Transitional Care: How to Minimize Errors and Maximize Outcomes

November 01, 2006 | Hypertension [1], Medicare Reimbursement [2], Atrial Fibrillation [3], Sleep Disorders [4]
By Dale P. Murphy, MD [5] and Maryjo Cleveland, MD [6]

An 84-year-old man with a history of stable angina, type 2 diabetes, hyperlipidemia, and hypertension presents to the emergency department with worsening dyspnea and peripheral edema.

THE CASE: An 84-year-old man with a history of stable angina, type 2 diabetes, hyperlipidemia, and hypertension presents to the emergency department with worsening dyspnea and peripheral edema. Congestive heart failure is diagnosed, and the patient is admitted to the care of a hospitalist. A standard therapeutic regimen, including diuretics, angiotensin-converting enzyme inhibitors, and oxygen, is instituted, in addition to the patient's home regimen of isosorbide mononitrate, glipizide, and amlodipine. The hospital substitutes pravastatin for the patient's atorvastatin. A Foley catheter is inserted by a urologist because of the patient's benign prostatic hypertrophy. The patient complains of insomnia and is given diphenhydramine. His hospital course is otherwise uneventful.

By the third day, the patient is stable enough for discharge. His social history reveals that he lives alone, does not drive, and has help from his daughter every Saturday. She lives 45 minutes away, works full time, and has 3 children. She picks the patient up at discharge, fills his prescriptions, drives him home, and instructs him to call her if he has any problems. A home health care nurse is instructed to check on him as soon as possible after discharge. During the next 5 days, the patient takes all his medications, old and new. He is having increased difficulty in starting his urine stream and feels that he is not emptying his bladder. He notices that his ankles are swollen. The home health care nurse makes her first visit 5 days after the patient's discharge. She finds him confused and short of breath and notes that his home smells of urine. She calls Emergency Medical Services to transport him to the hospital.

What are the most common errors in transitional care, and how can such care be improved?

Transitional care is defined as "a set of actions designed to ensure the coordination and continuity of health care as patients move between different locations or different levels of care in the same location." Thousands of these transfers occur daily. Some are emergent; others are nonemergent. Regardless of the degree of urgency, transitional care offers many opportunities for error and therefore many opportunities for improvement.

The case history outlined here provides an unfortunately common example of a failed transition to home after an uncomplicated hospitalization. In this scenario, there are at least 5 factors that illustrate the hazards of transitional care:

- The patient was cared for by a hospitalist, not his primary care physician, and no communication on admission or at discharge between the 2 physicians was documented.
- The hospital's substitution of pravastatin for atorvastatin resulted in the patient's use of 2 statins on his return home.
- The use of diphenhydramine for sleep probably contributed to urinary retention and delirium.
- The patient was discharged to a setting in which very little support was available, and the patient and caregiver were not instructed about the management of his condition.
- The home health care nurse was unable to visit for 4 days. A visit within 48 hours would have been optimal.

All of these factors, and possibly others, contributed to a rehospitalization that could easily have been avoided with better preparation for the transition to home. Troubled Transitions

The need for improved standards of transitional care has gained increasing attention recently for a number of reasons. First, it is now unusual for a single practitioner to follow a patient from outpatient...
status to hospital to skilled nursing facility. A different physician usually takes over at each site of care. Second, patients are transferred from one level of care to another before the appropriate time. Often, skilled nursing facilities are caring for patients whose complex medical needs required continued hospitalization only a decade ago. Third, patients are often transferred home without adequate support. Today, families are more mobile than ever. Fewer family members are available to provide ongoing care. Relatives who do live nearby often lead busy lives of their own and have little time or energy left for the significant demands of caregiving. Often, they are unaware of community resources that might be available to them.

For these and other reasons, the American Geriatrics Society (AGS) in 2003 produced a position statement that highlighted 5 key recommendations to improve the quality of transitional care.³ They may be summarized as follows:

1. Clinical professionals—such as a hospitalist and social worker—must prepare patients and their caregivers to receive care in the next setting and actively involve them in decisions related to the formulation and execution of the transitional care plan. This can be accomplished at a formal family meeting or more informally with a call to the patient's primary caregiver.
2. Communication between clinical professionals is essential to ensure high-quality transitional care.
3. Policies are needed at all levels that promote high-quality transitional care.
4. Education in transitional care should be provided to all health care professionals involved in the transfer of patients across settings.
5. Research is needed on ways to improve the process of transitional care.

As primary care physicians, we can easily implement the first 2 recommendations. From the moment a patient is admitted to the hospital, the discharge should be kept in mind. In the present case, it was likely that the patient would be discharged within 3 or 4 days. Ideally, the following steps should have been taken:

- A conversation with the patient's daughter early in the hospital course to help identify barriers to his return home.
- Discussions with hospital social workers to devise solutions to these problems.
- Continuous updates to the patient and his daughter about his condition and instructions about follow-up care at home.

Communication is the cornerstone of effective transitions. A fax or telephone call from the hospitalist to the primary care physician at the time of discharge to arrange follow-up and discuss potential problems is invaluable. This communication should contain a written or verbal summary of the problem list, medications (including reconciliation with earlier medication lists), allergies, advance directives, and information about current physical and cognitive function.⁴

The other AGS recommendations may lie outside of our current practice environment, but they are important issues for high-quality care. It is crucial that policies be developed at the national level (ie, Medicare reimbursement for transitional care, insistence by accreditation bodies on clear protocols) as well as at the local level (for example, a standard discharge form for all hospitals and skilled nursing facilities in a community). Teaching institutions must educate medical students, residents, nurses, and other health care personnel about the value of transitional care. Having learners on both the sending and the receiving ends will reinforce the value of shared information. For example, if residents are responsible for a small group of patients at a nursing facility, they will quickly understand the challenges of implementing a plan of care following discharge without adequate information.

Finally, further research is required to determine how best to smooth transitions. In one study of advance practice nurses who saw patients in the hospital and monitored them at home for 4 weeks, the readmission rate was reduced by 50%.⁵ In another study, a nurse functioned as a coach to empower patients to be their own advocates.⁶ This approach was equally successful. We must find ways to identify patients—especially vulnerable elderly persons—who are at high risk for poor transitions and develop economically feasible methods to overcome these risks.

The Table summarizes the components of effective transitional care.
### Table – Components of effective transitional care

<table>
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<tr>
<th>Component</th>
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<tr>
<td>Communication between the sending and receiving clinicians regarding:</td>
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<tr>
<td>• A common plan of care.</td>
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<tr>
<td>• A summary of care provided by the sending institution.</td>
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<td>• The patient's goals and preferences (including advance directives).</td>
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<td>• An updated list of problems, baseline physical and cognitive functional status, medications, and allergies.</td>
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<tr>
<td>• Contact information for the patient's caregiver and primary care practitioner.</td>
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<tr>
<td>Preparation of the patient and caregiver for what to expect at the next site of care.</td>
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<tr>
<td>Reconciliation of the patient's medications prescribed before the initial transfer with the current regimen.</td>
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<td>A follow-up plan for how outstanding tests and procedures will be managed.</td>
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STRAIGHTS FOR IMPROVED OUTCOMES
Although much remains to be done, considerable opportunity for improvement exists. For example, at our institution, improved transitional care is a high priority, and the following measures have been implemented (personal communication, Kyle Allen, DO, chief of the division of geriatric medicine, Summa Health System, Akron, Ohio):

- Improved communication among physicians at the different sites of care, particularly in complicated cases.
- Community partnerships with agencies such as the Area Agency on Aging, the Alzheimer Association, and Adult Protective Services have been forged to make transitional care more seamless.
- A preferred provider network with 27 for-profit cooperating skilled nursing facilities has been formed.
- A regional postacute transfer form has been created and put into use.
- A caregiver institute that empowers caregivers as patient advocates has been created.
- Improvements in transitional care programs are being sought at the medical executive and system levels, primarily by the division of geriatric medicine.

This collective approach stands to benefit the entire community, including patients and their families, physicians, hospitals, and postacute sites of care.

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