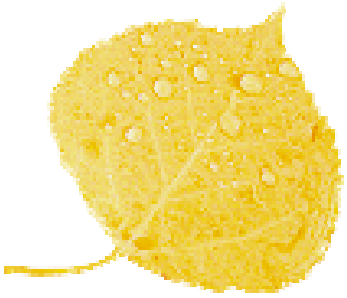
Aspen Transitional Care Conference Proceedings



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Contact Information:
Eric A. Coleman, MD, MPH
Division of Health Care Policy and Research
University of Colorado Health Sciences Center
Phone 303-315-0256; Fax 303-399-9596
Eric.Coleman@uchsc.edu

The recent Institute of Medicine report, *"Crossing the Quality Chasm[1]"* calls for greater integration of care delivered across different health care settings.

In response to this directive, national experts[2] in the field of transitional care[3] were convened in Aspen, Colorado for the Aspen Transitional Care Conference. The aims of this conference were: (1) to develop a research and policy agenda for improving the quality of transitional care; and (2) to delineate the critical next steps for advancing this agenda.

Bruce Vladeck, PhD, Acting Chair of The Brookdale Department of Geriatrics and Adult Development at Mt. Sinai School of Medicine provided the keynote address. Conference participants were organized into five working groups, each designed to represent an essential component needed to improve care transitions. These working groups included: financing and reimbursement; information transfer; patient and caregiver roles and skills; accountability and performance measurement; and intervention research.

The conference proceedings reported herein are organized around three key questions:

Question 1. What types of problems illustrate the inadequacies of care transitions?

Question 2. In the current delivery system, which health care professionals should be responsible for the different facets of the care transition?

Question 3. What aspects of care transitions should be addressed in a demonstration project designed to improve the quality of transitional care?

[1] National Academy Press: Washington DC, 2001.

[2] See Appendix for list of participants.

[3] For the purpose of this conference, transitional care was defined as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. Transitional care, which encompasses both the sending and the receiving aspects of the transfer, includes logistical arrangements, education of the patient and family, and coordination among health professionals involved in the transition.

Question 1. What types of problems illustrate the inadequacies of care transitions?

- **Medication Errors**
  - An inaccurate list of medications and allergies can potentially lead to medical errors.
- **Increased Health Care Utilization**
  - Poorly conducted transitions can lead to recidivism (i.e., high rates of re-hospitalization or emergency department visits), prolonged length-of-stay in the receiving institution (i.e., delays in initiation of rehabilitative services), and higher costs of care when medications are issued but not consumed.
- **Inefficient or Unnecessary care**
  - The receiving health care team may not receive essential clinical information needed to manage the patient in the next setting or may be unaware of what took place in the sending institution, leading to redundancy in assessment, diagnostic tests, and treatment.
- **Inadequate Staff Preparation**
  - The receiving health care team may not be adequately prepared or trained to manage the patient's condition (i.e., transition to an inappropriate setting) or the transfer may occur when staffing is inadequate (i.e., evening or weekend transfers).
- **Inadequate Patient Preparation**
  - The patient may not understand how to manage his or her condition and may not be aware of the warning signs that indicate that they need to seek immediate treatment.
- **Family or Caregiver Stress**
  - Family members and informal caregivers may have to expend considerable time to compensate for poorly executed transitions; time that they take away from employment or family obligations.
- **Inadequate Follow-Up Care**
  - The patient may not receive a timely follow-up appointment, may not be instructed about outstanding laboratory or diagnostic imaging tests, and may not know whom to call when advice is needed.
- **Litigation**
  - Poorly executed transfers can lead to litigation and thus have important implications for institutional risk management programs.
- **Dissatisfaction**
  - Poor communication between different care teams can undermine patients' confidence in their providers and can result in dissatisfaction with their care.

Question 2. In the current delivery system, which health care professionals should be responsible for the different facets of the care transition?

Care transitions require a coordinated effort involving the sending health care team[4], the receiving health care team, and the health care institution's administrative leadership:

The sending health care team is responsible for ensuring that:

- The patient is stable for transfer
- The receiving institution has the capacity to meet the patient's care needs
- The patient and caregiver understand the purpose and goals of the upcoming transfer
- The patient's goals and preferences are incorporated into the care plan
- All relevant sections of the transfer information form are complete
- A clinical summary and a discharge summary accompanies the patient during transfer
- The patient has a follow-up appointment with an appropriate health care professional
- A health care professional is available to patient, caregiver, and receiving health care team for at least 72 hours post-transfer to answer questions about the care plan

The receiving health care team is responsible for ensuring that:

- The transfer forms, clinical summary, and discharge summary are reviewed upon patient arrival
- The patient's goals and preferences are incorporated into the care plan
- Any discrepancies or confusion are clarified promptly with the sending health care team

Health care institutions are responsible for ensuring:

- Compliance with existing accreditation standards (JCAHO) governing discharge planning
- That existing institutional by-laws include explicit language that addresses protocols to ensure safe and efficient transfers

[4] The health care team may include a physician, nurse practitioner, physician's assistant, registered nurse, licensed practical nurse, pharmacist, physical or occupational therapist, social worker, or discharge planner.

Question 3. What aspects of care transitions should be addressed in a demonstration project designed to improve the quality of transitional care?

A demonstration project could be multifaceted and address:

- **Information Transfer Across Settings**
  - ◊ Evaluate the impact of an electronic medical record available across all sites of care
  - ◊ Entrust the patient with his/her medical information and evaluate impact on timeliness of care, medical errors, data integrity, and role in facilitating shared decision-making

- **Aligning Payment and Reimbursement Incentives with High Quality Transitional Care**
  - ◊ Create a bundled payment that provides for an entire care episode (i.e., acute and post-acute)
  - ◊ Create a new care coordination benefit under Medicare that would encompass transition-related care.

- **Targeting Patients At-Risk for Transition-Related Problems**
  - ◊ Develop and test the feasibility of an empirically-derived targeting strategy
  - ◊ Develop protocols to assess a patient's needs and capacity for self-care and determine the most appropriate care setting to provide the next phase of care

- **Testing New Models of Care Delivery**
  - ◊ Develop a demonstration that tests the feasibility and effectiveness of new roles for health care practitioners that are responsive to patients' needs across settings (e.g., a "Point Person" or a "Transition Coach")
  - ◊ These practitioners would ensure that patients' and caregivers' needs and preferences were incorporated into the transition plan, direct patients to the most appropriate transfer setting, communicate standardized clinical data to the receiving health care team, and ensure that follow-up care was delivered in a timely manner.

- **Identifying National "Best Practice" Sites for Transitional Care**
  - ◊ Develop a demonstration to identify national "best practice" sites and characterize the requisite elements needed for successful programs
  - ◊ Key elements might include clinical care protocols, support for patients and caregivers, integration of information systems, flexible financing arrangements, clinical and operational accountability, support from senior leadership, and strategic partnerships between health care and community entities.

Appendix: Conference Participants

Kyle R. Allen, DO Geriatric Medicine Summa Health System Akron OH	Patricia Archbold, RN, DNSc, FAAN Oregon Health & Science University School of Nursing Portland OR
Robert A. Berenson, MD Academy for Health Services Research and Health Policy Washington DC	Arlene S. Bierman, MD, MS Agency for Healthcare Research and Quality Center for Outcomes and Effectiveness Research Rockville MD
Peter Boling, MD Virginia Commonwealth University Richmond VA	Chad Boult, MD, MPH, MBA Johns Hopkins University Department of Health Policy & Management Baltimore MD
Richard J. Bringewatt National Chronic Care Consortium Minneapolis MN	Margaret Bull, PhD, RN, FAAN Marquette University College of Nursing Milwaukee WI
Alfred Chiplin, Jr, JD, MDiv Center for Medicare Advocacy, Inc. Healthcare Rights Project Washington DC	Eric A. Coleman, MD, MPH Division of Health Care Policy and Research University of Colorado Health Sciences Center Denver CO
Richard D. Della Penna, MD Kaiser Permanente Aging Network Oakland CA	G. Paul Eleazer, MD, FACP University of South Carolina Columbia SC
Janet C. Frank, DrPH UCLA Multicampus Program in Geriatric Medicine and Gerontology Los Angeles CA	Meghan B. Gerety, MD Geriatrics & Extended Care Audie Murphy Veteran's Hospital San Antonio TX
Steven M. Handler, MD University of Pittsburgh Pittsburgh PA	Gail Gibson Hunt National Alliance for Caregiving Washington DC
Ruth E. Katz, MA Office of Disability, Aging & Long-Term Care Policy, DHHS Washington DC	Andrew Kramer, MD Division of Health Care Policy and Research University of Colorado Health Sciences Center Denver CO

Kim Lehto-Smith Division of Health Care Policy and Research University of Colorado Health Sciences Center	Jane Isaacs Lowe, PhD The Robert Wood Johnson Foundation Princeton NJ
Katie Maslow Alzheimer's Association Washington DC	Robin E. Mockenhaupt, PhD The Robert Wood Johnson Foundation Princeton NJ
Christopher M. Murtaugh, PhD Center for Home Care Policy & Research Visiting Nurse Service of New York New York NY	Mary D. Naylor, PhD, RN, FAAN University of Pennsylvania School of Nursing Philadelphia PA
Carly Parry, PhD, MSW, MA Division of Health Care Policy and Research University of Colorado Health Sciences Center	Barbara Paul, MD Center for Medicare and Medicaid Services Baltimore MD
Cheryl Phillips, MD, AGSF, CMD Sutter Health Sacramento CA	Steven L. Phillips, MD, CMD Senior Dimensions Extended Care Reno NV
Philip Renner, MBA Director, Measures Development, NCQA Washington DC	David Sandman, PhD The Commonwealth Fund New York NY
W. June Simmons Partners in Care Foundation Los Angeles CA	Al Siu, MD, MSPH Mount Sinai Department of Medicine New York NY
Jodi Smith, RN, MSN, ND Division of Health Care Policy and Research University of Colorado Health Sciences Center	Ron Stock, MD, MA PeaceHealth Oregon Region Center for Senior Health Eugene OR
Anthony J. Tirone, JD, MBA JCAHO Washington DC	Bruce C. Vladeck, PhD Mount Sinai School of Medicine New York NY
Tom von Sternberg, MD Health Partners Minneapolis MN	Douglas M. White, PT, OCS Massachusetts General Hospital Boston MA
Nancy Whitelaw, PhD National Council on the Aging Washington DC	