Transitions in care, a.k.a. Discharge Planning

Laura Previll, MD, MPH
Medical Instructor in Geriatrics

Objectives:
• Challenges of “care transitions” or discharge planning
• Best practices
• Outline the financing of post acute care
• Differences between locations of post acute care

Where are they GOING?
Where are they FROM?

Discharges are “care transitions”:
• Movement of a patient from one care setting to another
• Occur at multiple levels
• All team members should participate
• Begin early
• Post-hospital: many different sites
  • Appropriate level of care
  • Ready to receive patient
• Physician needs to lead
• KNOW the interdisciplinary team and what they offer

Goals of Transitional Care
• Ensure coordination and continuity of care
• Patient’s goals, preferences, and clinical status known
• CARE PLAN, medication changes, follow-up
• Includes:
  • Logistical arrangements
  • Education of the patient and family
  • Coordination among the health profess
  • Follow up plan

Challenges to a good transition of care

Why do we care about poor care transitions?

Medication discrepancies can be common

- 14-30% of patients discharged from hospital to home experienced ≥ 1 medication discrepancies
- 30 day re-admission rate among patients with medication discrepancies (14.3%) higher than patients without (6.1%) (P=0.04)
- In 86% of SNF transfers, at least one medication order was altered (mean 1.4); 20% of changes resulted in an adverse event

Recommended follow up can have challenges

- Tests and procedures to be completed after discharge are often not done.
- Example here includes CT scans and GI workup
- Of recommended workups, 35.9% were not completed

<table>
<thead>
<tr>
<th>Workup Type</th>
<th>Total</th>
<th>Completed</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic procedure</td>
<td>115 (47.9)</td>
<td>50.4</td>
<td>49.6</td>
</tr>
<tr>
<td>Subspecialty referral</td>
<td>85 (35.4)</td>
<td>72.6</td>
<td>27.4</td>
</tr>
<tr>
<td>Laboratory test</td>
<td>40 (16.7)</td>
<td>85.0</td>
<td>15.0</td>
</tr>
<tr>
<td>Total</td>
<td>240 (100)</td>
<td>64.1</td>
<td>35.9</td>
</tr>
</tbody>
</table>

Ineffective transitions can lead to:

1. Wrong treatment
2. Delay in diagnosis
3. Severe adverse events
4. Patient complaints
5. Increased healthcare costs
6. RE-ADMISSION

Communication is not often automatic or efficient

- Direct communication between hospital physicians and primary care physicians occurred infrequently (3-20% of discharges).
- Discharge summary
  - Availability at first post-discharge visit low (12%-34%)
  - Remained poor at 4 weeks (51%-77%)
  - Affected quality of care in ~32% of follow-up visits
  - Lacked important information e.g., lab results, discharge medications, treatment, follow-up plan

Care transitions best practices

Identify who will provide help
Reconcile the Medications

Think about Nutrition and meeting daily needs

Know if Durable Medical Equipment (DME) will be needed

Know if Non Durable Equipment will be needed

Know what is possible in each care context

Recommendations on Principles and Standards for Managing Transitions in Care Between the Inpatient and Outpatient Settings from ACP, SGIM, SHM, AGS, ACEP, and SAEM

1. All transitions must include a transition record
2. Transition responsibility
3. Coordinating clinicians
4. Patient and family involvement and ownership of the transition record
5. Communication infrastructure
6. Timeliness
7. Community standards
Example: Measured improvement, system level, heart failure patients

<table>
<thead>
<tr>
<th>Quality Improvement and Performance Monitoring Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Partnering with other hospitals</td>
</tr>
<tr>
<td>2. Tracking the percentage of patients who were discharged with a follow-up appointment already scheduled for within 7 days.</td>
</tr>
<tr>
<td>3. Discharging patients with follow-up appointments already scheduled is associated with a 83% percentage point reduction in readmission rates.</td>
</tr>
</tbody>
</table>

Bradley, E.H., Spiera, R., Hotzel, L., et al. [2016]
INTERMAC 2015; 83:463

Transitions of care initiatives

Evidence-based, developed to improve patient outcomes

- Care Transitions Intervention (CTI) Eric Coleman, MD @ Colorado
  [https://innovation.cms.gov/marketplace/cti.jpg](https://innovation.cms.gov/marketplace/cti)
- Transitional Care Model (TCM) Mary Naylor, MD @ Penn
  [https://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf](https://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf)
- Better Outcomes for Older Adults through Safe Transitions (BOOST) SHM
- Geriatric Resources for Assessment and Care of Elders (GRACE) Indiana University
- Project RED (Re-Engineered Discharge), AHRQ

CMS Payment System

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;65 years, ESRD, or disabled qualify</td>
<td>Administered STATE level with federal matching funds</td>
</tr>
<tr>
<td>Administered FEDERAL level</td>
<td>Medical assistance for people with limited resources, &quot;categories&quot;</td>
</tr>
<tr>
<td>Part A: hospital care, home health services/skilled nursing care, and hospice</td>
<td>Level of state participation varies</td>
</tr>
<tr>
<td>Part B: physician visits, durable medical equipment, 80%, monthly fee</td>
<td>Rx Medications covered for DUALs (Medicare and Medicaid)</td>
</tr>
<tr>
<td>Part C (must have A and B to have C)</td>
<td>All states pay NH care</td>
</tr>
<tr>
<td>Medicare health plans, Medicare Advantage plans</td>
<td>NC MEDICAID EXPANSION</td>
</tr>
<tr>
<td>Part D: the medications, all can choose, many different plans</td>
<td>Source: CMS website and Gina Upchurch, senior Pharmacist</td>
</tr>
</tbody>
</table>

Affordable care act (ACA) changes to CMS

- Centers for Medicare and Medicaid services = CMS
- Medicare Innovation Center allocated $500 million to foster community-based care transition programs
- [https://innovation.cms.gov/](https://innovation.cms.gov/)
- Focus on reducing cost by changing the way we manage patients especially during transitions

Naylor et al. Health Affairs. April 2011 vol. 30 no. 4:746-754

Types of APMs

- Alternative Payment Models (APMs) include
  - Accountable care organizations (ACOs)
  - Bundled payments
  - Advanced primary care medical homes
- CMS implementing bundled payments that encompass longer episodes of care, more clinical services, and multiple clinicians and health care organizations:
  - CCJR Comprehensive care for joint replacement
  - OCM Oncology Care Model
  - BPCI Bundled Payments for Care Improvement Models
What Does Medicaid Cover?

- Doctor Bills
- Hospital Bills
- Prescriptions (excluding prescriptions for Medicare beneficiaries)
- Vision Care
- Dental Care
- Medicare Premiums
- Nursing Home Care
- Personal Care Services (PCS), Medical Equipment, and Other Home Health Services
- In-home care under the Community Alternatives Program (CAP)
- Mental Health Care

Discharge location by site:

<table>
<thead>
<tr>
<th>Site</th>
<th>Requirements</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Rehabilitation Facility</td>
<td>&quot;acute rehab&quot;</td>
<td>Patient must tolerate 3 hours of therapy per day requiring multiple disciplines (e.g., PT/OT/SLP); Usually post CVA, post amputation, other specific CPTs</td>
</tr>
</tbody>
</table>

Location, location, location

1. "Subacute Rehab" at Skilled Nursing Facility (SNF) (Try not to say Nursing home)
2. "Acute Rehab" or Inpatient Rehabilitation Facility (IRF)
3. Long Term Acute Care (LTAC)
4. "Long Term Care" at Skilled Nursing Facility (SNF) often people transition from sub acute rehab to LTC in a SNF.
5. Home with home health
6. Home
7. Hospice
EXAMPLE: Select Specialty Hospital

- 24-hour Respiratory Therapists
- ACLS Certified Nursing Care
- Case Management and Discharge Planning
- Clinical Pharmacy Services
- Daily Physician Visits
- Vent Weaning
- Bariatric Care

Select Specialty is an LTAC in Durham with branches nationwide

Sites of Post Acute Care

<table>
<thead>
<tr>
<th>Site</th>
<th>Requirements</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>Pt requires skilled nursing care</td>
<td>Medicare Part A pays 100% of changes for days 1-20</td>
</tr>
<tr>
<td>“subacute rehab” or long term care (LTC)</td>
<td>2 skilled needs</td>
<td>Days 21–100: cost after any other deductibles is roughly $164.50 in coinsurance per day of each benefit period (≤2017)</td>
</tr>
</tbody>
</table>

Post Acute Care in Skilled Nursing Facilities (SNF)

- Response to reduced length of stay in acute care
- Integrates features of acute care/rehab focused
- Interdisciplinary staffing
  - Social work onsite: LSW
  - Nursing: RN, LPN, CNA, wound care
  - Therapies: PT/OT/SLP
  - Medical: MD, PAs, NPs
  (rounding at facility at least Q72H-weekly, but available 24h/day)
  - Other clinical: dental, podiatry, vision, mental health, clinical pharmacist, dietician

Ancillary Services in SNFs

- Phlebotomy/Laboratory
- Radiology
- EKG
- IVs: peripheral, PICC
- Echocardiography/Holter monitors
- No Dobhoffs or Central Lines or ventilators
- Can have PEGs

Sites of Post Acute Care

<table>
<thead>
<tr>
<th>Site</th>
<th>Requirements</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health</td>
<td>MD orders (usually PCP) must certify that patient is homebound Intermittent RN, PT, SLP</td>
<td>Medicare Part A pays 100% for most professional services (e.g. PT/OT/SLP) and HHA Short term after discharge $0 for home health care services LONG TERM</td>
</tr>
</tbody>
</table>

Candidates for Home Health:

- Care of a pressure or venous stasis ulcer
- Physical therapy for a hip fracture
- PT and Occupational therapy after a stroke
- Family and patient education regarding diabetic monitoring and management
- Monitoring of vital signs and other clinical parameters in a patient with a CHF exacerbation
- Home safety evaluation

Courtesy of Jeremy Boal, MD
Once skilled service established other services may be available:

- Social work
- Home health aide services
- Occupational therapy
- Nutrition

### Sites of Post Acute Care

<table>
<thead>
<tr>
<th>Site</th>
<th>Requirements</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice (home or facility-based)</td>
<td>MD must certify that life expectancy is &lt; 6 months</td>
<td>Medicare A pays for most professional services and meds related to terminal illness MD services under Part B</td>
</tr>
</tbody>
</table>

### Housing Alternatives for Older Adults

1. Home
2. Senior Housing
3. Continuing Care Retirement Communities (CCRCs)
4. Assisted Living Facilities (ALFs)
   - Have a la carte nursing service options similar to SNF NOT paid for by MEDICARE
5. Residential Care Facilities, Board and Cares
6. Nursing Homes

### Medicare DOES NOT pay for

#### Home Health Aide
- Medicare funded
- Short duration
- Pt. must have concurrent acute skilled care
- A few hours per day
- Full range of ADLs
- From Certified Home Health Agency (CHHA); VN supervision

#### Personal Care (PC) Homemaker
- Chronic duration
- No need for concurrent acute skilled care
- IADLs & light ADLs
- Authorized by Area Agency on Aging (AAA)
- Funding from AAA

### More Information

- Government web sites
  - [https://www.medicare.gov/nursinghomecompare/search.html](https://www.medicare.gov/nursinghomecompare/search.html)
  - National Council on Aging: [https://www.benefitscheckup.org/](https://www.benefitscheckup.org/)
  - Senior Pharm-Assist [http://www.seniorpharmassist.org/](http://www.seniorpharmassist.org/)
- Home Care Medicine: AAHCP renamed in 2014 to AAHCM