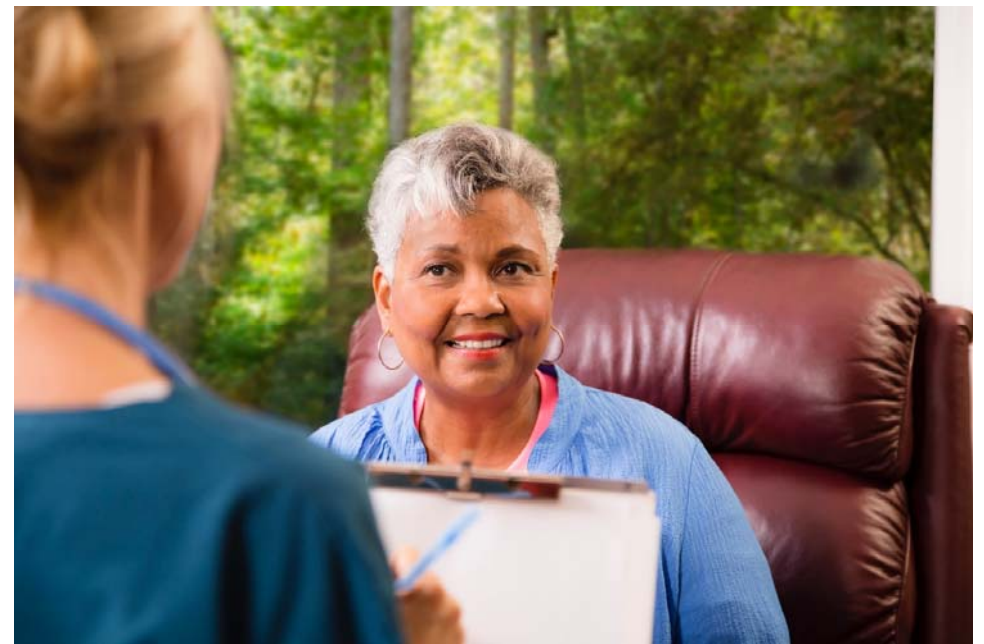


Interprofessional Geriatrics Training Program

Transitions in Care: Acute Care and the Older Adult



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Expert Interviewee: Susan Altfeld, PhD, MA(SW)

Learning Objectives

Upon completion of this module, learners will be able to:

1. Define transitional care
2. Discuss post-acute care discharge destinations
3. Identify risk factors for adverse outcomes from acute care, with special focus on older adults
4. Summarize effective strategies to facilitate safe transitions from acute care for older adults
5. Discuss the role and value of interprofessional support for older adults to ensure a successful transition from acute care

Transitional Care

Defining Transitional Care

Transitional Care

- Based on a comprehensive plan of care and the availability of health care practitioners who are well-trained in chronic care and have current information about the patient's goals, preferences, and clinical status

Non-Narrated Definition of 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 within the same location

Defining Transitional Care

Transitional Care Includes

- Logistical arrangements
 - Education of the patient and family
 - Coordination among the health professionals involved in the transition
-
- Transitional care is essential

Expert Interview: Susan Altfeld, PhD, MA(SW)

Expert Interview: Susan Altfeld, PhD, MA(SW)

Listen to Our Expert Discuss:

- Why is transitional care so important?
 - Interest in transitional care was generated by Jencks et al. (2009), which demonstrated that almost 20% of Medicare medical patients were readmitted within 30 days
 - Indicated a need for measures to prevent unnecessary hospitalizations

Expert Interview: Susan Altfeld, PhD, MA(SW)

Listen to Our Expert Discuss:

- What types of models exist within transitional care?
 - Several models have been developed that are detailed in this module to prevent hospital readmissions
- Some interventions include:
 - Phone interventions:
 - Must focus on more comprehensive evaluation of the patient post-discharge to be effective
 - These phone calls are not effective in preventing rehospitalization, as a brief check-in is not adequate in achieving significant outcomes

Expert Interview: Susan Altfeld, PhD, MA(SW)

Listen to Our Expert Discuss:

- Coaching models and home visiting models:
 - Include several visits to the home to reassess the patient and family situation
 - Have had impressive outcomes in preventing rehospitalizations

Assessment Question 1

Transitional care refers to a set of actions designed to ensure coordination of care as patients transfer between different health care settings as well as between levels of care in the same setting.

- a) True
- b) False

Assessment Question 1: Answer

Transitional care refers to a set of actions designed to ensure coordination of care as patients transfer between different health care settings as well as between levels of care in the same setting.

a) True (Correct Answer)

b) False

Types of Transitions

Types of Transitions

Take a moment and make a list of the post-acute care discharge destinations that you can think of...

Types of Transitions

*Review the list below. Which destinations are the same as those on your list?
What destinations included on your list are omitted in the list here?*

Post-Acute Care Discharge Destination List

- Home: with no supportive services
- Home: with outpatient therapy services (occupational and physical therapies [OT and PT])
- Home: with home health services (nursing)
- Home: and primary care physician (PCP), specialist
- Home: and community-based services (HCBS); non-medical services, e.g., Meals on Wheels

Types of Transitions

Review the list below. Which destinations are the same as those on your list? What destinations included on your list are omitted in the list here? (continued)

Post-Acute Care Discharge Destination List

- Family member's home
- Inpatient post-acute rehabilitation hospital
- Inpatient post-acute skilled nursing facility (SNF)
- Residential assisted living facility (ALF)/supportive living facility (SLF)

Transitions in Care for Older Adults

Transitions Are Common for Older Adults

- **22% experience a residential or health care transition each year** (Sato et al., 2011)
- **50% of transitions are post-hospitalization to the original residential setting, but 50% experience multiple and more complex transitions** (Sato et al., 2011)
- **> 17% of Medicare patients are rehospitalized within 30 days of discharge**
(U.S. Department of Health and Human Services, 2014)
- **> 75% of readmissions are potentially preventable** (Jencks et al., 2009)
- **\$12 billion in Medicare funding is spent on avoidable hospital readmissions**
(MedPac, 2007)

Managing Complex Conditions Requires an Interprofessional Team

Older Adults Are Especially Vulnerable

Older Adults Are More Likely to Have

- Multiple chronic conditions
- Cognitive impairment
- Activities of daily living (ADL) limitations
- Complex therapeutic and medication regimens
- Limited social support

Assessment Question 2

Older adults often need interprofessional support to avoid adverse post-discharge complications because they are more likely than younger people to have:

- a) Fewer chronic conditions
- b) Simple medication regimens
- c) Expansive social support
- d) Limitations in activities of daily living

Assessment Question 2: Answer

Older adults often need interprofessional support to avoid adverse post-discharge complications because they are more likely than younger people to have:

a) Fewer chronic conditions

b) Simple medication regimens

c) Expansive social support

d) Limitations in activities of daily living (Correct Answer)

Adverse Events

During Transitions: Older Adults Are At Risk

At Risk For

- **Medication errors** (Coleman et al., 2003; Sato et al., 2011)
- **Service duplication** (Sato et al., 2011)
- **Inappropriate care** (Naylor et al., 2004)
- **Critical omissions in care**

Negative Outcomes

- Negative outcomes of poorly planned or executed transitions of care include:
 - **Poor clinical outcomes** (Naylor et al., 2004)
 - **Inappropriate use of services (e.g., emergency visits)** (Sato et al., 2011)
 - **Readmission to hospitals** (Naylor et al., 1999; Sato et al., 2011)

Adverse Events Associated with Poor Care Transitions

- **Unplanned rehospitalizations** (Naylor et al., 1999; Sato et al., 2011)
- **Medication errors** (Coleman et al., 2003; Sato et al., 2011)
- **Redundant diagnostic testing** (Sato et al., 2011)
- **Lack of adherence with plan of care** (Naylor et al., 2004)
- **Nursing home placement** (Boling, 2009)
- **Caregiver burden** (Naylor et al., 2004)
- **Increased health care costs** (Naylor et al., 1999)
- **Increased mortality**



Factors Associated with Adverse Transition Outcomes

- Diagnosis of chronic obstructive pulmonary disease (COPD)
- Pneumonia
- Diabetes mellitus (DM)
- Cardiovascular disease (CVD)
- Psychiatric diagnosis
- Polypharmacy
- Cognitive impairment
- Living alone
- Activities of daily living (ADL) impairment
- Low-income
- Limited literacy
- Non-English speaking
- Home health needs

Adverse Effects of Transitional Care

Expert Interview: Susan Altfeld, PhD, MA(SW)

Expert Interview: Susan Altfeld, PhD, MA(SW)

Listen to Our Expert Discuss:

- What are some adverse effects of transitional care?
 - Preventing hospital readmissions
 - Over 80% of the patients who were discharged had unresolved issues when the contacts were made with them at the 48-hour post-discharge follow-up
 - For three-quarters of those patients, those issues had not been anticipated at all during the hospitalization

Expert Interview: Susan Altfeld, PhD, MA(SW)

Listen to Our Expert Discuss:

- What are some examples of these unresolved issues?
 - Patients do not realize the significant impact of this hospitalization on their endurance and issues that go into preparing to care for themselves post-hospital visit (e.g., meal planning, grocery shopping)
- How does cognitive decline impact transitional care?
 - Patients often experience a degree of cognitive decline in the hospital
 - Many without previous diagnoses have significant cognitive decline while in the hospital, often that is reversible

Expert Interview: Susan Altfeld, PhD, MA(SW)

Listen to Our Expert Discuss:

- How does cognitive decline impact transitional care? (continued)
 - Potential causes of cognitive decline during hospitalization
 - Patients under sedation
 - Lack of sleep during hospitalization
 - Effects of pain medication
 - Stress caused by hospitalization

Expert Interview: Susan Altfeld, PhD, MA(SW)

Listen to Our Expert Discuss:

- Preventing rehospitalizations
 - Discharge strategies that are ineffective for hospitalized older adults
 - Teach-back method, where a nurse or other practitioner teaches the patient the routine that they should be following once they get home
 - Practitioners anticipate that patients will retain that information, but it has now been found that a sizeable percentage of patients do not retain that information

Expert Interview: Susan Altfeld, PhD, MA(SW)

Listen to Our Expert Discuss:

- Preventing rehospitalizations
 - Discharge strategies that are ineffective for hospitalized older adults (continued)
 - Written instructions are also missed after discharge
 - Patients with minimal cognitive impairment that has not been previously recognized could impact their ability to successfully discharge
 - This might be the first time the cognitive impairment is manifested

Expert Interview: Susan Altfeld, PhD, MA(SW)

Listen to Our Expert Discuss:

- Is this a concern for all older adults?
 - Research study using a vignette-based memory task resembling discharge instructions with adults > 50 years of age (Calev et al., 2015)
 - Half of participants found to have impaired memory on this task

Assessment Question 3

All of the following are risk factors for adverse outcomes post-acute care EXCEPT:

- a) Diagnosis of chronic obstructive pulmonary disease (COPD), pneumonia, diabetes mellitus (DM), cardiovascular disease (CVD)
- b) Psychiatric diagnosis
- c) Polypharmacy
- d) Cognitive impairment
- e) Lives alone
- f) Activities of daily living (ADL) impairment
- g) Female gender
- h) Low-income
- i) Limited literacy
- j) Non-English speaking
- k) Home health needs

Assessment Question 3: Answer

All of the following are risk factors for adverse outcomes post-acute care EXCEPT:

- a) Diagnosis of chronic obstructive pulmonary disease (COPD), pneumonia, diabetes mellitus (DM), cardiovascular disease (CVD)
- b) Psychiatric diagnosis
- c) Polypharmacy
- d) Cognitive impairment
- e) Lives alone
- f) Activities of daily living (ADL) impairment
- g) Female gender
(Correct Answer)**
- h) Low-income
- i) Limited literacy
- j) Non-English speaking
- k) Home health needs

Effective Care Transitions

Why is This Even More Important Now?

Medicare Hospital Readmissions Reduction

- Developed as part of the Affordable Care Act (ACA)
- Established financial penalties for hospitals whose adjusted 30-day readmissions rates are higher than the national average
- Initially targeted three discharge diagnoses
 - Heart failure
 - Pneumonia
 - Acute myocardial infarction (MI)

Why is This Even More Important Now?

Medicare Hospital Readmissions Reduction (Continued)

- Expanded diagnoses to include
 - Acute exacerbation of COPD
 - Elective total hip arthroplasty
 - Total knee arthroplasty
- Beginning in FY2017, will also include
 - Coronary artery bypass graft (CABG) surgery

Why is This Even More Important Now?

Protecting Access to Medicare Act

- Passed in 2014
- Includes provisions for hospital readmission penalties for skilled nursing facilities (SNFs) beginning in 2018

A Case Example

Mr. Grayton: A Case Example

Mr. Grayton

- 93-year-old, WWII veteran
- Married, resides with 81-year-old wife in a two-story home
- Two children and five grandchildren visit frequently and are supportive
- Mostly homebound
- Walks independently with a walker and uses a wheelchair for longer trips outside the house
- Mild heart disease, urinary incontinence, suffers from post-traumatic stress disorder (PTSD), hearing loss, poor dentition, frail, osteoarthritis (OA) knee pain, history of falls, and sleep disturbances

Mr. Grayton: A Case Example

Mr. Grayton (Continued)

- Admitted through the emergency department (ED) after a fall in home
- Did not sustain any fractures
- Discharged home with home health care
- 10 medications prescribed

Mr. Grayton's Transition Home

Community primary care provider does not know
Mr. Grayton was admitted to the hospital

Mr. Grayton is afraid he will fall again and have to return to the hospital

Mr. Grayton's primary caregiver is overwhelmed and has to return to work

The Home Health Care Agency does not arrive on time

Mr. Grayton does not know which medications to resume and which to stop taking at home

Mr. Grayton is having difficulty coping with his mobility changes

Mr. Grayton's two children cannot agree how best to manage their father's medical needs

Mr. Grayton is feeling depressed and agitated because he cannot get around anymore like he used to

Mr. Grayton has questions about his medical bill and does not know what his insurance will cover

Mr. Grayton cannot afford his medications anyway

Mr. Grayton has no transportation to his follow-up medical appointments

Mr. Grayton is feeling isolated now that he's homebound

Mr. Grayton's regular community services are delayed

Missed Opportunities with Mr. Grayton

Preventing Adverse Outcomes of Acute Care Transitions Requires

- The patient's capacity to cognitively, physically, and psychologically manage self-care
- Key interprofessional team members, including:
 - Medication reconciliation and management: *Pharmacist*
 - Family's capacity (i.e., help the family): *Social worker, nurse, and occupational therapist (OT)*

Missed Opportunities with Mr. Grayton

Preventing Adverse Outcomes of Acute Care Transitions Requires (Continued):

- Key interprofessional team members, including (continued):
 - Adequacy and accessibility of the home environment: *Occupational therapist (OT)*
 - Provision of needed home health services: *Nurse, OT, physical therapist (PT), social worker*
 - Coordinate community-based services and supports: *Nurse, OT, physical therapist (PT), social worker*

Missed Opportunities with Mr. Grayton

- Physicians excel at identifying biomedical red flags but are likely to overlook psychosocial and environmental red flags in complicated cases (Weiner et al., 2010)
- What are the missed opportunities to contextualize Mr. Grayton's care?
- As you proceed through the module, see if you can identify ways in which to assess, prevent, or address some of the issues and problems this case presents

Mr. Grayton's Example: Key Considerations

- **Multiple domains impact risk for adverse outcomes of transitions:**
 - Professional communication from one level of care to another
 - Medication management and reconciliation
 - Patient and family's capacity to cognitively, physically, and psychologically manage patient's care
 - Adequacy and accessibility of the home environment
 - Provision of needed home health services
 - Community-based services and supports

Effective Care Transitions

- The Transitions of Care Consensus Conference identified a minimal set of essential data elements to be included in every transitional care record:
 - Principal diagnosis and problem list
 - Medication list (reconciliation) including over-the-counter/herbals, allergies, and drug interactions
 - Clearly identified the medical home/transferring coordinating physician/institution and their contact information
 - Patient's cognitive status
 - Test results/pending results

Effective Care Transitions Interventions

Domains Covered and Critical Issues

- Medication management and reconciliation
- Provider follow-up
 - Transportation
- Home health care delivery services, including:
 - Homemaker
 - Emergency response
 - Caregiver support
- “Red flags” and whom to contact 24/7

Effective Care Transition Interventions

1. Medication Management and Reconciliation

- The transition plan should include a current medication list, including
 - Over-the-counter
 - Herbals
 - Allergies
 - Drug interactions

Effective Care Transition Interventions

1. Medication Management and Reconciliation (Continued)

- This medication list should:
 - Be taken to every medical appointment and then updated after every medical appointment (reconciliation)
 - Include the prescribing provider's name and contact information
 - Include the pharmacy contact information
 - Be kept in a visible, easily accessible location in the event of any emergency

Effective Care Transition Interventions

2. Provider Follow-Up

- Importance of medical follow-up:
 - 50% of patients readmitted within 30 days of hospital discharge did not have an outpatient physician visit between the index admission (original hospital visit, not in narration) and readmission (Jencks et al., 2009)
 - This suggests that scheduling a provider appointment and making sure that it takes place are key to preventing adverse outcomes

Effective Care Transition Interventions

3. Home Health Services

- To receive home health services under Medicare, patients must be homebound
- Appropriate for older adults requiring intermittent skilled services, such as nursing, physical therapy, or speech therapy
- Should provide occupational therapy assessment and treatment, medical, social work, or home health aides

Effective Care Transition Interventions

3. Home Health Delivery

- Health care services in the home (not in narration) by an interprofessional team,

including:

- Nursing
- Social work
- Occupational therapy
- Physical therapy
- Dietician
- Pharmacist
- Physician

Effective Care Transition Interventions

4. Home and Community-Based Services (HCBS)

- Eligibility criteria and service availability may vary by location
- Programs for older adults receiving Medicaid are also being modified and, in many cases, expanded under managed care programs
- The Eldercare Locator is a useful resource:
 - www.eldercare.gov/Eldercare.NET/Public/About/Aging_Network/Index.aspx

Effective Care Transition Interventions

For a comprehensive training module on payment, see the ENGAGE-IL module “Community Services for the Older Adult: Access and Payment Systems” at engageil.com

Effective Care Transition Interventions

4. In-Home Services to Qualified Individuals

Meals on Wheels	Provides mid-day and evening meals delivered to individuals who cannot shop or prepare their own meals, often by a volunteer who also provides a sense of security and social contact to a homebound individual
Homemakers	Assistance with tasks essential to maintaining a household, such as housekeeping, laundry, food shopping, and meal preparation (some homemakers are allowed to provide transportation to medical appointments)

Effective Care Transition Interventions

4. In-Home Services to Qualified Individuals (Continued)

Personal care services or personal assistant	Assistance with bathing, feeding, walking, and other daily activities
Chore services	Where available, include minor home repairs, yard work, and general home maintenance
Telephone reassurance	Regular, prescheduled calls to homebound older adults, to reduce isolation and provide a routine safety check
Friendly visits	Periodic neighborly visits to homebound older adults to provide social contact and reassurance

Effective Care Transition Interventions

4. In-Home Services to Qualified Individuals (Continued)

Emergency response system	Electronic devices that allow individuals to contact a response center in the case of an emergency, such as a fall
Respite care	A break for family members from caregiving responsibilities for a short period of time
Transportation	Transportation to critical destinations, such as a doctor's office or the grocery store

Effective Care Transition Interventions

4. In the Community Services

Nutrition sites
and senior
centers

Provide needed socialization and meals
Centers provide lunch at no cost, or for a small fee, and
usually provide recreational activities

Adult day services

- Provide community-based care for individuals with multiple and special needs, such as Alzheimer's disease, developmental disabilities, traumatic brain injury, and vision and hearing impairments
- Helps reduce home family caregivers' burden and strain, enables family members to work outside the home, and provides the older adult with appropriate stimulation and social interaction

Effective Care Transition Interventions

5. “Red Flags” and Whom to Contact 24/7

- The Transitions of Care Consensus Conference identified a minimal set of essential data elements to be included in every transitional care record, and important information provided to the patient and caregiver
- The patient should keep this document in a visible, easily accessible location, such as on the refrigerator or near the phone, to be accessed in an emergency

Effective Care Transition Interventions

5. “Red Flags” and Whom to Contact 24/7 (Continued)

- The transition plan document or folder should include the following information:
 - “Red flags” of when to call provider (i.e., blood sugar reading over 200)
 - Principal diagnoses and problem list
 - Medication list or reconciliation, including
 - Over-the-counter
 - Herbals
 - Allergies
 - Drug interactions

Effective Care Transition Interventions

5. “Red Flags” and Whom to Contact 24/7 (Continued)

- The transition plan document or folder should include the following information (continued):
 - Name and contact information of the
 - Pharmacy
 - Physician
 - Home health agency
 - Department on Aging case worker
 - Transportation service company
 - Any company providing equipment or services (e.g., oxygen therapy)

Effective Care Transition Interventions

5. “Red Flags” and Whom to Contact 24/7 (Continued)

- The transition plan document/folder should include the following information:
 - Emergency contact: family or caregiver names and contact information, including powers of attorney (POA)
 - A copy of any advanced directives

Transition Care Planning

Transition Care Planning

- Should start early in hospital admission and include post-discharge follow-up
- Brief post-discharge follow-up phone calls are inadequate to prevent adverse events
- In-hospital teaching may not be retained due to:
 - Pain, sedation, or cognitive deficits limiting ability to recall and apply teaching
 - Written instructions frequently lost or misplaced during transition from hospital
 - Patients may underestimate stress and fatigue post-discharge

Assessment Question 4

Good transition care planning should start early in the hospital admission and include post-discharge follow-up. Good planning can eliminate many of the preventable adverse events for older adults post-hospitalization.

- a) True
- b) False

Assessment Question 4: Answer

Good transition care planning should start early in the hospital admission and include post-discharge follow-up. Good planning can eliminate many of the preventable adverse events for older adults post-hospitalization.

a) True (Correct Answer)

b) False

Care Transition Programs

Expert Interview: Susan Altfeld, PhD, MA(SW)

Listen to Our Expert Discuss:

- What improvements can be made to transitional care models?
 - Practitioners must consider models that will provide follow-up post-discharge
 - Determine when patients are better able to retain the information and when they need the information
 - HIPAA regulations can exacerbate the problem
 - Information from the medical team needs to be communicated directly to the patient and cannot be communicated to family and friends without permission

Expert Interview: Susan Altfeld, MA(SW), PhD

Listen to Our Expert Discuss:

- Which transitional care models are successful?
 - Transitional Care Intervention (Eric Coleman)
 - Transitional Care Model (Mary Naylor)

What Works?

Successful Evidence-Based Transitional Care Interventions Include:

- Care Transitions Program
- Transitional Care Model
- Project BOOST
- The Bridge Model
- Project RED

Care Transitions Program

- Developed by Coleman & Berenson (2004)
- Four-week program
 - One home visit
 - Three telephone follow-up contacts with a program “coach”
- Focus on:
 - Medication self-management
 - Development and maintenance of personal health record
 - Adherence to follow-up visits with physician
 - Ability to identify and respond to “red flags”
 - www.caretransitions.org

Transitional Care Model

- Developed by Naylor et al. (1999)
- 1- to 3-month intervention by an Advanced Practice Nurse (APN)
- Emphasizes holistic and comprehensive assessment and long-term planning
- Includes multiple home visits and telephone contacts
- Transitional care nurse coordinates care team
- Nurse accompanies patients to outpatient visits
- Multidisciplinary and collaborative approach that emphasizes identification of patient and family needs and goals
 - www.transitionalcare.info

Project BOOST

- BOOST was developed by the Society of Hospital Medicine to improve the quality of care transitions (Hansen et al., 2013)
- Focus on improving the discharge planning workflow
- Set of toolkits and project management tools that can be adapted to the needs of the hospital setting
- “8 P’s” assessment tool to identify patients at high-risk of post-discharge complications
- BOOST provides long-term technical assistance and support to organizations implementing the model
 - www.hospitalmedicine.org/Web/Quality_Innovation/Mentored_Implementation/Project_BOOST/Project_BOOST.aspx

Bridge Model

- Social work-led, interdisciplinary model of transitional care
- Comprehensive biopsychosocial assessment as a key activity to lead intervention
- Emphasizes collaboration among hospital, community-based health providers, and social service providers in the community aging network
- Develops family- and patient-centered continuum of care by bridging health and social service resources
- Designed to be adapted to fit unique needs and resources of each site
 - www.caretransitions.org

Project RED (Re-Engineered Discharge)

- From Boston University Medical Center
- Hospital-based program focusing on reducing readmissions through modification of the discharge planning process
- Detailed set of toolkits to guide redesign of discharge planning, including:
 - Assessment of existing processes
 - Program implementation
 - Patient telephone follow-up
 - Adapting RED for diverse patient populations
 - www.bu.edu/fammed/projectred/index.html

Resources

www.bu.edu/fammed/projectred/index.html Accessed December 20, 2016

www.caretransitions.org Accessed December 20, 2016

www.eldercare.gov/Eldercare.NET/Public/About/Aging_Network/Index.aspx Accessed December 20, 2016

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