Transitions of Care: A Topic for the Present and Future

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Transitions of care, an ongoing area of concern with renewed interest and ongoing research, refers to a set of actions designed to ensure the coordination and continuity of health care as patients transfer between locations or between levels of care within the same location. Discussions about quality of care, patient satisfaction, and physician satisfaction in relation to nursing home care are incomplete without a review of transitions of care. This topic is of particular interest due to the increasing number of patients who go from acute health care settings to short term stays in nursing homes (or skilled admissions) and then return to the community. JCAHO and other quality assessment organizations are now evaluating elements of transitions of care directly related to patient safety issues, such as the appropriate reconciling of medications across the continuum of care, and the quality and quantity of information provided in hand-offs during transfer of care. How do we make the transition process easier for us and better for our patients?

Although simple enough in concept, transitions of care prove to be often ineffective. With today's shortened hospital stays, increased use of nursing homes for "skilled" or post-acute care, restricted resident work-hours, development of hospitalist physicians, and "SNF-ists," (skilled nursing facility) hand-offs occur frequently. Rarely does the outpatient primary care physician follow the patient into the hospital, to the nursing home and back to the office. Different medical record systems, and the restrictions placed by the concern for health care privacy have made getting records or information over the phone very difficult. Dr. Eric Coleman, a geriatrician and a researcher, likens each piece of the puzzle to an independent silo of information—acute care hospital, nursing home, patient, and outpatient practice. Each silo thinks of itself as an independent system, and information exchange between them is not always easy. Incentives for communication are not always obvious. We all understand that it is part of good care and agree with the principle, yet why does it not always happen? Time constraints, system problems, and lack of system-wide emphasis on the problem can prevent us doing what we know is the right thing to do. Until there is a focused way to connect the silos of care, or an easier method of communication and information transfer, the process will continue to be a challenge. In addition, there are no financial or performance rewards for excellence in transitional care. There are no Medicare quality or performance indicators to assess the effectiveness of transitional care.

All the fault does not lie within the health care system. Patients can and should participate in the process as well, but are not often encouraged to do so. Or patients feel unable to navigate the system. Those of us who care primarily for older patients rarely see patients who are actively involved in their care, know their medications, list their specialists, procedures, and dates, and understand their diagnoses. More commonly, we hear hazy answers, such as “I had surgery on my stomach,” or “I take a heart pill,” or “you know, the little blue pressure pill.”

The fault, though, lies more with the system than the patient or physician. The traditional medical culture, especially for the older adult, has been paternalistic. Doctors managed everything, and patients trusted them to handle all problems. In a culture of long-standing, continuous doctor-patient relationships, such an approach could succeed; it fails in today’s climate of multiple and frequent hand-offs. As a result, patients (or their caregivers) do not understand the problem list, and do not take responsibility for keeping records, carrying medication lists, and urging doctors for thorough explanations, so that the patients can give those explanations to other practitioners down the road. Also, a number of older adults have trouble comprehending what is explained to them. Finally, some patients have difficulty reading and writing.

For all of the above reasons, Coleman puts the barriers to good transitional care under three categories: 1) the delivery system; 2) the clinician; and 3) the patient. Anecdotally, every practitioner can think of a patient who has come and gone from the hospital multiple times over a short period, or been hospitalized and then discharged to a nursing home for skilled rehabilitation before returning home. Even more commonly, there is the patient who sees a specialist for evaluation, laboratory and imaging testing or medication changes and then returns to the office for a routine visit. Medicare data, for 2003, show 12,713,090 total discharges from short stay hospitals; 39,320 of those discharges were in Rhode Island. The total number of admissions to skilled nursing facilities nationally in 2003 was 2,332,549; 9,450 were in Rhode Island. There were 270,000 home visits in Rhode Island in 2003, and 7,804 nursing home residents in the state as of 2005. Finally, studies indicate that of these skilled nursing facility residents, 19% will return to the acute care hospital within 30 days.

Adverse events are linked to transitions of care. A 2003 study evaluated 400 patients after hospital discharge, typically 24 days after discharge: 76 patients had had an adverse event during the transition period to home; 23 of these were deemed preventable after extensive review, and 66% of the events were related to adverse drug events. This adverse events rate of 19% was significantly higher than studies of adverse events during hospitalization in the same era, which found rates of 2.9-3.7%. Given multiple care settings and practitioners, the risk of poly-pharmacy becomes compounded; times of transition are especially risky. When patients come into the hospital, medication lists are not always available. Even when the list is available, more urgent priorities supersede. “Necessary” medications are continued, while others are let lapse until the patient is “stable,” often, never to be resumed. Also, it has become common practice to add “prophylactic” and “as needed” medications, such as proton pump inhibitors, sleeping pills, and a
bowel regimen for elderly patients in the hospital. At discharge, careful medication reconciliation may be omitted; prior medications should be verified and restarted, no-longer-necessary hospital-specific ones stopped, and new medications added and cross-checked with previous ones. Patients often go home with medication lists that do not identify previous regimens, or continue medications for which they do not carry a diagnosis; e.g., acid suppressants. A recent study, examining medication discrepancies in the post-hospital period, found that 14.1% of patients (n=375) experienced one or more medication discrepancies. About half the discrepancies were related to patient factors, while system problems accounted for the other half. Of interest was the higher re-hospitalization rate among patients who experienced discrepancies - 6.1% (p=0.4) in thirty days.

In summary, many practitioners, as well as many patients, face transitional care disruptions daily. Research data support the frustrations and anecdotal experiences of practitioners; adverse events are associated with inadequate transitional care. There is also a cost implication—investing in transitional care will reduce re-hospitalizations and acute care visits from skilled nursing facilities.

There are steps that can be taken on individual, educational and systems levels to make the transition process safer and easier. To discuss solutions starting with the clinician, simply being aware of the problem and taking the time to review medication lists at each transition, to educate patients about their diagnoses and medications, and to obtain records and information from other practitioners would be a first step. For example, taking the time to communicate with colleagues at different institutions when a patient is admitted to the hospital or to a skilled nursing facility, or evaluated in the emergency department will encourage successful transitions. A five-minute phone conversation may save patients unnecessary tests or hospitalizations.

As part of the Brown internal medicine residency’s mandatory Geriatrics block rotation, we have incorporated transitions of care as a theme. House staff are getting didactic presentations on the topic, as well as seeing first hand admissions of new skilled nursing home patients, whom they have seen in the hospital, to a nursing facility. They encounter a new skilled admission, having to piece together the events in the hospital, the previous history and the follow up. They see first hand the information they receive from the hospital and how it is not often easy to reconcile the medication list and history to form a plan of care for the skilled stay. Due to residency work-hour restrictions, hand offs occur more frequently; this is day-to-day training in transitions. These experiences, coupled with formal curriculum during their intern year Geriatrics rotation will make today’s residents more facile with transitional care.

The Agency for Healthcare Research and Quality (AHRQ) has started to emphasize patient safety concerns directly related to transitional care in its funding priorities, and will likely do more in the future. Given moves toward pay for performance in Medicare, it is likely that measures of transitional care will be included to provide additional incentives to foster adequate transitional care. On a state system level, Lifespan has recently instituted a Continuity of Care form that integrates with the Physician Order Management system. On admission to the hospital, this form records the patient’s outpatient medications and doses. Upon discharge, the hospital medication profile is transferred into the mediation list. The completing physician must then go through each medication and decide whether to resume, continue or discontinue. New medications or discontinued medications require a reason for the changes. Use of such forms will likely improve the utility and appropriateness of patients’ discharge medications and help practitioners in the office, home health agencies and in skilled nursing facilities.

Finally, at the patient level, physicians should encourage patients to take responsibility for their health care information. In the office setting, providing standard forms for patients to fill-in medication history, allergies, health care wishes, medications, and names of all their physicians is a first step. Patients should be advised to carry this form at all times. It is enough information for another practitioner to start with when caring for patients in different settings. A recent study evaluated interventions designed to improve transitional care, and piloted the Care Transitions Intervention. In this randomized controlled trial of 750 patients, Coleman studied patients and their caregivers, since the pairing is the common denominator among the many transfers of care. The intervention group had focused education and support to assist them in medication management; creating, and maintaining a personal health record; recognizing the signs of a worsening of their condition; when to call for advice; and how to maintain regular follow up. The intervention employed transition coaches, who were advanced practice nurses, and registered nurses and supported and promoted the patients’ and caregivers’ independence and ownership in their own care. The main outcome measured was re-hospitalization within 30, 90, or 180 days of discharge. At all three time intervals, the intervention group had statistically significant lower rates of re-hospitalization, as well as significantly lower hospital costs at 90 and 180 days, despite the increased up front cost to provide the transition coach and intervention.

The results of this study are promising. Providing patients with the tools, encouragement and support to take control of their own health care information can improve continuity of care, prevent future hospitalizations, and decrease costs. The study team’s personal health record can be adapted to any practice setting. A website was created by the research group at University of Colorado Health Sciences Center, who are the Care Transitions Intervention team.
describes the interventions plan, provides the resources necessary, and has downloadable forms, including the personal health care record. Patient education and empowerment is a proven technique to improve the challenges of transitional care. As further proof, the Care Transitions Measure developed by Coleman and his team (measurement tool to assess patient satisfaction with transition of care and level of knowledge about diagnosis and medications) recently received The National Quality Forum’s endorsement.10

Transitional care has been integral to health care since its inception, but managing transitions successfully has become more challenging. Less continuity of care is the rule, driven by increasing patient volumes, more sub-specialized physicians, new breeds such as the hospitalists and “SNF-ists”, and residency work hour restrictions in teaching hospitals. Patients generally defer to their health care professionals to maintain and coordinate their information. The wave of the future is increased communication, electronic medical records that cross over independent institutions, and mandated quality and performance measures that encourage good transitional care. Easy first steps are the use of medication reconciliation at each step of a transition, verbal or written communication with practitioners accepting hand-offs, and initiatives to encourage patients to ask questions and take ownership of their personal health records. Rhode Island is already on its way; electronic records are being used in many of our hospitals, and Continuity of Care Forms are in use at the Lifespan hospitals.

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RESOURCES:

REFERENCES
5. The Henry Kaiser Family Foundation: http://www.statehealthfacts.org/

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