Transition Interventions: What Works, What Doesn’t, and for Whom?

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Presenter Disclosure Information

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Transition Interventions

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None

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None
Objectives

- Describe system issues that contribute to poor heart failure (HF) outcomes
- Describe how and why transition interventions improve HF outcomes
- Examine what works and discuss how we might incorporate these approaches in practice
Why do HF Outcomes Remain Poor?

- Care delivery is provided in “silos”
- Silos have different cultures of care
- Providers across sites do not communicate
- Recent changes (e.g., “hospitalists”) complicate this issue
- No single provider is accountable
- Patients may not have supporters living close by
“Fundamental Disconnect”
Most Care is Provided in Hospitals, but after Hospital Discharge…

- 49% of patients experience ≥1 error *(failed plan)* in:
  - medication continuity
  - diagnostic workup
  - test follow-up

- 19-23% suffer an adverse event *(injury)*
  - most frequently an adverse drug event
  - Half of adverse drug events are considered preventable

- High rehospitalizations rates
  - Almost 20% of hospitalized patients are readmitted within 30 days and HF is the major contributor

- Low satisfaction with care
A Breakdown in Communication

- 75% of the time, discharge summaries fail to arrive in time for the follow-up appointment.
- Patient discharge summaries often fail to include important information:
  - primary diagnosis
  - details about the hospital course
  - follow-up plans
  - whether lab test results are pending
  - patient/family counseling

Tsilimingras & Bates, 2008
Systems Support the Problem

- Financial, regulatory, and professional barriers reinforce silos
- Business model of reimbursement
  - Emphasis on acute care
  - Medicare cutting home care services
- Perverse financial incentives
  - Paid for illness not health

“In this insanity of economics of health care, the patient always loses.”
Peter Van Etten, President, Stanford Health Services
Continuity of Care:
20+ Years of Testing Various Approaches

- Disease Management
- Discharge Planning
- Care Coordination
- Transitional Care
Meta-Structure

Continuity of Care Processes

Pre-Hospital Settings
- Systems & Providers
- Interventions
- Patients & Families
- Outcomes

Hospital Settings
- Systems & Providers
- Interventions
- Patients & Families
- Outcomes

Post-Hospital Settings
- Systems & Providers
- Interventions
- Patients & Families
- Outcomes

Patient Transition

Discharge Planning Process

Disease Management Process

Transitional Care Process

Adapted from Holland & Harris, 2007
Analysis of 15 CMS Demonstration Projects

- Between 2002 and 2005, 18,309 Medicare patients enrolled
- Nurses provided patient education and monitoring (mostly via telephone) to improve adherence and ability to communicate with physicians
- Patients contacted 2 x/month on average; frequency varied widely
- **Results:** 13 of 15 programs showed no significant differences in hospitalization
- In 3 programs, Medicare expenditures were 9-14% lower
- No effects on treatment adherence, little effect on quality of care indicators
- “…care coordination programs without a strong transitional care component are unlikely to yield net Medicare savings.”
- “Programs with substantial in-person contact...moderate to severe patients can be cost-neutral and improve some aspects of care.”

Peikes et al, 2009
Transitional Care

- Transitional care is the “sending” and “receiving” aspects of care
- ...a set of actions designed to ensure the coordination and continuity of healthcare as patients transfer between different locations or different levels of care within the same location

(Coleman & Boult, 2003)
Key Principles of Transitional Care

- Essential services are provided
- Providers communicate with each other
- Caregivers are involved in planning
- Patients are given clear advice on how to manage their conditions
  - How to recognize warning symptoms
  - How to contact a health professional who is familiar with their care
  - How to seek care in the new setting

3 Promising Transition Interventions

1. Increasing access to proven community-based services

2. Improving transitions within acute hospital settings

3. Improving patient handoffs to and from acute care hospitals

Naylor & Keating, 2008
Community-Based Services

- **Hospital at home** ([www.hospitalathome.org](http://www.hospitalathome.org))
- Developed by the John Hopkins School of Medicine
- Meets clinical process measures and quality standards at rates similar to the acute hospital
- Quicker functional recovery, less chance of delirium
- Greater opportunities for patient teaching
- Better communication with caregivers, less stress for families
- Reductions in mortality
- Shorter length of stay
- Total costs lower for patients with HF or COPD
  - Especially for conditions that use substantial laboratory tests and procedures

(Frick et al 2009; Leff, 2005, 2008, 2009; Marsteller, 2009)
Community-Based Services

- **Day Hospitals** modeled after a program offered in the British healthcare system
- Example: Collaborative Assessment and Rehabilitation for Elders (CARE) program at Penn
- Interdisciplinary program directed by a geriatric nurse practitioner (GNP)
- Targets community-based older adults at high risk for hospitalization and other adverse outcomes
- Access to health, palliative, and rehabilitation services for a few days each week up to 9 weeks
- Improves function and decreases hospital use

(Harrison et al, 2002; Neff et al, 2003)
Transitions within Settings

- Transitions within hospitals (ED to ICU to stepped down to general medical surgical unit) associated with errors
- **Acute Care for Elders** (ACE) developed at the University hospitals of Cleveland
- Daily interdisciplinary team conferences
- Nurse initiated guidelines for preventive and restorative care
- Starting discharge planning on admission
- Actively including family members

**Results**: Higher levels of function at discharge, shorter length of hospital stay, decreased hospital costs

(Panno et al, 2000)
Transitions within Settings

- **Professional-Patient Partnership Model** used in Baltimore to improve discharge planning for HF patients

- Nurses and social workers engage patients and caregivers in the discharge planning process

- They complete a questionnaire to assess needs at discharge, watch a videotape on post discharge care management, and receive information on accessing community services

- **Results**: Better prepared to manage after discharge, caregivers more satisfied with their role

(Bull, et al 2000)
Improving Handoffs

- **Care Transitions Coaching** at the University of Colorado

- Advanced Practice Nurse (APN) “Transitions Coach” teaches patient and caregiver skills needed to promote cross-site continuity of care

- Coaching begins in the hospital and continues for 30 days after discharge

- **Results**: Lower rehospitalization rates, lower costs

(Coleman, 2006)
Improving Handoffs

- Care Transitions Coaching
  - Model fidelity
    - Dedicated, trained coach without additional duties
    - Home visits essential
    - Focus on patient’s goals
  - Selection of transitions coach
    - Experienced, empowered, employed, flexible, excellent communicator
  - Model execution
    - Goals, timelines, outcome measures, committed stakeholders, ongoing meetings
  - Support to sustain the model
    - Contingency plan for staff turnover, plans for expansion

Eric Coleman
Improving Handoffs

- **APN Transitional Care Model** at Penn
  - APN’s assume primary responsibility for a high risk patients during and after hospitalization
  - Home visits, telephone follow-up 7 days/week
  - **Results:** Improved satisfaction, better quality of life, reduced rehospitalizations, decreased cost

![Diagram](image)

Naylor et al 1994, 2000, 2004

*While the estimated costs of home visits were higher for the intervention group, they were more than off-set by the decrease in hospitalization, resulting in average savings of $4,545 per patient.*
Not all Transition Interventions are Effective

Why?

DOSE
Why do Some Approaches Work?

- Analysis of 333 interaction logs created by APN during 5 trials
  - Very low birth weight infants (N = 39)
  - Women with unplanned cesarean birth (N = 61)
  - High risk pregnancy (N = 44)
  - Hysterectomy (N = 63)
  - Elders with cardiac medical and surgical diagnoses (N = 139)

- Greater mean APN time and contacts per patient associated with greater improvements in patient outcomes and greater healthcare cost savings

(Brooten et al 2003)
HOW CAN WE USE THIS INFORMATION IN PRACTICE?
How Can We Use This Information in Clinical Practice?

Maybe a *Hospital at Home* Program would work for you:

- Do you lack enough hospital beds/capacity?
- Do you have established home health care delivery capabilities?
- Are your physicians interested in and able to care for patients in the home environment?
- Do you admit a large volume of Medicare patients with community-acquired pneumonia, HF, or COPD?
- Does your institution view itself as an innovator in developing new models or systems of care?
How Can We Use This Information in Clinical Practice?

- Consider use of the standardized patient assessment tool advocated by CMS for use at acute hospital discharge and at post-acute care admission and discharge
  - The Continuity Assessment Record and Evaluation (CARE) tool
  - Measures health and functional status on hospital discharge
  - Measures changes in severity and other outcomes
### VI. Functional Status: Usual Performance

**A. Core Self Care:** The core self care items should be completed on ALL patients. (Complete during the 2-day assessment period.)

Code the patient’s most usual performance using the 6-point scale below.

**CODING:**

Safety and Quality of Performance – If helper assistance is required because patient’s performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

6. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.

5. **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.

4. **Supervision or touching assistance** – Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.

3. **Partial/moderate assistance** – Helper does LESS THAN

| A1. Eating | The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency. |
| A2. Tube feeding | The ability to manage all equipment/supplies related to obtaining nutrition. |
| A3. Oral hygiene | The ability to use suitable items to clean teeth. Dentures: The ability to remove and replace dentures from and to mouth, and manage equipment for soaking and rinsing. |
How Can We Use This Information in Clinical Practice?

- Recognize the integral role of family caregivers
  - FACED classification and rating system
    - F = financial
    - A = advocacy
    - C = care coordination
    - E = emotional support
    - D = direct care provision
How Can We Use This Information in Clinical Practice?

- Focus on transitions within your specific settings
- Explore services existing in your community
- Develop systems to assure bidirectional communication between clinicians
- Specify who’s accountable for patients referred to home health, SNF, etc. on hospital discharge
H2H Hospital to Home

- Quality Initiative from the American College of Cardiology (ACC) and Institute for Healthcare Improvement
- Focused on the 20% of Medicare patients readmitted to hospital within 30 days of discharge
  - HF most common reason for readmission
  - Total cost of readmissions $17.4B in 2004
- Goal is to reduce all-cause re-admission rates among patients discharged with heart failure or acute myocardial infarction by 20% by Dec 2012

http://www.h2hquality.org/
Remember this Slide?
Key Principles of Transitional Care

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Position Statement of the American Geriatrics Society
Focus on 3 main domains:

1. Medication management post-discharge
   - Is the patient familiar and competent with their medications and do they have access to them?

2. Early follow-up
   - Does the patient have a follow-up visit scheduled within a week of discharge and are they able to get there?

3. Symptom management
   - Does the patient fully comprehend the signs and symptoms that require medical attention and who to contact if they occur?
How Can We Use This Information in Clinical Practice?

- Anyone committed to reducing unnecessary readmission is welcome, not just hospitals:
  - Private practices, home health agencies, nurses, hospitalists, pharmacists and all front line providers are invited to actively participate
- There is no fee to participate at this time
- Fully committed partners in H2H agree to:
  - Obtain Administrative Support
  - Assemble an Improvement Team
  - Develop an Improvement Plan
  - Report on Progress through periodic brief surveys
There’s More to Learn…

- How best to facilitate transition from home to hospital?
- What about transitions to and from other settings (e.g., skilled nursing facilities)?
- How can we support family caregivers better?
- Which patients are at risk for a difficult transition?
- How should be determine the match between patient characteristics, intervention choice, and intervention dose?
- Can we identify an empirically defined appropriate follow-up interval?
  - Currently rather arbitrary and generic
- What about other providers and provider teams?
  - APN versus RN or social worker
  - APN and social worker teams
Take Home Message

- Some approaches that are efficacious in controlled clinical trials are not effective when moved to the real world
- Need more research!

- Essential Elements of Care:
  - Continuity of care
  - Face to face contact
  - Time spent with patients
  - An individualized approach