Care Transitions

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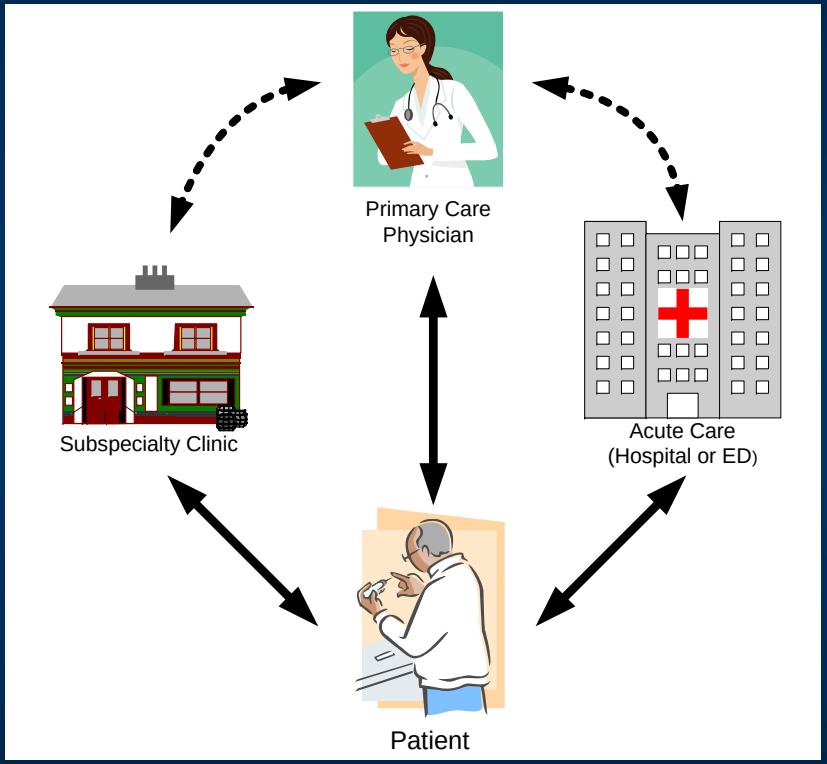
ACGIM Conference

Our goals…

- Discuss the importance of transfers of care
- Recognize barriers to performing a safe and effective discharge
- Review what is currently known about care transitions in medicine
  - Focus on successful interventions
- Prepare you to improve care transitions at your own institution

Background

- Effective communication and coordination during care transitions especially important for patient-centered care
  - Central to medical home concept
  - admission and discharge from the hospital



Understanding how well we are doing…

Transitions Theater

“Piecing it all Together”

Based on qualitative data collected as part of 1P20 HS017119 AHRQ
A Model for Effective Inpatient Ambulatory Care Transitions

What did you observe?

Barriers	**Observations/Thoughts**
Cultural (e.g., not following proper procedures, unprofessional behavior, etc.)	
Communication (e.g., vague terms, incomplete information, lack of verification, etc.)	
Environmental (e.g., distractions and obstacles interfering with completing proper care transition)	
Other	
Facilitators	**Observations**
What went well in this scenario?	

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Debrief

- Was this realistic?
- What barriers did you observe?
- Why were the barriers present?

Does communicating with PCPs during patient transitions matter?

Is there any data?

Problems During Care Transitions

- Adverse events and rehospitalization *(Moore, et al. 2003; Forster, et al. 2003)*
- Medication discrepancies on admission and discharge *(Cornish, et al. 2005; Coleman, et al. 2005)*
- Physicians unaware of critical tests pending at discharge *(Roy, et al. 2005)*
- Patients confused about care plan *(Coleman, et al. 2005)*
- Patients are a more reliable source of post-discharge adverse events than medical records *(Weissman, et al. 2008)*

Arora and Farnan, 2008

Communication with PCPs is Suboptimal

- While 68% of PCPs believe hospitalists are a good idea, only 56% satisfied with communication *(Pantilat, et al. 2001)*
  - 1/3 believed had received discharge summary in a timely fashion
- Direct communication between hospital physicians and PCPs occurred infrequently (3%-20%) *(Kripalani, et al, 2007)*
  - Discharge summary often not available
    - Relates to PCP dissatisfaction
  - Discharge summaries lacked key information (meds, follow up appt)
- *What do patients think?*

Arora and Farnan, 2008

Specific Aims

- To understand patient perceptions of communication between hospital physicians and their PCPs
- To explore the association between PCP awareness of hospitalization and patient reported post-discharge complications

Patient Phone Interviews

- Phone interviews conducted with patients
  - 2 weeks after hospital discharge
  - Oversampled frail elders
- 12 open-ended questions
  - Perceptions of communication between their hospital physician and their PCP
  - Post-discharge complications using critical incident technique *(Flanagan)*
    - *"Did anything bad or inconvenient happen following your hospital stay, such as readmission, problems with medications, missed test, etc?"*
  - audio-taped, transcribed, coded in ATLAS.ti

Methods

- Patient Interviews
  - % of post-discharge complications
- PCPs faxed a survey 2 weeks after discharge
  - *"Where you aware your patient had been hospitalized?"*
    - % PCP aware of admission
- Chi square tests
  - Association of PCP awareness of hospitalization with patient report of post-discharge complication

Results

- 64 patient interviews completed from 112 eligible patients (57%)
  - 42% of patients reported experiencing a post-discharge complication
- 40 PCP surveys completed out of 64 interviewed patients (63%)
    - 30% reported being unaware of hospitalization

Patient Perceptions of PCP Communication

Category (n*)	**Representative Quote**
Uncertainty of how physicians communicate with PCP (40)	*"I don't know if they spoke to each other over the phone or if they had any kind of communication" (64725)*
Assumption of good communication with PCP (24)	*"I presume that they would communicate with one another, especially [inpatient attending] and [PCP]" (64725)*
Obligation to communicate with PCP (16)	*"I think they should because there are two doctors who are attending me and they should have communication with each other" (64315)*

*n represents number of incidences/quotes

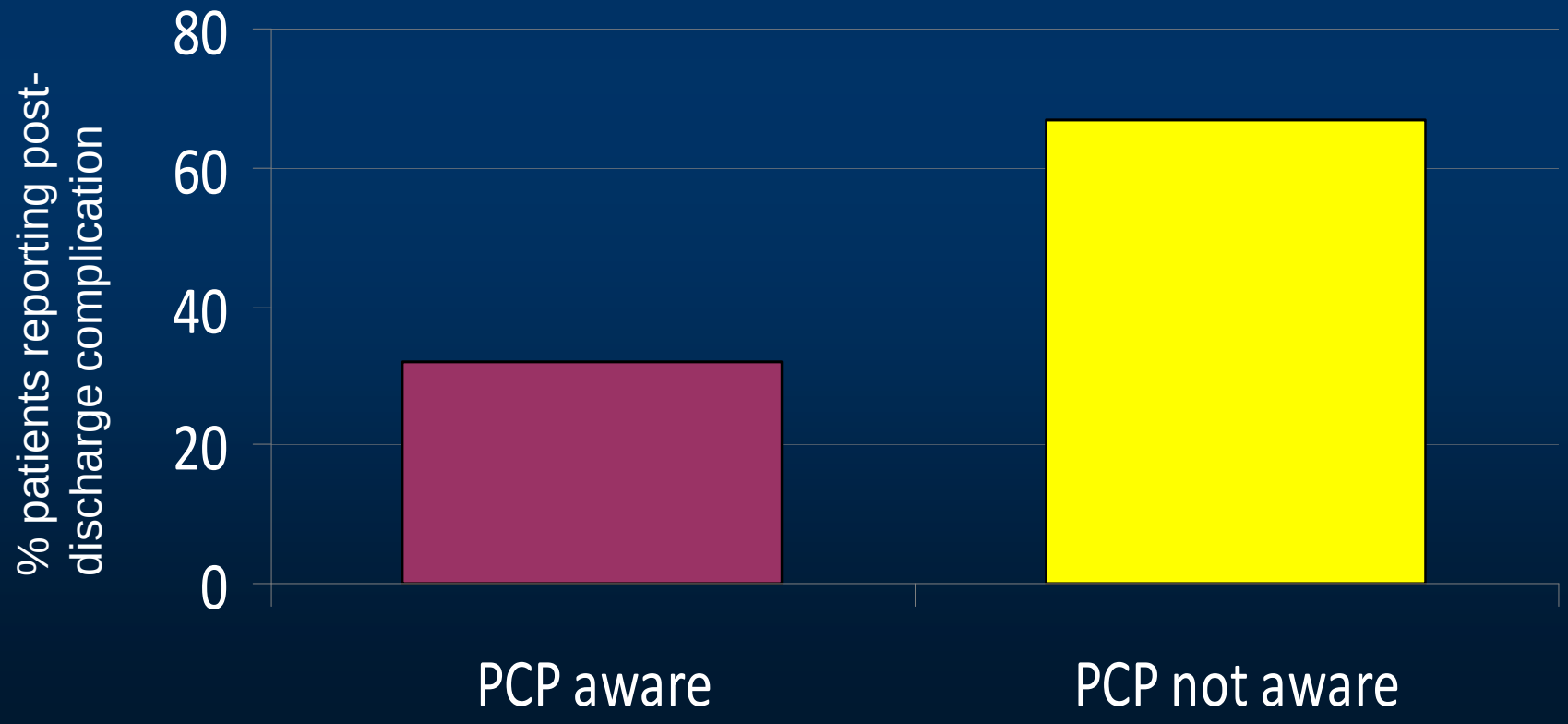
Results-Post-discharge complication (n=42)

Category (n)	Representative incident (patient)
Difficulty with follow-up test or appt (12)	*"I had an earlier [follow-up appointment] with him but [missed it because] …staying at my daughter's I didn't have access to a car" (65743)*
Needed re-evaluation Readmitted or ER visit (10)	*"They let me come home, and then that morning they said when I got my house I was on the floor... that's why I had to go back to the hospital" (64861)*
Problems with medications or therapy (8)	*"we thought everything was settled…wasn't having any problems until I got hospitalized and came home and started trying to get my oxygen" (64743)*
Not prepared for discharge (8)	*"I needed a copy of his discharge papers from the hospital for insurance purposes…They didn't give me a discharge paper" (64908)*
Hospital complication or question (4)	*"Now they're finding out all this bleeding but they don't know where I'm bleeding from." (65226)*

Post-discharge complications & PCP awareness of hospitalization

Patients whose PCPs were not aware of their hospitalization were more likely to report a post-discharge complication

32% PCP aware vs. 67% PCP not aware; p=0.05



Limitations

- Small Sample Size
- Single institution
- Selection bias
  - Difficulty reaching patients due to lack of phone etc.
  - No observable differences between responders and nonresponders
- Recall bias
  - Adverse events

Conclusion

- Communication between hospital-based physicians and PCPs is variable, and often does not occur due to presence of a variety of barriers
  - Results in PCPs trying to “piece together” what happened and in negative patient experience
- Patients were two times more likely to report a post-discharge complication when their PCP was not aware of their hospitalization

Strategies to Improve Care Transitions

- Medication Reconciliation
  - Joint Commission National Patient Safety Goal
- Improve timeliness and quality of discharge summaries *(Kripalani, et al, 2007)*
  - Computer generated discharge
  - Standardized templates
- Care Transitions Intervention *(Coleman, et al, 2006)*
  - "Transitions coach" → patient empowerment
  - Care Transitions Measure
- Project RED and Project BOOST

Arora and Farnan, 2008

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Questions or Ideas?

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Audience Poll

Current Practices in Care Transitions at Your Institution

Care Transitions at Your Institution

- How many of your programs have an electronic health record?
  - How many of these electronic health records enable communication with PCPs at discharge?
    - Are you satisfied with the discharge information that is obtained from an electronic health record that is sent to a PCP?

Care Transitions at Your Institution

- Does your program/institution use a standard template for to convey information to PCPs?

Care Transitions at Your Institution

- Are there any policies or procedures that are used to guide communication with PCPs when patients are hospitalized?

Care Transitions at Your Institution

- Do you have formal training for new staff on how to communicate during care transitions?

Focus on Care Transitions

- Increasing physician specialization
  - Disease specialists (cardiologists, endocrinologists, etc.)
  - Rise of hospitalists
    - physician caring for patient during hospitalization is not the patient's PCP
- Distributed nature of health care services
  - Skilled nursing facilitites, home health etc.

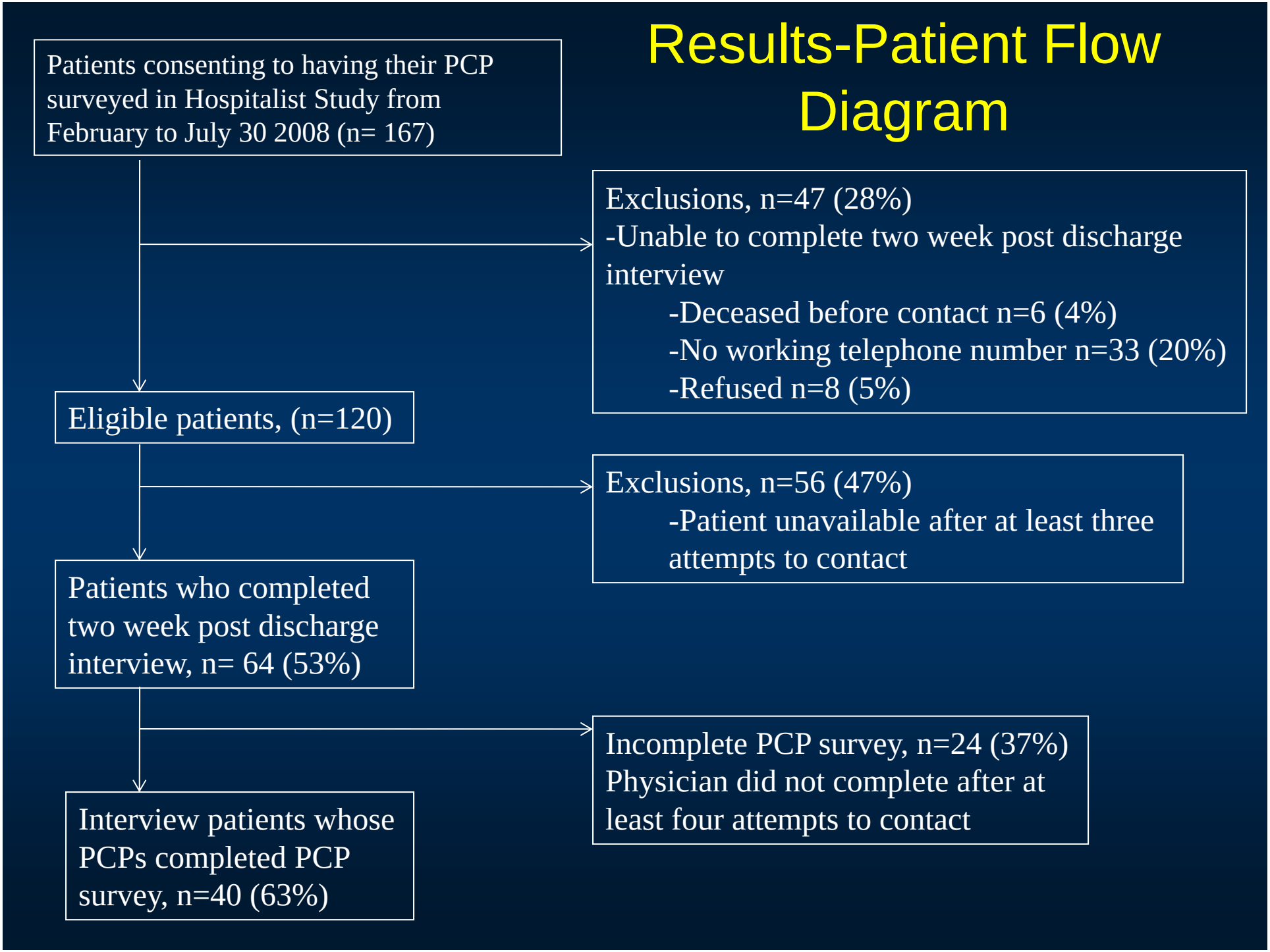
Understanding the Patient Experience

Negative Emotions and Empowerment

Category (n*)	Sub-Category (n*)	Representative Incident
Negative Emotions (43)	Frustration (28)	*"…you don't have any decision in your own healthcare at all. I think that's terrible" (64743)*
	Confusion over the patient's own plan of care (15)	*"there were all sorts of other tests that different doctors whom I never even knew why they wanted to do these things" (65021)*
Patient Empowerment (24)	Proactive in contacting physicians (19)	*"I made certain that everybody let [PCP] know exactly what I was doing the whole time I was in and out and all of that" (63457)*
	Patient has third party advocate (7)	*"The only reason they found out is because her [home] nurse was concerned enough to call and keep inquiring about how she was doing." (65552)*
	Patient proactive in his or her own healthcare (5)	*"I am not scared of the doctors and scared to speak up, especially when it comes to my body and my health" (64525)*

*n represents incidences/quotes

Results-Patient Flow Diagram



Results-Patient Demographics

Table 1 Patient Characteristics (n=64)	**n (%)**
Mean Age , years (SD)*	73 ±15
Female Sex	44 (69)
African American	45 (70)
Live in own house or apartment	48 (75)
Proxy used for interview	6 (9)
Mean Length of Stay, days (SD)*	5.3 ±6.1
Hospitalized in year prior to admission	31(48)
On-site PCP (University of Chicago)	45 (70)