Chapter One: Getting Started

Chapter Outline

Chapter Overview

Care transitions programs are a hot topic in today's discussion for improving safety and quality in health care. If your organization is considering developing a care transitions program, it will be helpful to understand what care transitions programs address, what the basic evidence tells us for supporting care transitions, and what interventions look like. This chapter provides many basic resources that will begin your research into care transitions. As you begin your investigation, this chapter and toolkit will provide some perspectives for why care transitions programs are important to the mission of the Aging Network and a unique opportunity to address community approaches for supporting the health, independence, and choice of older adults, individuals with disabilities, and their caregivers.

An Introduction to Care Transitions—The Basics

Care transitions refer to the shift experienced by individuals from one provider or setting to another. Transitions in setting of care (e.g., from hospital to home or nursing home, or from facility to home and community based services) for people living with serious and complex illnesses are prone to errors. Medication errors, poor communication and coordination between providers from the inpatient to outpatient setting, and a rising incidence of preventable adverse events have drawn national attention to efforts to improve the safety and effectiveness of transitions across the continuum of care, including both medical services and home and community based services and supports. Providers from both sides of health care and home and community based social support are aware of the ill effects of poor transitions, but struggle with fragmentation and lack of collaboration across settings, limited resources, and an expanding aging population with multiple chronic conditions.

Older adults experience more than 13 million transitions across the continuum of care a year, and these transitions can be risky and confusing when there is inadequate coordination among professionals and/or information provided to patients and families.[2] Consumers and caregivers are often the only consistent element during transitions, and are frequently expected to serve an active role without adequate information or tools to successfully perform this function.[3]

2 Transitional Care Leadership Summit, July 6-7, 2006. http://www.healthresearchforaction.org/transitional-care-leadership-summit

3 Improving Transitions of Care: Findings and Considerations of the "Vision of the National Transitions of Care Coalition," National Transitions of Care Coalition, September 2010

Poor transitions across the continuum of care can also have potentially serious and harmful outcomes. Readmission to the hospital, medication errors, and unnecessary nursing home placement are linked to poor transitions.[4] Researchers estimate that one in five Medicare beneficiaries who are discharged from hospitals are readmitted within 30 days, one-third are readmitted within 90 days, and the national fiscal impact to Medicare was $17.4 billion in 2004.[5] Some studies have found that between 40 percent and 50 percent of readmissions are linked to social problems and lack of community resources.[6] Increased access to long-term services and supports provided by the Aging Network as part of a larger care transitions program can address this critical barrier to smooth transitions across care settings.

Recent developments, including the passage of the Affordable Care Act (ACA) in March 2010, have led to greater interest by Federal agencies, insurance companies, and hospitals in better coordinating care and services when individuals transition from one care setting to another. For example, to further encourage careful hospital discharge planning and safe care transitions, Section 3025 of the ACA calls for progressive reduction in Medicare payments to hospitals beginning in 2012 based on the rate of 30-day readmissions for Medicare beneficiaries. The goal is to ensure that the hospital discharges are accomplished appropriately and that care transitions occur effectively and safely. The goal is not to avoid re-hospitalization if that is the best treatment option for an individual.

4 Coleman, E. A. and Fox, Peter D. on behalf of the HMO Care Management Workgroup (2004). One Patient, Many Places: Managing Health Care Transitions, Part I: Introduction, Accountability, Information for Patients in Transition. Annals of Long-Term Care: 25-32.

5 Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H. Rehospitalizations Among Patients in the Medicare Fee for Service Program. N Engl J Med 2009; 360:1418-1428

6 Proctor et al. (2000) Adequacy of Home Care and Hospital Readmission for Elderly Congestive Heart Failure Patients. Health and Social Work 2000; 25(2): 87-96(10)

Evidence Based Care Transitions Models

There are several evidence based care transitions models that offer individuals and caregivers short-term support as they transfer between care settings such as hospitals, nursing facilities, and the community. Some of these models also address system level changes in health care and other provider settings to improve internal processes for supporting care across settings. In most care transitions interventions, consumers are first engaged while in acute care settings and then followed intensively over a period of approximately one to three months after discharge to the community. Common themes across models include:

- Identification of a specific staff person to provide transitional care support
- Interdisciplinary communication/coordination, patient activation
- Enhanced post discharge follow up

The goal is to ensure that consumers and their caregivers understand post-discharge instructions for medication and self care, recognize symptoms that signify potential complications requiring immediate attention, and make and keep follow-up appointments with their primary care physicians.

What do we mean by evidence based programs?

A growing body of research in the social and behavioral sciences has demonstrated that certain approaches and strategies in combination with each other can positively impact important social issues such as chronic disease or medication management. Many of these effective approaches and strategies have been packaged into programs targeting specific outcomes. Those programs that have been found to be effective based on the results of rigorous evaluations are often called "evidence based." »

« An important element of evidence based programs is that they have been evaluated rigorously in experimental (such as randomized control trial) or quasi-experimental studies.

These evaluations are often subject to critical peer review. Through these reviews, experts in the field examine the evaluation's methods and agree with its conclusions about the program's effectiveness. These findings are then published in scientific, peer-reviewed journals.[7]

Resources

- Chart: Six Examples of Evidence Based Care Transitions Models
- Care Transitions in New Hampshire: Steps for Choosing a Model (Slides from 2011 Administration on Aging, Centers for Medicare & Medicaid Services (CMS), Department of Veterans Affairs (VA) National Grantee Meeting)

How the Aging Network Supports Care Transitions

Improving hospital and nursing home transitions and the broader issue of supporting individuals in their communities will take more effort than any single entity. A coordinated, community based approach that includes health care and social service partners has been recognized as an effective strategy to improve health and lower health care related costs. Individuals live their lives in the community, repeatedly moving across the continuum of care during their lifetime. The coordination of health care and social service providers is essential to ensuring that individuals are able to experience smooth transitions from one setting to another and age in place in the community. As the health care delivery system experiences a shift toward payment for performance and quality, the Aging Network will serve an important role in ensuring safe and seamless transitions from multiple care settings.

As the backbone of the Nation's long-term services and support system, State Units on Aging (SUAs), AAAs, Native American aging programs, and ADRCs provide support to more than 11 million older adults, individuals with disabilities, and caregivers each year. These services are vital to helping people maintain their health and independence and remain engaged in community life. The Aging Network's infrastructure provides an important existing vehicle to driving change and quality in local communities, while assisting in statewide and regional diffusion of models and best practices. Several core elements and infrastructure are critical to building successful strategies for supporting care transitions, including:

- Care coordination and service delivery expertise
- Extensive experience with older adults and caregivers
- Quality assurance, monitoring, and outcomes
- Trusted community presence
- Contracting power brokers

Supporting care transitions is not a new activity for the Aging Network. Since 2003, AoA and the Centers for Medicare & Medicaid Services (CMS) have funded care transitions work through ADRC and Person-Centered Hospital Discharge Planning Model Grants. Many of the partnerships developed and lessons learned from these programs will translate into expanded care transitions efforts. For more information about ADRCs and Care Transitions, please visit: http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_caretransitions/index.aspx.

7 Cooney, S.M. et al. Evidence-Based Programs: An Overview, What Works Wisconsin—Research to Practice Series, October 2007. http://www.uwex.edu/ces/flp/families/whatworks_06.pdf

Resource

- Care Transitions: What Do These Programs Look Like and How Can the Aging Network Play a Role? (Slides from the 2011 AoA, CMS, VA National Grantee Meeting)

Steps to Getting Started with Care Transitions

While preparing for all of the organizational and partnership components may seem overwhelming, there is a great power to coming together: Taking a community approach can start with a simple dialogue and elevating local awareness. What will motivate your organization to action? Mission? Cost or payment/reimbursement changes? Regulation, legislation? Threat of punishments, fines? Satisfaction of doing the right thing? Clear information on what works and what doesn't? "Everybody else is doing it?" Being both flexible and focused as you develop your initial approach, as well as over time, will help with overcoming challenges and delays.

Resource

- Checklist for Getting Started with Care Transitions

Choosing a Model—A Case Study

This chapter discusses the basics related to care transitions and presents some examples of evidence based models that are effective tools for reducing preventable hospitalizations and improving individual care as consumers and caregivers experience a transition in health care settings. While selecting an evidence based care transitions model will not likely be your first step in planning a new care transitions program, this case study from Missouri's Hospital Discharge Planning Grant presents a concrete perspective on how selecting a model was worked into the partnership's planning process.

Our hospital discharge planning workgroup included staff from three hospitals, our AAA, one local Center for Independent Living, and individuals from the University of Missouri Institute for Human Development. A major part of the workgroup's charge was reviewing, in detail, several care transition models. We examined Project BOOST, Project RED, and Care Transitions Intervention. Different aspects of these models were identified by various workgroup members as addressing specific challenges in discharge planning. Some workgroup members were already aware of these models, and respective hospitals were already implementing certain aspects of some/all of them. All members of the workgroup felt that implementing any one of these models was unattainable by their

respective institutions/organizations. Therefore, the workgroup concentrated on what, if anything, could be utilized from these models to enhance more effective discharges. We agreed that the main goal, found in all three models, was the hospital-to-home transition. Common aspects of these models that the workgroup considered essential were patient/person-centered planning, teach-back methods, and post-discharge follow up. Workgroup members felt that they had incorporated, or were already in the process of incorporating, patient-centered planning and teach-back methods. We identified post-discharge follow up with individuals to be a major challenge as well as not having the time to contemplate possible non-medical service needs that may not be directly obvious to hospital social workers or discharge planners, nor related to the individual's current hospitalization.

Missouri Department of Health and Senior Services Division of Senior and Disability Services Hospital Discharge Planning Grant

Questions to Consider and Practical Advice from the Field

Q: What general advice do you have for those getting started?

Consider taking the time to apply for a private planning grant through a local foundation. We used our time during our planning grant to develop lists of common stakeholders (statewide, local leaders, advocates, service providers, seniors, and caregivers), host planning meetings, and ask questions. *Community Connections Program, Carol Woods Retirement Community, Chapel Hill, NC*

Have a project coordinator shadow a discharge planner/counterpart at the hospital. This can create buy-in from the hospital staff and build enthusiasm for the project. Also coordinating between partners for staffing protocol, job descriptions, etc., would be helpful. *Kansas Department on Aging, Hospital Discharge Planning Grant*

Have a clear understanding of the benefits of a person-centered approach, especially while planning with outside stakeholders. Also be willing to refine roles based on each individual's skills and expertise. Finding a champion among each stakeholder group was particularly helpful. *South Carolina Bureau of Senior Services, Hospital Discharge Planning Grant*

Our lessons learned have included identifying opportunities to break down long-existing silos and sense of territoriality, identifying cultural and procedural difference between different types of providers, identifying clear roles for stakeholders, and developing a clear cross setting "team," maintaining ongoing monitoring and tweaking of each approach, and maintaining focus on the patient. We continuously educated everyone involved. *Quality Insights (PA QIO) regarding work with Southwestern PA AAA and Westmoreland County AAA from the QIO 9th Scope of Work Care Transitions Theme*

To cover the full continuum of care, it will be important to know the politics of a community. One way to go about learning about how organizations relate to one another is to begin by talking to one or two critical organizations (e.g., a hospital or a clinic). From there, an organization can work with that partner to build a more comprehensive network of partners that cover a broader continuum of care by discussing together who to approach next. *AAA of Central Texas, ADRC Evidence-Based Care Transitions Program*

Additional Resources

Administration on Aging Resources

- AoA's Aging and Disability Resource Centers and Care Transitions http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_caretransitions/index.aspx
- Aging and Disability Resource Center Technical Assistance Exchange: Care Transitions Page http://www.adrc-tae.org/tiki-index.php?page=CareTransitions
- AoA's Health Reform Page http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx

Centers for Medicare & Medicaid Services Resources

- Care Transitions Quality Improvement Organization Support Center http://www.cfmc.org/caretransitions/Default.htm
- CMS: Community Based Care Transitions Program http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313
- Center for Medicare and Medicaid Innovation http://innovations.cms.gov/
- Discharge Planning Checklist http://www.medicare.gov/publications/pubs/pdf/11376.pdf

Agency for Healthcare Research and Quality (AHRQ) Resources

- AHRQ Health Care Innovations Exchange http://www.innovations.ahrq.gov/index.aspx
- AHRQ Improving the Hospital Discharge Process http://www.ahrq.gov/qual/projectred/

National Coalitions

- National Transitions of Care Coalition http://www.ntocc.org/
- Long-Term Quality Alliance http://www.ltqa.org/
- National Coalition on Care Coordination http://www.nyam.org/about-us/social-work-leadership/

Foundations

- The Foundation Center http://foundationcenter.org

Tools

- What is the Aging Network?
- Checklist—Getting Started with Care Transitions