Goals of Effective Transitions of Care

- Provide safe discharge
- Provide a seamless, continuous patient-centered care plan for geriatric patients
- Decrease unnecessary admissions to the hospital
  - 20% of Medicare pts readmitted within 30 days of discharge from hospital
- Decrease post discharge mortality & morbidity due to poor transitions of care

Types of Transition Possible from ED & Hospital

- **Home** - Utilize hospital **DIC** model: Medication reconciliation, medication self-management, pt centered med record, PCP or specialist follow-up, "red flag" knowledge indicating worsening of condition.
- **Hospital Admission** - All hospital admissions should meet non-physician review (NPR) to ensure necessity of admission for acute care. Use evidence-based criteria (i.e., InterQual [McKesson]). With disagreement between NPR & admitting doctor, case referred to independent reviewer physician to approve or deny admission.
- **Observation Status** - Refers to specific, clinically needed services including short term treatment/s, further patient assessment or reassessment that may lead to inpatient admission or discharge. This "outpatient" status in the hospital can be converted to an inpatient admission based on specific severity and intensity of treatment criteria as defined by insurance companies and Medicare. The observation status is designed to prevent unnecessary admissions, denial of payment & penalties.
- **Acute Rehabilitation** - This is an acute care, inpatient rehab facility. Patients can be directly admitted from home but are usually admitted after an acute hospitalization. Medical conditions must be stable but still require medical management daily by a physician. The ideal patient for this facility would be anticipated to return home or to an assisted living to qualify. Patients must be able to participate in 3 hours daily of rehab/5 days/wk. Unlike that this transition of care could be initiated from ED.
- **Sub-Acute/Skilled Nursing Facility (SNF)** - This facility provides a less intense level of rehab than an acute rehab facility. This transition typically occurs as a consequence of an acute hospitalization. Unlike transition from ED under current Medicare rules of 3 day hospital stay.
- **Hospice** - Provides comfort care to patients with terminal illness in the final phase of life. Medicare hospice benefit requires: life expectancy <6 months with & without cancer diagnoses, hospice program must be certified. This transition can be initiated in the ED to home, SNF, or residential hospice facility.

Transitions of Care Statistics

- In 2008, 2.7 million visits to ED by patients in extended care facilities (ECF)
- EDs & ECFs typically operate without any formal integrated system of care
- 10% of ECF residents are transferred to ED without "any" documentation
- 90% of ECF residents are transferred without information essential to the visit
- When "transfer forms" exist, less than 50% are completed by nursing home

Quality Indicators for Transitions of Care – SAEM Geriatric Task Force

Eleven Quality Indicators have been recommended for transitions between nursing homes & EDs. These indicators can help clinicians target Quality Improvement efforts.

"**Quality Indicators 1–4: Critical Data for the Nursing Home-to-ED Transfer**

If a nursing home resident is transferred to an ED, THEN the nursing home should provide the following written information on the transfer paperwork:

1. Reason for transfer and specific instructions from primary ECF physician
2. Code Status/Copy of Advanced Directive
3. Medication allergies
4. Contact Information: for the nursing home, the primary care or on-call physician, and the resident’s legal health care representative or closest family member"

"**Quality Indicator 5: Medication List**

5. IF a nursing home resident is transferred to an ED, THEN the nursing home should provide a medication list in the transfer paperwork"

"**Quality Indicator 6: Tests Requested by Nursing Home Providers**

6. IF a nursing home provider requests that specific tests be performed in the ED, THEN the EP should document performance of the requested tests (or document in the medical record why the tests were not performed)"

"**Quality Indicator 7: Communication between Nursing Home & ED Providers**

7. IF a nursing home resident will be released from an ED back to the nursing home, THEN the EP should document communication with a nursing home provider or the primary care or on-call physician prior to discharge from the ED (or document attempts to do so)"

"**Quality Indicators 8 & 9: Critical Data for the ED-to-Nursing Home Transfer**

If a nursing home resident is discharged from the ED back to the nursing home, THEN the ED should provide the following written information in the transfer paperwork:

8. ED diagnosis
9. Tests performed with results (and tests with pending results)."

"**Quality Indicators 10 & 11: Care Provided After ED Visits**

10. IF a nursing home resident is discharged from the ED back to the nursing home and physician follow-up is recommended, THEN the patient should receive the follow-up (or the medical record should indicate why the follow-up did not occur).
11. IF a nursing home resident is discharged from the ED back to the nursing home and the ED provider prescribes or recommends a medication, THEN the nursing home should administer the medication (or document in the medical record why the medication was not administered)."

References


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