Transitions of Care: An opportunity to improve care, experience and reduce waste

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• Clinical outcomes
  • Increase in mortality
  • Increase in morbidity (temporary or permanent injury or disability)
  • Increase in adverse events
  • Emotional and physical pain and suffering for consumers, carers and families
• Waste
  • Additional primary health care (PHC) or emergency department (ED) visits
  • Additional or duplicated tests
  • Preventable readmissions to hospital
  • Additional costs to consumer, family, health system and community
• Experience
  • High level of consumer and provider dissatisfaction with coordination of care across primary care / hospital interface.
  • Delays to appropriate treatment and community supports

The evidence base for the impact of these problems is variable. There is little quantitative evidence for the impact of problems specifically due to clinical handover or other specific components of transition of care as most of the research does not focus measure this directly.
Clinical aspects of care transfer
PLUS
Patient’s needs, preferences, experiences

Clinical information
Physical and mental functional status of patient
Suitability of patient’s home environment
Availability of carer, family, support system
Ability to obtain medicines, needed healthcare & social services / availability of transportation
The Key Steps

A high level transition of care process

1. Start
2. Multi-disciplinary transition planning
3. Transition plan
4. Transition of Care (1)
5. Tracking system

High risk of failed transition? YES NO
Higher Risk Group

- There are a number of predictive risk tools e.g. LACE, HARP, PARR, 8Ps
- The evidence for their utility is variable and depends on the dataset used
  - “Most current readmission risk prediction models perform poorly…but in certain settings may prove useful”
  - Importance of GP data as the denominator (population health perspective)
  - Incorporating functional and social variable improves discrimination

References:
Kansagara, D. et al. (2011) Risk prediction models for hospital readmission: a systematic review. Jama,
Bundle of Interventions

transition plan → Transition of Care (1) → Medication Safety, Information Transfer, Patient/Carer Involvement

(1) All patients
Overview of medication reconciliation in acute care.

- Medication reconciliation is widely recommended to avoid unintentional discrepancies between patients’ medications across transitions in care.
- Medication reconciliation alone probably does not reduce postdischarge hospital utilization within 30 days but may do so when bundled with other interventions that improve discharge coordination.
- Pharmacists play a major role in most successful interventions.
Information transfer

• Timely
• Accurate
• Content
  – discharge diagnosis, treatment received in hospital, results of investigations and the follow-up required, pending diagnostics
• Availability
• Human factors

Patient and Carer Involvement

• Under-utilised
• Needs to be personalised;
• Involvement is variable from passive participants to being the key actor
• Key element is behaviour change – patient activation
Activation is developmental

Level 1
- Individuals tend to be passive and feel overwhelmed by managing their own health. They may not understand their role in the care process.

Level 2
- Individuals may lack the knowledge and confidence to manage their health.

Level 3
- Individuals appear to be taking action but may still lack the confidence and skill to support their behaviours.

Level 4
- Individuals have adopted many of the behaviours needed to support their health but may not be able to maintain them in the face of life stressors.

Low activation signals problems (and opportunities)

<table>
<thead>
<tr>
<th></th>
<th>MORE ACTIVATED Patient</th>
<th>LESS ACTIVATED Patient</th>
</tr>
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<tbody>
<tr>
<td>Readmitted to the hospital within 30 days of discharge</td>
<td>12.8%</td>
<td>28%</td>
</tr>
<tr>
<td>Experienced a medical error</td>
<td>19.2%</td>
<td>35.8%</td>
</tr>
<tr>
<td>Have poor care coordination between health care providers</td>
<td>12.6%</td>
<td>41.8%</td>
</tr>
<tr>
<td>Suffer a health consequence because of poor communication among providers</td>
<td>13.2%</td>
<td>48.6%</td>
</tr>
<tr>
<td>Lose confidence in the health care system</td>
<td>15.1%</td>
<td>59.8%</td>
</tr>
</tbody>
</table>

Source: Adapted from AARP & You, “Beyond 50.09” Patient Survey. Published in AARP Magazine. Study population age 50+ with at least one chronic condition. More Involved=Levels 3 & 4, Less Involved=Levels 1 & 2

Most activated are less likely to miss medication doses

Discharge planning is one of the most promising interventions.
(EU Handover project - http://handover.eu/index.html)
Interventions (1)

- Multi-disciplinary transition planning
- Transition plan
- Enhanced patient/carer involvement
- Medication Safety
- Examples of interventions:
  - Self management
  - Coaching
  - Community resources

(1) All patients
Interventions (2)

- Start
- High risk of failed transition?
- Multi-disciplinary transition planning
- Care coordination/Case management

Examples of interventions:
- Assessment prior to transition
- Proactive follow up
- Single point of access
- Team coordination
Anticipate and build in reliability

A high level transition of care process

Modified. v3.0
Wed Jul 01 2015

Start ➔ High risk of failed transition? ➔ YES ➔ Multi-disciplinary transition planning ➔ Transition plan ➔ Transition of Care (1) ➔ Tracking system

NO ➔
Tracking

36% of post discharge interventions are not completed
A High Level Transitional Care Process

A high level transition of care process

Modified. v3.0
Wed Jul 01 2015

Start

High risk of failed transition?

YES → Multi-disciplinary transition planning

NO → Transition plan

Transition of Care (1)

Medication Safety
Information Transfer
Patient/Carer Involvement

Tracking system

Assessment prior to transition
Proactive follow up
Single point of access
Team coordination

Self management
Coaching
Community resources

DI: All patients
Moving beyond readmission penalties: Creating an ideal process to improve transitional care

Journal of Hospital Medicine
Volume 8, Issue 2, pages 102-109, 26 NOV 2012 DOI: 10.1002/jhm.1990
Clinician Roles and Responsibilities During Care Transitions of Older Adults

![Diagram showing the relationship between role perception, role execution, promoters, barriers, conformance perception, and ambiguity in accountability.](http://onlinelibrary.wiley.com/doi/10.1111/jgs.12084/full#jgs12084-fig-0001)
Summary

• Effective transitions important for safety / quality

• Can be improved through:
  – The right structure
    • Role clarity
    • Shared clinical practice guidelines and protocols
    • Enablers
  – The right process
    • Individualised and stratified interventions
    • Communication and working as one system
    • Preparing patients and caregivers

• Culture is important

• Effective change management critical
Key Issues

- How to identify / target high risk patients?
- Who should be accountable for transition of care?
- Is there a role for a ‘transition of care’ structure e.g. transition care team
- How to best help carers / family to be effective advocates
- What levers will facilitate clinicians to take a more pro-active role
- Evaluating reliability in implementation of key elements and understanding variations in capability, capacity.
Thank you