intensive care settings (e.g., skilled-nursing or rehabilitation facilities) or the home.

Currently being tested among cognitively impaired hospitalized older adults and long-term care recipients being transferred to and from acute care hospitals.

Source: http://www.innovativecaremodels.com/care_models/21 Accessed on August 13, 2009.

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Care Transitions Intervention

Developed by:

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Professor of Medicine

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Care Transitions Intervention (continued)

What is the model?

- During a four-week program, patients with complex care needs and family caregivers receive specific tools and work with a Transition Coach™ to learn self-management skills that will ensure their needs are met during the transition from hospital to home.

Source: http://caretransitions.org/documents/CTI_Summary.pdf Accessed on August 13, 2009. (c) Eric A. Coleman, MD, MPH

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Care Transitions Intervention (continued)

The intervention focuses on four conceptual domains referred to as pillars:

1. Medication self-management.
2. Use of a dynamic patient-centered record, the Personal Health Record.
3. Timely primary care/specialty care follow-up.
4. Knowledge of red flags that indicate a worsening in the patient's condition and how to respond.

Source: http://caretransitions.org/documents/CTI_Summary.pdf Accessed on August 13, 2009. (c) Eric A. Coleman, MD, MPH

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Care Transitions Intervention *(continued)*

What are the key findings?

- Patients who received this program were significantly less likely to be readmitted to the hospital, and the benefits were sustained for five months after the end of the one-month intervention. Patients who received this program were also more likely to achieve self-identified personal goals around symptom management and functional recovery.

Source: http://caretransitions.org/documents/CTI_Summary.pdf Accessed on August 13, 2009. (c) Eric A. Coleman, MD, MPH

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Project RED *(Re-Engineered Discharge)*

Developed by:

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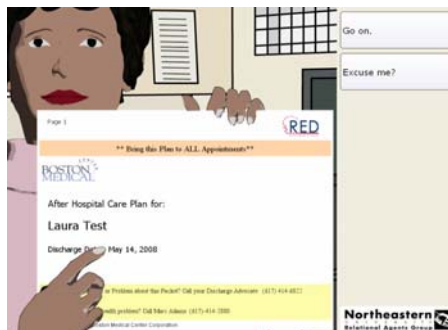
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Project RED (continued)

Meet Louise.

- Animated conversational character that simulates face-to-face interaction between a patient and a nurse.
- Based on a detailed analysis of how human nurses explain written medical instructions to patients.

Patients interact with Louise by using a touch-screen display that is mounted on an articulated arm so that patients can interact with the discharge system from a variety of positions in their hospital bed.



Source: <http://www.bu.edu/fammed/projectred/meetlouise.html> Accessed on August 20, 2009

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Bottom Line Messages . . .

- Transitions-of-care gaps are a major cause of adverse patient outcomes, including safety issues and preventable rehospitalizations.
- Since the “common denominator” in these transitions is the PATIENT (resident), the community and patient (resident)/caregiver element must be included in the solution in order for successful care transitions to occur.
- Everyone in the health care continuum is equally responsible for safe and thorough transitions.

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The Institute of Medicine (IOM) Report

- 1999 *To Err is Human*
 - “at least 44,000 Americans die each year as a result of medical errors . . . results of the New York study suggest that number may be as high as 98,000”



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IOM's Proposed Solution

Health care organizations should:

- Define leadership responsibility.
- Identify and learn from errors.
- Set performance standards.
- Implement safety systems.

To Err is Human: Building a Safer Health System
Institute of Medicine

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Physician Reactions

Then:

“So what if the IOM report has the effect of exaggerating the magnitude of error in the public’s mind? So what if it appears condescending?”

Now:

“If the error was apparent, 81 percent would disclose it; 50 percent said they would reveal less obvious mistakes. Overall, 56 percent of doctors chose responses that mentioned the event but not the error; 42 percent said they would fully disclose that the problem was the result of a mistake.”

First Do No Harm –To Err is Human Effective
Clinical Practice, Nov/Dec 2000

The Washington Post
When a Doc Will Tell
Sept. 12, 2006; Page HE03 45

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Health Care Reform

- HAC/POA Initiative
- Public-reporting of 30-day hospital readmission rates
- RAC Audits
- EHR
- NHVBP program
- CMS QIS Process
- MDS 3.0
- Transparency of care outcomes (PrUs, PRs)

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Reimbursement Barriers



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Medicare Trustees Report Shows Serious Financial Status of Medicare Program

The trustees report that Medicare's Hospital Insurance (HI) Trust Fund will become insolvent earlier in 2019 than reported last year (2007).

“We need to transform the program from being a passive bill-payer to an active purchaser of health care by giving quality and cost information to providers and beneficiaries to choose the most effective and efficient care,” said Weems (Kerry).

Source: CMS Press Release: *Medicare Trustees Report Shows Serious Financial Status of Medicare Program*
<http://www.hhs.gov/news/press/2008pres/03/20080325a.html> Accessed on January 8, 2010.

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**Medicare Trustees Report Shows
Serious Financial Status of Medicare
Program (continued)**

Weems continued, “...*We can do this by enhancing competitive bidding strategies, paying more to higher quality providers than lower quality, and demonstrations that use care coordination, bundling and electronic health records.*”

Source: CMS Press Release: *Medicare Trustees Report Shows Serious Financial Status of Medicare Program*
<http://www.hhs.gov/news/press/2008pres/03/20080325a.html> Accessed on January 8, 2010.

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Expand the Concept . . .

Improving
Transitions:
One patient
at a time



Improving
Transitions:
Every
patient, every
time

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Questions?

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Web Sites

Transitional Care Model (TCM)

http://www.innovativecaremodels.com/care_models/21/overview

The Care Transitions Program

<http://caretransitions.org/index.asp>

National Transitions of Care Coalition (NTOCC)

<http://www.ntocc.org/>

Project Boost

http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/project_boost_background.cfm

Project RED

<http://www.bu.edu/fammed/projectred/index.html>

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Over 1 million drug-related injuries occur every year in health care settings. The Institute of Medicine estimates that at least a quarter of these injuries are preventable.

To find out how to prevent medication errors, go to
<http://www.hsag.com/azproviders/drugsafety.aspx>.



www.hsag.com

This material was prepared by Health Services Advisory Group, the Medicare Quality Improvement Organization for Arizona, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services.

The contents presented do not necessarily reflect CMS policy.

Publication No. AZ-9SOW-6.2-011210-01

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