BRIDGING THE GAPS: TRANSITION OF CARE FOR THE OLDER ADULT

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Objectives

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- Summarize the meaning of care transition for the older adult
- Review different care transition models and how they impact the older adult's quality of life
- Discuss the importance of caregiver involvement and health care professionals' roles in care transition
- Recognize the impact of effective transition of care on improving health outcomes and reducing healthcare costs

The Story of Walter Altman

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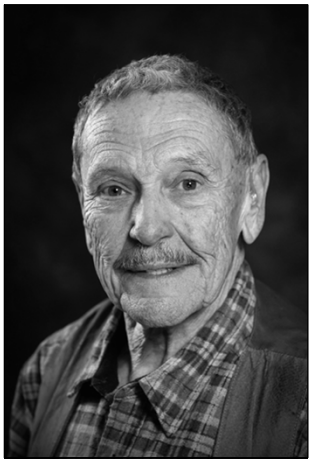
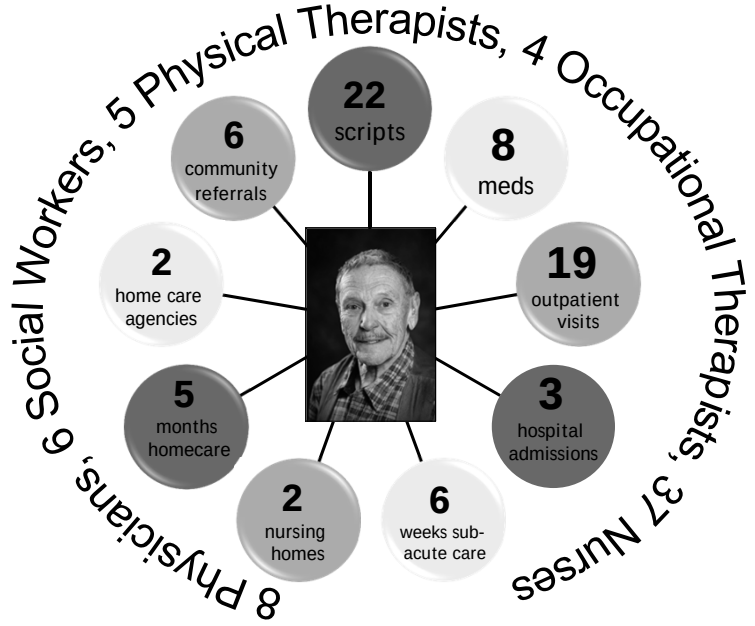
- 79 year old widower
- Retired teacher, lives alone
- Income: small pension
- Daughter lives 10 miles away, has three teenagers
- Five chronic conditions
- Three physicians
- Eight medications



In the past year, Walter has had…



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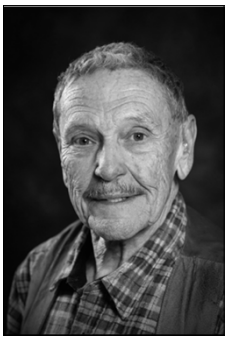
Walter

- Confused by care, meds
- Gets discouraged
- Adherence to care is poor



Walter's daughter

- Stressed
- Reduced work to half-time
- Considering nursing homes

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For those with complex needs, the health care system is:

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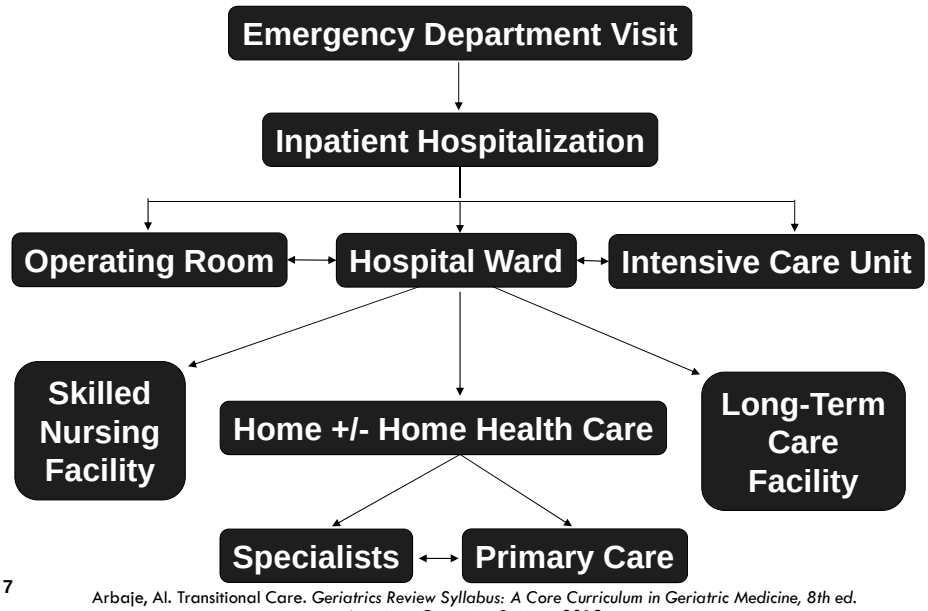
Fragmented
Discontinuous
Difficult to access
Inefficient
Unsafe
Expensive

"A nightmare to navigate"

Crossing the Quality Chasm: A New Health System for the 21st Century. Institute of Medicine Report, 2001

Transitions within the U.S. Healthcare Environment



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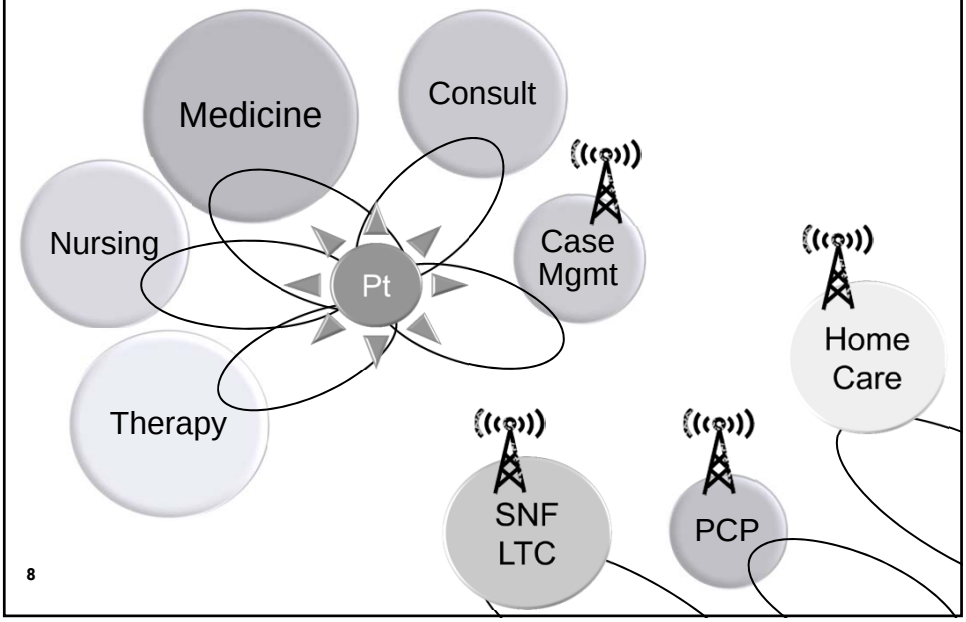
Arbaje, Al. Transitional Care. *Geriatrics Review Syllabus: A Core Curriculum in Geriatric Medicine, 8th ed.* American Geriatrics Society: 2013

Worlds Apart

Arbaje, Al, et al. The Older Person in Transition: Implications for Pathways of Transitions of Care, in "Pathways through the Transitions of Care for Older Adults." *Annual Review of Gerontology and Geriatrics.* 2011



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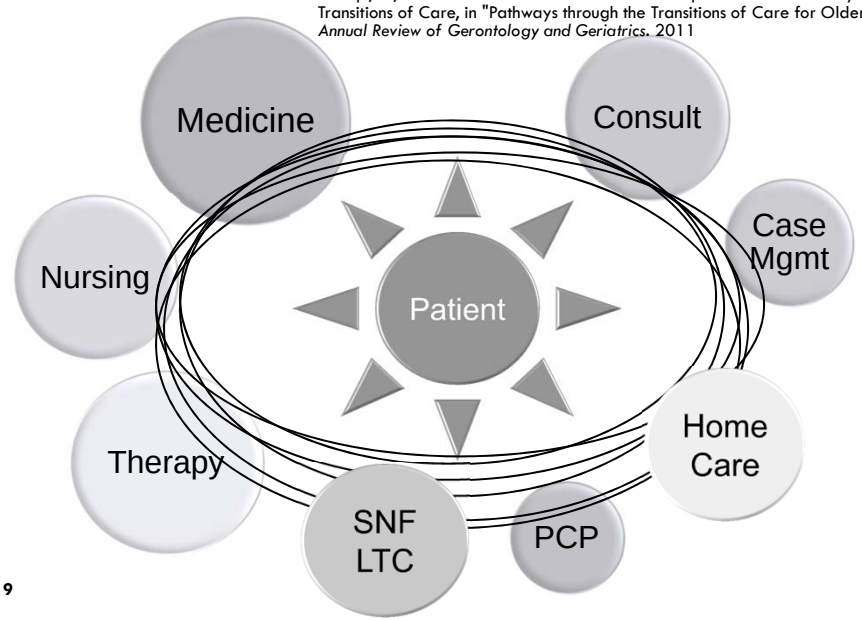
Shifting the Center of Gravity

Arbaje, AI, et al. The Older Person in Transition: Implications for Pathways of Transitions of Care, in "Pathways through the Transitions of Care for Older Adults." *Annual Review of Gerontology and Geriatrics*. 2011



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Transitional Care

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- 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 within the same location.

Coleman, EA. *J Am Geriatrics Soc*. 2003 (51)4:549-55

Care Transitions out of the Hospital

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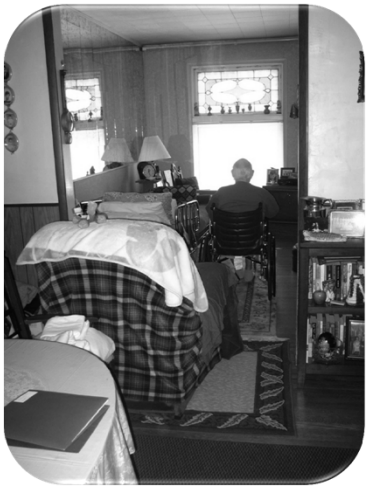
- Common, complicated, and costly
- Older adults are particularly vulnerable
- Going home with home care is especially risky



Coleman, EA, et al. *J Am Geriatrics Soc.* 2004 (39)5:1449-65
Jencks, SF, et al. *N Engl J Med.* 2009 (360)14:1418-28
Arbaje, AI. Transitional Care. *Geriatrics Review Syllabus, 8th ed.* 2013
Murtaugh, CM. *Medical Care.* 2002 (40)3:227-36

Skilled Home Healthcare

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Care Delivery Challenges

- Homebound patients
- Residential environment
- Dependence on informal caregivers
- Short-term duration
- Intermittent care
- High adverse event and rehospitalization rates

Ongoing Needs

- Measures
  - Track transitions
  - Assess quality
  - Provide real-time feedback

Madigan, EA. *Home Health Nurse.* 2007 (25)3:191-7
Levine, C, et al. *Milbank Q.* 2006 (84)2:305-31
Wolff, JL, et al. *Med Care.* 2008(46)11:1188-93
Carayon P, ed. *Handbook of Human Factors and Ergonomics in Health Care and Patient Safety, 2nd ed.* 2012

Transitional Care 1.0

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- Identification of at-risk patients and transitions
  - Screen for cognitive/functional impairment
  - Assess living situation and usual source of care
- Provider-provider communication
  - Provide info to PCP at key transition points
  - Verbal communication when urgency/uncertainty exists
- Timely and quality discharge summaries
- Medication management and reconciliation
  - Address goals of care
- Provide support after discharge
  - Use of home healthcare when appropriate
  - Enhance self-management
  - Follow-up phone call/visit

National Transitions of Care Coalition (www.ntocc.org)

Transitional Care Model
Transitionalcare.info

The Care Transitions Program
Caretransitions.org

GUIDED CARE
Guidedcare.org

Older Adults' Transition Patterns in the U.S.

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- 1 in 4 transition annually
- 1 in 3 transition 2+ times after discharge
- Half of transitions are to hospital and back
- The rest are not easily predictable

Sato, M, Arbaje, AI, et al., *Gerontologist*. 2010 (31)2:170-8
Coleman, EA. *Health Serv Res*. 2003 (39)5:1449-65

Older Adults Are Not All the Same:
Diagnoses Alone Do Not Define Risk

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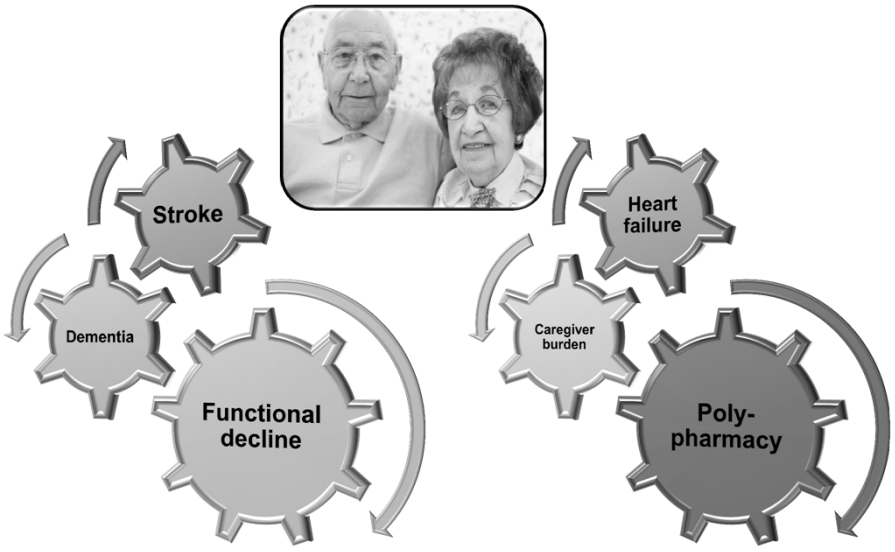

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Older Adults are at Increased Risk

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- More conditions, providers, and healthcare encounters
- Delirium!!!
- Cognitive and functional impairment
- Additional transitions (SNF, home care)
- Complex medical regimens
- Self-management challenging
- Caregiver support

Arbaje, AI. Transitional Care. *Geriatrics Review Syllabus: A Core Curriculum in Geriatric Medicine, 8th ed.* American Geriatrics Society: 2013

Risk Factors for Readmission

Bowman EH, Arbaje AI. Models of Care to Transition from Hospital to Home. "Acute Care for Elders: A Model for Interdisciplinary Care." (in press)

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Patient-level
• Prior recent hospitalization (30 days) • Longer hospital length of stay • Increased number of chronic medical problems • Functional disability • Unmet functional needs • Male gender* • Older age • Member of racial/ethnic minority* • Unmarried*

Factors Promoting Ideal Execution of Roles During Care Transitions

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Patient-Level	Provider-Level	Nature of Information
- Older age - Poor informant - Clinically complex - Major change in status - Adherence problems - Limited health literacy	- High interest or involvement in patient's care - Increased concern about patient - Knows PCP - Personally admitted patient	- Very important or urgent - Serious or uncertain diagnosis - Incidental findings not fully evaluated - Information about family dynamics - Major or end-of-life decisions

Schoenborn, NL, Arbaje, AI, et al., *J Am Geriatrics* Soc. 2013 (61)2:231-6

Challenges from Older Adults' Perspectives

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- Discharge
  - Time when patient finds out about discharge vs. actual time of discharge
  - Instruction and discharge instructions although provided tend to be forgotten
- Transport to home
  - Getting into and out of vehicle
  - Needing caregiver support
- Once at home
  - Following medication regimens
  - Environmental challenges

Arbaje, AI, et al. Ongoing work

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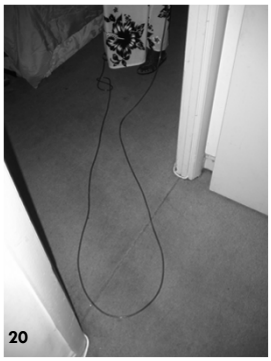

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In their own words…

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- "We had no inclination that we were leaving [the hospital]."
- "I come up from [therapy], lunch is sitting there, and in the same breath they go, 'Pack up your bags, you're going home'."

Challenges from home care clinicians' perspectives

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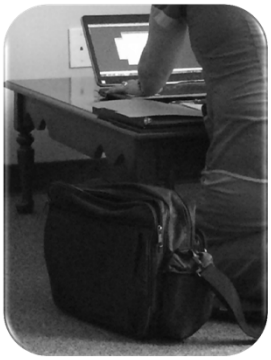
- Incomplete documentation
- Medication reconciliation at patient's home
- Communication with physicians for clarifications



In their own words…

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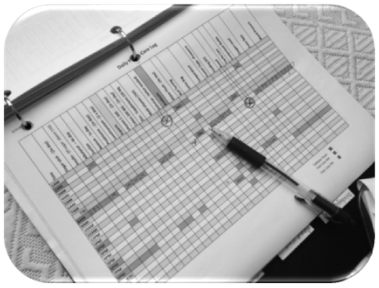
- "The ideal transition would be … being given adequate notice [about] what the needs of the patient are … [and] not at the last minute when they are ready to go out the door."



Home care coordinator

In Their Own Words…

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- "I'd say about 50% of the time there seems to be something that requires a call to the doctor to get straightened out."

Home care nurse

Promising Innovations

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- Policy
- Organizations
- Providers
- Patients

Common Threads: Coaches, Guides, Navigators

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- Assessment of symptoms
- Understanding of hospitalization, diagnoses, test results, and treatment plan
- Medication and self-management
- Ensuring follow up and implementation of plan of care
- Creation and understanding of emergency plan
- Inpatient- or outpatient-based programs

Strategies for Specific Transitional Care Challenges

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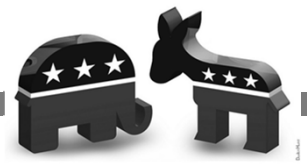
Transitional Care Challenge	Strategies
Minimizing rehospitalization of nursing home residents	Leadership and staff education, development of communication tools and care pathways, reviews of acute care transfer cases Example: INTERACT model
Prevention and management of geriatric syndromes in hospitalized older adults experiencing care transitions	Staff development tools, new nursing care models, clinical practice protocols, home-based care Examples: Acute Care for Elders (ACE) units, Mobile ACE units, Hospital at Home, Nurses Improving Care for, HealthSystem Elders (NICHE) model

Arbaje, AI. Transitional Care. *Geriatrics Review Syllabus: A Core Curriculum in Geriatric Medicine, 9th ed.* American Geriatrics Society: in press

Policy Innovations



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- Restructuring reimbursement
  - Reimbursement for cross-site communication
  - Distinct benefit for transitional care
  - Bundling acute and post acute care services for episodes of care
- Performance measurement
  - Grants for development of measures
  - Comparisons across delivery systems

Coleman, EA. *J Am Geriatrics Soc.* 2003 (51)4:549-55

Possible Metrics

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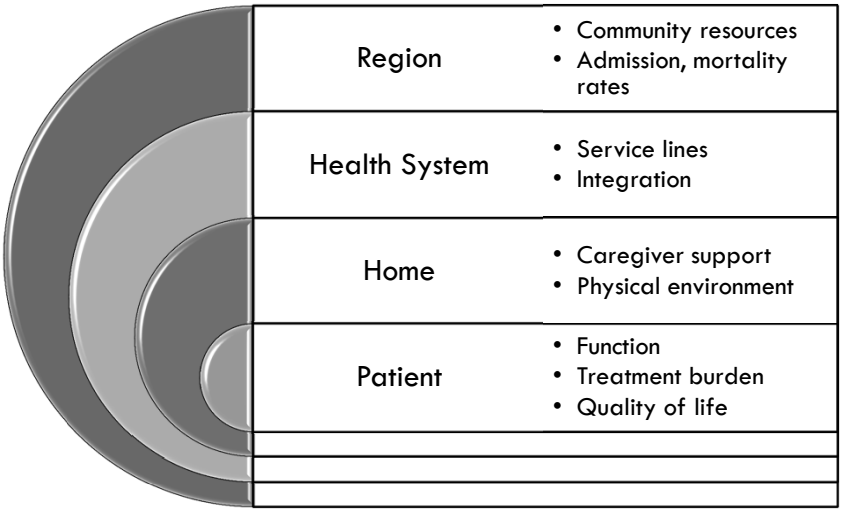

Arbaje, AI, et al. *J Gen Int Med.* 2014 (29)6:932-9

Care Transitions Measure (CTM) - 3

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- When I left the hospital, I clearly understood the purpose for taking each of my medications.
- 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.
- When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

www.caretransitions.org

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Organizational Innovations

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- Information technology
  - Computerized ordering
  - Decision support
  - Electronic health record
- Coaches, guides, navigators
- Integration of delivery systems

Coleman, EA. *J Am Geriatrics Soc.* 2003 (51)4:549-55

Creating Recovery Scenarios

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Scenario	Possible Recovery Plan
Patient level	
Patient not able to obtain all medications	• Vouchers to purchase medications • Bedside or home delivery • Reassessment of goals of care • Transportation arrangements for medication pickup

Arbaje, Al, et al. *J Gen Int Med.* 2014 (29)6:932-9

Creating Recovery Scenarios

33

Scenario	Possible Recovery Plan
Health system level	
Durable medical equipment does not arrive as scheduled (e.g., oxygen, walkers, hospital bed)	• Emergency assistance hotline to reach home care agency • Send out temporary supplies
Post-acute facility or home care agency concerned about patient's clinical status or unclear about plan of care	• Emergency assistance hotline to reach case manager or healthcare providers • Access to inpatient EMR, nursing assessments, and medication administration records

Arbaje, AI, et al. *J Gen Int Med.* 2014 (29)6:932-9

Provider Innovations

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- Training
  - Patient preference assessment
  - Provider-to-provider communication
  - Community resources
- Standardization
  - Test results
  - DC summaries
  - Follow-up phone calls
- Team-based care
  - Multi-disciplinary rounds

Coleman, EA. *J Am Geriatrics Soc.* 2003 (51)4:549-55

Patient Innovations

35

- Personal health record
- Patient-activation and self-management
- Group primary care visits
- Support groups for patients and caregivers

Coleman, EA. *J Am Geriatrics Soc.* 2003 (51)4:549-55

Practical Solutions

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- Communication during admission and discharge
- Timely and quality discharge summaries
- Medication reconciliation
- Use of home healthcare when appropriate
- Patient/caregiver preparation for next site
- Follow-up phone call or visit to patient after discharge

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	Transitional Care 1.0	Transitional Care 2.0
Screening	Patient-level	Home environment System level Regional level
Target processes	Discharge planning Communication	Palliative care Caregiver activation Systems redesign
Settings	Hospital	Community Ambulatory care Assisted living Skilled/long-term care Home
Data sources	Medical records Administrative data Patient report	Organizational data Caregivers Healthcare providers
Intervention	Coaches Navigators	Regional HIT Transportation Home-based care

Summary

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- Transitional care is important element for safe and effective health care.
- Poor transitional care is especially dangerous for older adults.
- Innovative solutions to improve transitional care should target different components of the health care system.

Dropping the Baton

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"[In a relay race]…

You hold onto that baton while the other person takes it– you don't throw them the baton."

CONTACT INFORMATION

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Health tips for older adults:
www.youtube.com/aarbaje