Transitional Care Workgroup Preparation Materials

Meeting Date: July 12, 2013

Patient-Centered Outcomes Research Institute (PCORI)
1828 L Street, NW
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Washington, DC 20036

Topic Brief: Models of Transitional Care

Comparative effectiveness of different models of transitional care (hospital to home)

What are the effects of different models of transitional care on patient safety and other patient-centered outcomes?

Vignette:
It is March 5, 2018, and Jane Smith is about to be discharged from Center Hospital, where she was diagnosed with several chronic conditions, which have left her unable to fully take care of herself. She will be leaving with several new medications and the hospitalist’s recommendation to “change your diet and activity level.” A new transitional care program has just been implemented at Center Hospital and is available to patients and caregivers, at their request.

Question for workgroup participants:
From your current perspective (patient, caregiver, clinician, payer, etc.), what are three or four questions that you would want answered before deciding whether to participate in this transitional care program?

Assignment for workgroup participants:

- Share your three to five questions on the day of the workgroup meeting. This should take no longer than two to four minutes.
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<tr>
<th>Topic</th>
<th>Brief Description</th>
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<tr>
<td><strong>Introduction</strong></td>
<td><strong>DESCRIPTION OF TRANSITIONAL CARE</strong>&lt;br&gt;• Care strategies designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care.&lt;br&gt;• Based on executing an overall plan of care run by health providers who are familiar with different care settings and who have current information about patient goals, preferences, and clinical status.&lt;br&gt;• Includes making logistical arrangements, educating the patient and caregivers, reconciling medications, and coordinating providers involved in the care process.&lt;br&gt;• Occurs at multiple levels: within settings (primary–specialty care), between settings (hospital–home), and/or across health states (curative–palliative care).</td>
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<td><strong>Relevance to patient-centered outcomes</strong></td>
<td><strong>PATIENT-CENTERED OUTCOMES</strong>&lt;br&gt;• Quality of life&lt;br&gt;• Function&lt;br&gt;• Patient satisfaction&lt;br&gt;• Medication discrepancy or error&lt;br&gt;• Adherence or compliance&lt;br&gt;• Knowledge (medication or other)&lt;br&gt;• Adverse event&lt;br&gt;• Mortality&lt;br&gt;• Caregiver strain</td>
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<td><strong>Burden on Society</strong></td>
<td><strong>PREVALENCE</strong>&lt;br&gt;• Individuals with chronic conditions (expected to reach 125 million by 2020) may see up to 16 physicians in one year.&lt;br&gt;• According to one study, one in five patients discharged to home from the hospital experienced an adverse event within three weeks of discharge (60% medication related).&lt;br&gt;• Of hospitalized patients age 65 and older, 23% were discharged to another institution and 11.6% were discharged with home health care.&lt;br&gt;• 19.6% of all Medicare beneficiaries were re-hospitalized within 30 days. Approximately 90% of these re-hospitalizations were unplanned, with an estimated cost to the Medicare program of $17.4 billion.</td>
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<td>Effects on patients’ quality of life, productivity, functional capacity, mortality, use of healthcare services</td>
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<td>---------------------------------------------------------------</td>
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<td>• Medication errors</td>
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<td>o Medication errors harm an estimated 1.5 million people each year in the United States, costing the nation at least $3.5 billion annually. An estimated 60% of medication errors occur during times of transition: upon admission, transfer, or discharge of a patient.</td>
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<td>• Inefficient/duplicative care</td>
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<td>o Missing test results, discharge summaries, referrals, and medication lists may require patients to schedule redundant and avoidable appointments, which also requires additional copayments. The financial burden can pose significant adherence barriers, potentially leading to therapeutic, safety, economic, and psychosocial problems.</td>
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<td>• Inadequate patient/caregiver preparation—leading to dissatisfaction</td>
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<td>o Lack of clear, consistent education, training, and instructions by providers decreases patient adherence to care plans.</td>
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<td>▪ According to the October 2012 report “Home Alone,” based on a national survey conducted jointly by the United Hospital Fund and the AARP Public Policy Institute, nearly half of the estimated 42 million unpaid caregivers in the United States perform complex medical and nursing tasks, such as medication management—including administering IVs and injections—wound care, and operating specialized medical equipment and monitors for a family member with multiple chronic conditions.</td>
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<td>• Nearly 18% of Medicare beneficiaries are re-hospitalized within 30 days of discharge, with 13% of those readmissions potentially avoidable, ultimately estimated to cost $12 billion.</td>
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<th>How strongly does overall societal burden suggest that comparative effectiveness research on alternative approaches should be given priority?</th>
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<td>Healthcare experts have long identified fragmentation in the US healthcare system as a high priority issue that must be addressed to improve care quality and efficiency. In 2001, the Institute of Medicine issued “Crossing the Quality Chasm: A New Health Care System for the 21st Century,” a report that called for increased care coordination across the healthcare system. In 2008, the National Priority Partnership identified care coordination as one of six national priorities, and the enactment of the Affordable Care Act in 2010 put in place several initiatives specifically designed to address gaps in care occurring between healthcare settings. Overall, there is significant focus on improving communication between providers, patients, and caregivers; increasing the use of case managers and care coordinators; ensuring medication reconciliation; establishing accountability among various providers in the care continuum; and considering implementation of payment system incentives to help achieve successful care transitions.</td>
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<th>Options for Addressing the Issue</th>
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<td>Based on recent systematic reviews, what is known about the relative care models?</td>
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<td>• Improving Patient Handovers from Hospital to Primary Care: A Systematic Review (Annals of Internal Medicine, September 2012)</td>
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<td>o Of the 36 included studies, 25 (69.4%) showed statistically significant effects in favor of the intervention group, and 34 (94.4%) described multicomponent interventions. Effective interventions included medication reconciliation; electronic tools to facilitate quick, clear, and structured summary generation; discharge planning; shared involvement in follow-up by hospital and community providers; electronic discharge notifications; and web-based access to discharge info for practitioners.</td>
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Have recent innovations made research on this topic especially compelling?

• **AFFORDABLE CARE ACT**
  - Hospital Readmissions Reduction Program (Sec. 3025, Sec. 10309)
  - Medicare Community Care Transitions Program (CCTP) (Sec. 3026)
  - HHS/CMS Electronic Health Record Mandate

• **LEADING MODELS OF TRANSITIONAL CARE**
  - *Better Outcomes by Optimizing Safe Transitions (BOOST)—122 US and Canadian sites*
    - Reduce 30-day readmission rates
    - Improve patient satisfaction scores and H-CAHPS related to discharge
    - Improve flow of information between hospital and outpatient providers
    - Identify high-risk patients and target specific interventions to mitigate risks
    - Improve patient and family preparation for discharge
    - Comprehensive intervention and implementation guide, longitudinal technical assistance (i.e., face-to-face implementation training), BOOST collaboration/communication between sites, and BOOST data center
  - *Transitions of Care Model—Nurse-driven comprehensive transition plan*
    - Targets cognitively intact older adults with multiple chronic conditions
    - Nurse coordinates discharge plan with family and hospital provider team, implements the plan in patient’s home, assists patient with management, and facilitates communication and the transition to community providers
    - Is the focus of one current and three completed National Institutes of Health–funded randomized controlled clinical trials
    - Studies are underway to expand testing the model among older adults in long-term care transitioning to and from acute settings
  - *Care Transitions Program*
    - Support patients and families
    - Increase skills among healthcare providers
    - Enhance the ability of health information technology to promote health information exchange across care settings
    - Implement system-level interventions to improve quality and safety
    - Develop performance measures and public reporting mechanisms
    - Influence health policy at the national level
  - *Transitions in Care 2.0 Action Agenda—10 steps for chronically ill adults and caregivers*
    - Identification of caregivers and guided self-assessment of training/support needs
    - Discussions with caregivers about patient’s condition
    - Caregiver preparation for transition (including training and support on tasks such as medication management, mobility, diet, etc.)
    - Assisting patient and family caregivers in identifying community healthcare services and resources

How widely does care now vary?

• In a study on hospital discharge communication to primary care, direct communication between the hospital and primary care setting occurred only 3% of the time. At discharge, a summary was provided only 12% of the time, and this occurrence remained poor at four weeks post-discharge, with only 51% of practitioners providing a summary. This standard affected quality of care in 25% of follow-up visits.
A summary of current and recent trials

**SELECTED SMALL-SCALE STUDIES**
- Variation by who is leading the intervention (e.g., nurse, pharmacist, social worker, or community worker)
- Variation by the type of intervention (e.g., HIT-based, patient coaching, patient-empowering strategies, information sharing, multi-component QI interventions)
- Variation by the types of patient-centered outcomes measured (mortality, function, health-related quality of life, symptoms, satisfaction, self-efficacy, caregiver perspective)

Examples of some specific measures used in current or recent care transitions studies include:
- Readiness for Hospital Discharge Scale (patient version and RN version)
- Care Transitions Measure (CTM-3)
- The Assessment of Quality of Life (AQoL) instrument
- Caregiver Strain Index

**SELECTED LARGE-SCALE STUDIES and PROGRAMS**

**STUDIES**
- **Medicare Community Care Transitions Program (CCTP) (Sec. 3026)—CMS/CMMI**
  - 102 participating organizations; five-year pilot
  - Performance measures: outcome (readmissions), process (follow-up care), adverse effect (ED visits), patient experience (HCAHPS, CTM-3, PAM-13), individual CBO evaluations
- **Better Outcomes by Optimizing Safe Transitions (BOOST)**
  - 122 sites United States and Canada
  - See above listed aims in “Have recent innovations made research on this topic especially compelling?” section of this document

**PROGRAMS**
- **TC-QuIC (Transitions in Care-Quality Improvement Collaborative)**
  - Ran from March 2010 to June 2012, addressing transitions of chronically or seriously ill patients between care settings, with a focus on involving caregivers
  - Round 1: 26 organizations or units within organizations; Round 2: 19 organizations or organizational units
  - 45 healthcare provider teams
- **Partnership for Patients (PfP) campaign—Health Research & Educational Trust (HRET)/CMS**
  - Provide quality improvement education and training with nearly 1,800 hospitals recruited by 33 state hospital association partners
- **READI (Readiness Evaluation And Discharge Interventions): Implementation as a Standard Nursing Practice for Hospital Discharge—Marquette University**
  - A multi-site study to determine the impact on post-discharge utilization (readmission and ED visits) and costs of implementing a discharge readiness assessment as a standard nursing practice for adult medical-surgical patients discharged to home
  - Additional outcomes measures include actions taken by discharging nurse in response to discharge readiness assessment, nurse perceptions of patient readiness for hospital discharge, and patient perception of discharge readiness
  - The study will run January 2014 through June 2016 and aims to enroll 24,000 participants
### Summary of research

There is opportunity to compare across different models of transitional care and also opportunity to evaluate current models of transitional care on comprehensive patient-centered outcomes. There may be potential to expand upon existing large-scale research programs, as well as possibly funding novel research addressing comprehensive patient-centered outcomes. Furthermore, there is a lack of research focused on addressing specific priority populations and patient characteristics (i.e., socioeconomic status, community resource availability, etc.).

### How likely is it that new comparative effectiveness research on this topic would provide better information to guide clinical decision making?

New CER on this topic is needed to guide clinical decision making in the following areas:
- Comparing different types of transitional care, such as primary care–based, nurse-based, or medical center–based.
- Measuring patient-centered outcomes, including those important to caregivers, using evidence-based, validated tools.
- Differences in outcomes based on age, sex, race, ethnicity, socioeconomic status, comorbid conditions, or setting type.
- Evidence on how best to implement transitional care strategies in real-world settings.
- Evidence on how best to target transitional care to the specific patient-centered outcomes that are most relevant for each patient and how best to shape the transitional care teams accordingly.

### Potential for New Information to Improve Care and Patient-Centered Outcomes

#### What are the facilitators and barriers that would affect the implementation of new findings in practice?

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<th>FACILITATORS</th>
<th>BARRIERS</th>
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<tr>
<td>• Significant impact for all transitioning patients and their caregivers</td>
<td>• Lack of time for medical providers to adequately assess patients</td>
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<td>• Focus on this issue from Institute of Medicine, National Priority Partnership, and the Affordable Care Act</td>
<td>• Lack of training for medical providers in communication between settings</td>
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<td>• Increasingly educated and involved patients and caregivers in care</td>
<td>• Lack of availability of integrated electronic health records in some locations</td>
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<td>• Aging population</td>
<td>• Lack of resources, including additional personnel or services</td>
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#### How likely is it that the results of new research on this topic would be implemented in practice right away?

- There is significant opportunity to supplement existing research with new research that focuses more on outcomes that matter to patients and caregivers. Furthermore, consideration of the difficulties related to culture change in practice, resource restrictions, and other barriers to implementation must be taken into consideration. Research that includes strategies focused on successful adoption of transitional care models has the potential for sooner implementation.
REFERENCES


PROGRAM REFERENCES
Clinicaltrials.gov READI (Readiness Evaluation And Discharge Interventions): Implementation as a Standard Nursing Practice for Hospital Discharge

CMMI Community-based Care Transitions Program (CCTP)

CMS Partnership for Patients

Eric Coleman and colleagues The Care Transitions Program

Mary Naylor and colleagues Transitional Care Model

Society of Hospital Medicine Project BOOST: Better Outcomes by Optimizing Safe Transitions

United Hospital Fund TC-QuIC: A Quality Improvement Collaborative

United Hospital Fund, May 2013 Transitions in Care 2.0: An Action Agenda

*PCORI Topic Brief: Improving Healthcare Systems—Models of Transitional Care*