

Transitional care

Effective strategies to facilitate safe transitions including Comprehensive Medication management

Presented by University of Illinois at Chicago

Objectives



The learners will be better able to:

- Define transitional care
- Discuss the different types of transitions across settings
- Identify risk factors for adverse outcomes from poorly planned transitions
- Summarize effective strategies to facilitate safe transitions including Comprehensive Medication management
- Discuss the role and value of MFP Transition Coordinator's support to ensure successful transitions

Definition of 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 person's goals, preferences, and clinical status
- A set of actions designed to ensure the coordination and continuity of healthcare as persons 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 planning is essential

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Why is transitional care 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 hospitalization

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Models within transition care

- Several models have been developed that are detailed in this module to prevent hospital readmissions
- Some interventions include:
 - **Phone interventions**, however
 - 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

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Models within transition care

- **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

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Types of Transitions

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Post-Acute 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
- 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)

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Transitions are common

- 22% experience a residential or health care transition each year (Sato et al., 2013)
- 50% of transitions are post-hospitalization to the original residential setting, but 50% experience multiple and more complex transitions (Sato et al., 2013)
- > 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)

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Adverse Events

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During Transitions

MFP participants are at Risk For

- Medication errors
- Service duplication
- Inappropriate care
- Critical omissions in care

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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)

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Adverse Events associated with poor 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

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Factors association 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

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Effective Care Transitions

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Why is this even more important now?

Medicare Hospital Readmissions Reduction

(Center for Medicare & Medicaid Service, 2016)

- 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)

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Why is this even more important now?

Medicare Hospital Readmissions Reduction (cont)

(Center for Medicare & Medicaid Service, 2016)

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

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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

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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

(Snow et al., 2009)

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Effective Care Transitions

Domains Covered and Critical Issues:

1. Medication management and reconciliation
2. Provider follow-up
3. Home health care delivery services, including: Homemaker, Emergency response and caregiver support
4. Home and community based services
5. *Red flags* and who to contact 24/7

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Effective Care Transitions

1. Medication Management and Reconciliation

The transition plan should include a **current** medication list, including

- Over-the-counter
- Herbals
- Allergies
- Drug interactions

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Effective Care Transitions Strategies

1. Medication Management and Reconciliation (Continued)

The 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

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Medication Management

1. Medication Management and Reconciliation (Continued)

Definitions:

- The systematic assessment of the pharmacotherapy of an individual patient that aims to evaluate and optimize medication by providing a recommendation or by making a direct change (Christensen & Lundh, 2016)
- No universally accepted definition, but it generally involves an assessment of the efficacy and harms of each medication prescribed

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Comprehensive Medication Management (CMM)

1. Medication Management and Reconciliation (Continued)

- Defined by the Patient-Centered Primary Care Collaborative (PCPCC) for use in the Patient-Centered Medical Home (PCMH) model
- CMM ensures each patient's medications (prescription, non-prescription, alternative medication, traditional vitamins, or nutritional supplements) are individually assessed to determine that each medication is appropriate for the patient, effective for the medical condition, safe to take (given the comorbidities and other medications being taken), and able to be taken by the patient as intended (PCPCC, 2012)

Comprehensive Medication Management includes:

Assess	}	<ul style="list-style-type: none"> Assessment of medication-related needs Identification of medication-related problems
Plan	}	<ul style="list-style-type: none"> Development of a care plan with individualized therapy goals and interventions Follow-up evaluation to determine patient outcomes

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When is medication management performed?

- During hospitalization (Christensen & Lundh, 2016; Schmader et al., 2004)
- After hospital discharge (Schmader et al., 2004)
- Over 2 visits (Lenaghan et al., 2007; Smith et al., 2011; Williams et al., 2004)
- Multiple visits (at ≥ 3 clinic visits) (Hanlon et al., 1996; Smith et al., 2011)
- In between physician visits (with pharmacist) (Reidt et al., 2016; Smith et al., 2011)
- When caregivers are present or absent (Lenaghan et al., 2007)
- Keys are to be aware that the process is continuous, and should be completed at each visit
- Particular attention should be given to **time of care transitions** (Christensen & Lundh, 2016; Eischens et al., 2010; Reidt et al., 2016)

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During you home visits

- Determine who the medication manager is at home (e.g., participant or caregiver) and what organizational tools (e.g., pill boxes) are used
- Screen for any new symptom that could be attributable to adverse drug event, side effect, or allergy to medication (Lee et al., 2009)
- Ask about all medication-related concerns and barriers such as cost, complicated regimen, visual or functional impairment, low literacy, etc.

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Discrepancies

1. Medication Management and Reconciliation (Continued)

Discrepancies are common when comparing patient-reported medication use with prescribers' orders

- Upon comparison of medication bottles to the medical record, one private practice found medication discrepancies in 75% of patients
- Most frequent discrepancies included using medications not accounted for in the medical record (51%), stopping recorded medications (29%), or taking different doses (20%)
- Older age, greater number of medications, and having more than one prescriber were significant predictors of discrepancies

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Asking about medication use

1. Medication Management and Reconciliation (Continued)

For each medication, ask these open-ended questions:

- What did your physician tell you this medication is for? (Prescriptions)
- Why are you using this product? (Non-prescriptions)
- How do you take this medication?
- How is this medication working for you?

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Ask about medication compliance

1. Medication Management and Reconciliation (Continued)

Morisky Medication Adherence Scale

- Do you ever forget to take your medicine?
- Are you careless at times about taking your medicine?
- When you feel better do you sometimes stop taking your medications?
- Sometimes if you feel worse when you take your medication, do you stop taking it? (Morisky et al., 1986)

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Ask about medication compliance

Blame-Free Open-Ended Questions

- These medications are difficult to take every day. How often do you miss/skip one?
- There are quite a few medications on this list. How many of these do you take?
- Most people don't take all of their medications every day. How about you?
- In a given week, how often would you say you miss a medication? Or drug A? Or drug B?

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Ask about medication compliance

1. Medication Management and Reconciliation (Continued)

Cost-Related Non-adherence

- During the past 3 months, have you not filled a prescription because it was too expensive?
- During the past 3 months, have you skipped a dose or taken a smaller dose to make the prescription last longer because you were worried about the cost of the medicine? (Marcum et al., 2013; Soumerai et al., 2006)

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Improve compliance

1. Medication Management and Reconciliation (Continued)

Randomized controlled trials looking at interventions to improve adherence yielded mixed results:

- Highest quality trials frequently involved enhanced support from family caregivers or allied health professionals such as pharmacists who delivered education, counseling, or daily treatment support
- Simplifying medication regimens (Claxton et al., 2001)
- Adherence decreases dramatically for persons taking four times a day regimens vs. once daily regimens

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Improve compliance

1. Medication Management and Reconciliation (Continued)

- Involving participants in developing their care plan may improve adherence if the patient feels invested in his/her own plan of care
- An accurate updated medication list should be provided to participants with a summary of key details (medication name, purpose, dose and dosing schedule) (Shrank et al., 2007)
- List should be written in person-friendly language for intended use by the participant
- Advise participant to share this list with other health care providers and keep a copy to share if admitted to a hospital or nursing home

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Effective Care Transitions Strategies

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) 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*

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Effective Care Transition Strategies

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

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Effective Care Transition Strategies

4. Home Health Delivery

Health care services in the home by an interprofessional team, including:

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

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Effective Care Transition Strategies

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

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Effective Care Transition Strategies

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 participant should keep this document in a visible, easily accessible location, such as on the refrigerator or near the phone, to be accessed during in emergency

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Effective Care Transition Strategies

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

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Effective Care Transition Strategies

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)

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Effective Care Transition Strategies

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

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Transition Care Planning

From Acute Care setting (hospitals)

- 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

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Improvements

What improvements can be made to transitional care models?

- Professionals must consider models that will provide follow-up post-discharge
- Determine when participants 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 participant and cannot be communicated to family and friends without permission

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Recommendations


Focus on:

- One home visit, multiple telephone follow-up contacts with a program “coach”
- 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”

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Risk Assessment

Forms H & I




Medical:
 #37: Participant having **repeated unplanned hospitalizations**
 #38: Participant having **repeated unplanned emergency room visits**
 #40: Participant have other conflicting diagnoses/conditions or multiple disabilities that need to be addressed
 #48: Participant take nine or more medications (including over-the-counter medications)
 #49: Participant need assistance with or close monitoring of medications
 #66: Participant has other medical conditions that are not addressed in the questions above

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Risk Assessment

Forms H & I




Engagement:
 #67: Participant at risk due to diminished mental capacity or impaired judgment such that he/she may not comprehend the seriousness of his/her decisions related to the plan of care
 #68: Participant at risk due to lack of awareness or understanding of the illness or disability
 #70: Participant at risk due to a lack of understanding of, inability or unwillingness to adhere to plan of care
 #71: Participant at risk of a **significant negative change** in medical status due to non-adherence with medications
 #72: Participant at risk of a **significant negative change** in medical status due to non-adherence with medically related supports

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Mitigation Plan

Form J




- **Arrange for** and monitor caregiver(s) and/or services.
- Develop and monitor a back up plan, personal resource list and caregiving schedule that includes available family member(s), caregivers and agencies, contact numbers, expected duties and schedules, and who to contact when there are service problems.
- Provide contact numbers for access to safe activities through consumer support group, peer supports, recovery specialists and/or community outreach programs (e.g., libraries, churches, NAMI, GROW, CILs, etc.).
- Arrange for Personal Emergency Response System (PERS) and monitor delivery/installation.
- Develop and monitor **backup plan** with participant of what they should do if caregiver(s) do not show up or perform the needed activities.
- **Arrange for** the delivery of medical supplies, durable medical equipment, or other medical devices.
- Arrange for and **monitor** necessary safety items, assistive technology/devices and/or home modifications to enhance home safety and accessibility.

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Mitigation Plan


Form J



- Arrange for and monitor education on the importance of taking **medication(s)** as prescribed, proper administration, side effects and overdose precautions.
- Arrange for and monitor **education** on diagnoses/conditions.
- Arrange, verify and **monitor appointment(s)** with healthcare provider for new onset or worsening symptoms.
- Monitor participant for risk(s) and update care plan to **prevent future accidental hospitalizations and ED visits.**
- Educate participant on lab test results and any follow up instructions.
- Arrange for review of medication(s) with a healthcare provider and monitor.
- **Arrange for and monitor** visiting nurse, family member or informal caregiver to provide medication administration and medication monitoring.

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Questions



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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/Agin_g_Network/Index.aspx Accessed December 20, 2016
- engageil.com Accessed January 26, 2017
- www.hospitalmedicine.org/Web/Quality___Innovation/Mentored_Implementation/Project_BOOST/Project_BOOST.aspx Accessed December 20, 2016
- www.transitionalcare.info Accessed December 20, 2016

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