One Patient, Many Places: Managing Health Care Transitions

A Report from the HMO Workgroup on Care Management

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Foreword

The HMO Workgroup on Care Management represents both health plans and group practices that are capitated by health plans for a significant portion of revenues. Health plans and capitated provider groups are referred to, collectively, as Managed Care Organizations (MCOs). Workgroup participants hold senior medical and patient care management positions within their respective organizations, all of which enroll significant numbers of older adults under Medicare capitation, known as Medicare+Choice, contracts. The Workgroup's activities are lodged at the AAHP-HIAA Foundation, and AAHP-HIAA staff members provide invaluable support.

Over the past nine years the HMO Workgroup on Care Management has met quarterly to discuss ways in which the delivery of care to Medicare beneficiaries can be improved. This report is the eighth to be released. The other Workgroup reports are:

- Identifying High-Risk Medicare HMO Members
- Planning Care for High-Risk Medicare HMO Members
- Essential Components of Geriatric Care Provided Through Health Maintenance Organizations
- Establishing Relations with Community Resource Organizations: An Imperative For Managed Care Organizations Serving Medicare Beneficiaries
- Geriatric Case Management: Challenges and Potential Solutions in Managed Care Organizations
- Risk Screening Medicare Members Revisited
- Improving the Care of Older Adults with Common Geriatric Conditions

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Peter D. Fox
Chair

Acknowledgments

The HMO Workgroup on Care Management:

Ellen Aliberti, BSN, MS, CCM
Director of Continuity of Care
Health Plan of Nevada
Las Vegas, Nevada

Danielle Butin, MPH, OTR
Manager of Health Promotion and Wellness
Oxford Health Plans
White Plains, New York

Jan Clarke, MD, MPH
In-Patient Program
Advocate Health Centers
Chicago, Illinois

***Eric A. Coleman, MD, MPH**
Associate Professor
Divisions of Health Care Policy Research and Geriatric Medicine
University of Colorado Health Sciences Center
Denver, Colorado

Richard D. Della Penna, MD
Director, Kaiser Permanente Aging Network
Kaiser Permanente Program Office
Oakland, California

Joyce Dubow
Senior Policy Advisor
AARP Public Policy Institute
Washington, D.C.

† Peter D. Fox, PhD
President
PDF, LLC
Chevy Chase, Maryland

Brian Hayes, MD, CMCE
Executive Medical Director, Utilization Management
Horizon Blue Cross and Blue Shield of New Jersey
Newark, New Jersey

Bonnie Hillegass, RN, MHA
Vice President and Chief Clinical Officer
Sierra Health Services, Inc.
Las Vegas, Nevada

Christine Himes, MD
Director of Geriatrics
Group Health Cooperative
Seattle, Washington

Martha Jones, BSN, PHN, CCM
Vice President, Regional Care Management
HealthCare Partners
Los Angeles, California

Joy Luque, RN, BSN, CCM
Director, Case Management
PacifiCare
Cypress, California

Paul Mendis, MD
Chief Medical Officer
Neighborhood Health Plan
Boston, Massachusetts

Carol Raphael
President and CEO
Visiting Nurse Service of New York
New York, New York

Robert J. Schreiber, MD
Chairman, Department of Geriatrics
Lahey Clinic
Burlington, Massachusetts

W. June Simmons, LCSW
President and CEO
Partners in Care Foundation
Burbank, California

Ingrid Venohr, RN, PhD
Director, Senior Programs
Kaiser Permanente
Denver, Colorado

Nancy A. Whitelaw, PhD
Director, Vital Aging Studies – Health Studies
The National Council on the Aging
Washington, D.C.

* *Served as scientific advisor*
† *Served as Convener and Chair*

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Section 1

Introduction

This report addresses how Managed Care Organizations (MCOs)[1] can improve the quality of transitions among care venues for members with complex care needs. In this report, care transitions are defined as patient transfers from one care setting to another. Although transfers within one particular setting (such as from a hospital intensive care unit to a general medical ward) can be problematic, this report focuses on transfers between care settings, including hospitals, skilled nursing facilities (SNFs), the patient's home, outpatient primary care and specialty clinics, and assisted living and other long-term care facilities.

Challenges related to transitional care pervade all payment mechanisms. However, MCOs that are capitated under the Medicare+Choice (now called the "Medicare Advantage") program have the flexibility and incentives necessary to coordinate care seamlessly across integrated settings. To capitalize upon this potential, MCOs need to move beyond traditional utilization management aimed at monitoring service use in individual settings to a broader focus that includes improving the efficiency and effectiveness of transfers to different venues. Government agencies at both the state and federal levels and accrediting bodies, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), also can play a role in improving care transitions.

Not all patients undergoing transitions are at high risk for adverse events; however, those with poor transitional care plans are particularly likely to "fall through the cracks." This report focuses on adults with complex acute or chronic conditions who require care in multiple settings within the health care system. There is no distinction in this report between non-aged adults with complex care needs and seniors because the challenges involved in executing high-quality transitions are generally the same for both populations.[2]

Transitions from one care setting to the next often parallel transitions in health status (1-3). Patients transferred between sites may have a new diagnosis or a change in functional status that affects their ability for self-care. Since most of these episodes are triggered by acute problems that are unplanned, neither patients nor their families know what to expect nor do they realize just how vulnerable patients can be during transitions. This is particularly true if the patient has not returned to his or her baseline physical or cognitive functional state in the interval between hospital discharge and the first follow-up encounter with a health professional. By default, coordination and continuity during this particularly vulnerable time often falls to family members or other informal caregivers.

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[1] Managed care organizations (MCOs) include health maintenance organizations and other health plans with capitated contracts to serve Medicare beneficiaries. They also include providers (e.g., hospitals or group practices) that are capitated by health plans.

[2] Children are not considered within the purview of this report because they may have special needs or social or family situations that differ from those of adults. However, some of the findings may be relevant.

In many respects, the term "health care system" is a misnomer. There are few mechanisms in place for coordinating care across settings, and often no single practitioner or team assumes responsibility during patients' transitions. The following two examples illustrate the challenges of coordinating care across settings:

During a single episode, a 70-year-old man experiencing an exacerbation of congestive heart failure may receive care from:

- a disease management case manager over the phone,
- a primary care practitioner (PCP) in the ambulatory setting,
- physicians and nurses in the emergency department,
- hospitalists and nurses during an inpatient admission, and, finally,
- visiting nurses in the home.

Likewise, an 86-year-old woman who sustains a hip fracture may require treatment from:

- orthopedic surgeons and anesthesiologists;
- hospitalists, nurses, physical therapists, occupational therapists, and social workers in an acute hospital;
- SNF physicians (commonly referred to as "SNFists"), nurses, physical therapists, occupational therapists, and social workers in a SNF;
- nurses, physical therapists, and occupational therapists upon return to her home from a home health care agency; and, finally,
- a PCP and nurses in the primary care setting.

Transfers among care settings are common. Twenty-three percent of hospitalized patients over the age of 65 are discharged to another institution, and 11.6 percent are discharged with home health care (4). An estimated 19 percent of patients discharged from a hospital to a SNF are readmitted to the hospital within 30 days (5).

One study tracked post-hospital transitions for 30 days in a large, nationally representative sample of Medicare beneficiaries. Transitions in this study were defined as transfers to or from an acute hospital, skilled nursing or rehabilitation facility, or home with or without home health care. Overall, 46 unique care patterns were identified during this 30-day time period. Sixty-one percent of care episodes resulted in one transition, 18 percent in two transitions, 9 percent in three transitions, 4 percent in four or more transitions, and 8 percent resulted in death. These episodes were further categorized as uncomplicated versus complicated. Uncomplicated post-hospital care episodes were defined as a sequence of transfers from higher to lower intensity care environments without recidivism, while complicated post-hospital care episodes were defined as the opposite sequence of events. Using this approach, as many as 1 in 4 episodes were categorized as complicated (6). Although some of this recidivism can be attributed to the natural course of chronic conditions, these statistics suggest that transition-related problems are common.

There are a number of reasons for MCO leadership to take an interest the management of care transitions. Poorly executed transitions are associated with inefficiencies and the duplication of tests and services that needlessly increase the cost of care by leading to greater utilization of hospital, emergency, post-acute, and ambulatory services (7-9). The consequences of poorly executed transitions may also include negative publicity, member complaints, and litigation that requires staff time and resources in order to resolve.

In the sections that follow, this report proposes specific strategies for improving the care for patients in transition, including:

- ensuring accountability for patients in transition,
- facilitating the effective transfer of information,
- enhancing practitioners' skills and support systems,
- enabling patients and caregivers to play a more active role in their transitions,
- aligning financial and structural incentives to improve patient flow across care venues, and
- initiating a quality improvement strategy for care transitions.

Each section of this report includes recommendations for actions that MCOs can take to improve the quality of care delivered to their patients undergoing transitions. In addition, examples of best practices currently employed in MCOs are provided in order to demonstrate that these recommendations are not only feasible but also add value and potentially contribute to a favorable bottom line (such as reducing duplication, preventing recidivism to high intensity care venues, and improving patient safety). Finally, a clinical vignette, based on actual events, extends across each of the sections to illustrate the key challenges involved in managing care transitions and the interdependency of each of the sections. An introduction to the case is provided below.

Vignette

Mr. RJ is an 80-year-old retired security guard who lives at home with his wife, a retired high school cafeteria worker. He plays nine holes of golf twice a week. He is a member of an MCO and has a long-standing relationship with his PCP. His problem list includes hypertension, osteoarthritis of the knees, mild renal insufficiency, prostatic hypertrophy, and impaired short-term memory. His medications include lisinopril, acetominophen, and a multivitamin. Approximately six months ago, an acute decline in his mental status was associated with a trial of narcotic analgesics for his arthritis. Consequently, narcotic analgesics are listed on his outpatient chart under medication allergies/intolerances.

During a round of golf, Mr. RJ inadvertently stepped into a hole on the green, causing him to fall and fracture his left hip. He was taken to a nearby hospital that contracted with his MCO. The following day, he underwent surgery at the hospital to repair his hip fracture. His pain management was satisfactory without the use of narcotics.

(To be continued in the next section…)

Section 2

Accountability

Vignette (continued)

Mr. RJ was transferred to a SNF for rehabilitation on a Friday. Three days later, he had not been seen by a physician. Mr. RJ became increasingly anxious that no one seemed to be in charge of his care and expressed his concern to the SNF administrator. The administrator determined that Mr. RJ had been transferred without orders or notification of an attending SNF physician.

(To be continued in the next section…)

Recommendations

MCOs should:

- Establish policies and procedures for members undergoing transitions and educate contract providers and facilities as to their content.
- Ensure that members undergoing care transitions have an identified and responsible practitioner at all times.
- Establish performance standards for care transitions and monitor performance against these standards.
- Contract only with practitioners and institutions that meet pre-defined standards.
- Forge collaborative relationships among providers to establish performance expectations and monitor quality.

Statement of Problem

MCOs are accountable for members' care transitions. This accountability includes contracting with institutions or practitioner groups that meet or exceed performance standards and ensuring that this quality is maintained over time. Furthermore, MCOs must provide members with timely notice of impending transfers or the discontinuation of services (10). Providers are accountable for measuring and monitoring care processes that reflect the quality of care transitions. To accomplish this, quality measures for transitions are needed that can identify problems and potential etiologies. These measures need to assess the extent to which patients are prepared to be transferred and to follow their proposed care plan. Without measurement, there is little opportunity for quality improvement.

In addition, accountability needs to be better defined for individual practitioners. As the vignette illustrates, it is often unclear which practitioner is responsible for the patient in the interval between discharge from one setting and admission to another. Additionally, a PCP may see a patient for follow-up after hospitalization without the benefit of knowing what transpired in the hospital or during home health care. During these intervals, patients are particularly at risk for "falling through the cracks" and not knowing whom to call with questions or concerns. The resulting anxiety may generate unnecessary utilization, such as a trip to the emergency department. Patients need to have available to them an identifiable and responsible health care practitioner at all times during this vulnerable period.

Mechanisms to ensure accountability tend to follow the same pattern as health care reimbursement and financing mechanisms—that is, they are structured around care delivered within a single setting rather than across settings. Federal quality assurance programs reinforce care delivery silos by focusing on care delivered within a given setting rather than across settings. Mandated federal data reporting requirements (e.g., the Minimum Data Set [MDS] for nursing home patients and Outcome and Assessment Information Set [OASIS] for home health patients) do not address issues of quality across transitions. Further, the effort necessary to comply with data reporting requirements can be so demanding that staff have little capacity to respond to the needs of practitioners at the patient's next site of care.

Currently, regulatory or accrediting bodies pay little attention to the quality of transitions. JCAHO standards include language relating to the exchange of information during transfers (11), but they do not adequately address the problem. For example, one standard states that, "The hospital ensures coordination among the health care professionals and services or settings involved in a patient's care." This standard reflects the perspective of the sending institution and not that of the receiving institution. The hospital is merely charged with describing how information is transferred rather than actually demonstrating how well it performs that task. The perspective of the receiving institution needs to be incorporated into such standards.

Proposed Solutions

Enhancing accountability begins with setting expectations for both the sending and receiving health care teams. Exhibit 1 summarizes the core functions that need to be accomplished in order to meet the needs of patients undergoing transitions. To ensure that these activities are routinely completed for each transition, performance measures should be implemented that address the processes of care delivered to patients in transition. These measures could be used for both internal quality assurance activities and public reporting and accountability.

Exhibit 1. Core Functions for Meeting the Needs of Patients in Transition (12).

Both the sending and receiving care teams are expected to:

- Shift their perspective from the concept of a patient discharge to that of a patient transfer with continuous management.
- Begin planning for a transfer to the next care setting upon or before a patient's admission.
- Elicit the preferences of patients and caregivers and incorporate these preferences into the care plan, where appropriate.
- Identify a patient's system of social support and baseline level of function (i.e., how will this patient care for him or herself after discharge?).
- Communicate and collaborate with practitioners across settings to formulate and execute a common care plan.
- Use the preferred mode of communication (i.e., telephone, fax, e-mail) of collaborators in other settings.

The sending health care team is expected to ensure that:

- The patient is stable enough to be transferred to the next care setting.
- The patient and caregiver understand the purpose of the transfer.
- The receiving institution is capable of and prepared to meet the patient's needs.
- All relevant sections of the transfer information form are complete.
- The care plan, orders, and a clinical summary precede the patient's arrival to the next care setting. The discharge summary should include the patient's baseline functional status (both physical and cognitive) and recommendations from other professionals involved with the patient's care, including social workers, occupational therapists, and physical therapists.
- The patient has a timely follow-up appointment with an appropriate health care professional.
- A member of the sending health care team is available to the patient, caregiver, and receiving health care team for 72 hours after the transfer to discuss any concerns regarding the care plan.
- The patient and family understand their health care benefits and coverage as they pertain to the transfer.

The receiving health care team is expected to ensure that:

- The transfer forms, clinical summary, discharge summary, and physician's orders are reviewed prior to or upon the patient's arrival.
- The patient's goals and preferences are incorporated into the care plan.
- Discrepancies or confusion regarding the care plan, the patient's status, or the patient's medications are clarified with the sending health care team.

Three existing measures attempt to assess specific aspects of transitional care. Researchers at RAND and UCLA developed the Assessing Care of Vulnerable Elders (ACOVE) survey tool, which includes items designed to assess processes of care coordination and continuity that potentially reflect the quality of care transitions (13). The Workgroup is of the opinion that the time intervals associated with some of these items are overly long, however. The Care Transitions Measure (CTM) was developed by researchers at University of Colorado Health Sciences Center to assess the quality of care transitions from the perspective of the patient or his or her proxy. CTM scores have been shown to be significantly associated with a patient's return to a hospital or emergency department after discharge (14). The Patients' Evaluation of Performance in California (PEP-C) Survey, which was designed by the California Health Care Foundation for their pay-for-performance initiative, includes items that address the quality of care during transitions (15). Exhibit 2 displays selected items from each of these measures.

Exhibit 2. Selected Items Pertaining to Transitional Care from Existing Measures.

Assessing Care of Vulnerable Elders Measure (13)

- If a vulnerable elder is discharged from a hospital to home and he or she received a new prescription medication or a change in medication before discharge, then the outpatient medical record should acknowledge the change within 6 weeks of discharge.
- If a vulnerable elder is discharged from hospital to home and survives at least 4 weeks after discharge, then he or she should have a follow-up visit or documented telephone contact within 6 weeks of discharge and the physician's medical record documentation should acknowledge the recent hospitalization.
- If a vulnerable elder is discharged from hospital to home, then there should be a discharge summary in the outpatient physician or nursing home record within 6 months.

Care Transitions Measure (14)[3]

- The hospital staff took my preferences into account in deciding what my health care needs would be after discharge.
- Before I left the hospital, the people that were going to help me when I got home clearly understood what my health care needs were.
- Before I left the hospital, I had a phone number I could call day or night to get answers to my questions.
- Before I left the hospital, I clearly understood how to take each of my medications.

Patients' Evaluation of Performance in California Survey (15)

- Transition to home: How well did doctors and nurses explain what to expect after patients leave the hospital?
- Coordination of care: How organized and efficient were doctors, nurses, and other hospital staff?
- Respect for patient preferences: Did patients feel treated with respect and as a partner in the health care process?
- Involvement of family and friends: Did hospitals encourage the involvement of family and friends?

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[3] To obtain the Care Transitions Measure, send an email to Eric.Coleman@uchsc.edu.

In addition to using established measures of transitional care, MCOs can design their own approaches. For example, they can add questions to existing satisfaction surveys, such as the Hospital Consumer Assessment of Health Plans Survey (HCAHPS®), to obtain feedback from their members on the transitional care experience (16). MCOs can also telephone members following transitions (e.g., from a hospital to a skilled nursing facility) to discuss their experiences. Finally, MCOs can examine other indicators that may be reflective of suboptimal transitional care, such as recidivism back to the acute care setting.

Performance measurement can then form the basis for continuous quality improvement (CQI) initiatives as well as joint initiatives with network facilities. For example, the scope of morbidity and mortality (M&M) conferences routinely held in most hospitals can be expanded to include an examination of poorly executed care transitions as part of a CQI initiative. The Lahey Clinic in Massachusetts conducts M&M conferences quarterly that focus on hospital readmissions from SNFs and whether they could have been prevented. What is novel about these conferences is that practitioners and administrators from both the sending (i.e., the hospital) and receiving institutions (i.e., contract SNFs) attend and review recent cases with the goal of identifying opportunities for quality improvement. As a result of these meetings, benchmarks have been established for the percent of patients who are transferred back to a higher level of care within a defined time period (i.e., 72 hours), and existing institutional by-laws have been modified to include explicit language indicating how contract facilities should ensure safe and efficient transfers. Harvard Vanguard, a large multi-specialty group practice in Massachusetts, conducts similar CQI meetings with MCO representatives, including the medical director of hospital programs, hospitalists, and SNFists. Together, they attempt to determine and analyze the root causes of poor transitions and propose potential solutions.

HealthCare Partners, a large group practice in Southern California, formed a care management team focused on improving outcomes for patients transferred from the hospital to the SNF. One of their initiatives aims to improve the content and distribution of discharge summaries. The team has established a benchmark that PCPs should receive discharge summaries within one business day after hospital discharge. In some hospitals, an inpatient physician maintains primary responsibility for managing the patient in both the hospital and the SNF. Also, the same care manager follows patients in the hospital, the SNF, and into the home. When the patient arrives home, the care manager conducts a follow-up phone call to assess the patient's condition, ascertain that ordered services such as skilled home care or durable medical equipment have been received, ensure that the patient has a PCP follow-up appointment, and, if appropriate, initiate a referral to an ambulatory care social worker or disease manager. These strategies promote continuity across care settings and obviate the need for an additional care "hand-off."

Greater accountability also entails ensuring that patients in transition know whom they can contact with questions or concerns. At each point along the care episode, a clearly identified and accountable health care practitioner needs to be available to the patient until the next practitioner assumes responsibility. At Group Health Cooperative, hospitalists write the initial orders for those patients transferring to a contract SNF, and then receiving physicians in the nursing home co-sign the orders. Hospitalist physicians at the Lahey Clinic communicate directly with receiving practitioners (e.g., PCPs, SNFists, or nurse practitioners in the SNF) via telephone within 48 hours of a patient's discharge to ascertain that the treatment course and care needs are understood. Sierra Health Services in Nevada ensures that patients are able to reach a practitioner who has access to their care plan 24 hours a day, seven days a week.

Advocate Health Centers, a large group practice in Chicago, has implemented a program to manage patients in hospitals, SNFs and custodial care facilities. At the time of transfer between any of these settings, key clinical information is exchanged between the sending and receiving practitioner using a two-way pager or telephone. The sending team also communicates this information to the SNF via voicemail. In addition, a dictated discharge summary is available to the receiving team and PCP within 24 hours of transfer. Home health nurses are encouraged to discuss with hospitalists or SNFists, as appropriate, any questions they may have regarding a recently discharged patient's management until the patient's first PCP follow-up visit. Finally, case managers contact patients who have been discharged to home from the hospital or SNF to assess whether the discharge plan is being followed and is continuing to meet the patient's needs.

It is also important for MCOs to promote both accountability and safety in the area of medication management. Group Health Cooperative conducted a pilot project in which clinical pharmacists telephoned members age 80 years and older within 3 to 6 days after the initiation of a new medication to ascertain compliance and potential adverse events. As a result of this monitoring, more than 20 percent of members had a clinically significant change in medication (17). At Luther Midlefort hospital in Wisconsin, patients are not discharged from the hospital until any potential discrepancies are resolved between their pre- and post-hospital medication regimens (18). HealthCare Partners follows the same practice and has found it to be an excellent opportunity for educating patients and ensuring that PCPs have an accurate and up-to-date medication list.

There are also steps that MCOs can take to ensure that providers are accountable for the care delivered during transitions to the next venue. MCOs can mitigate risk by educating providers, patients, and caregivers about what to expect during transitions. Plans also need to contract with SNFs and home health agencies that have demonstrated the capability for providing high quality care. The contracts should include clear language that provides for the execution of safe transfers and clear lines of responsibility for core activities such as information transfer. HealthCare Partners is creating a "compact" vendor agreement that is modeled after a successful initiative aimed at delineating the responsibilities of PCPs and specialists during referrals. The agreement includes specific guidelines for care to ensure that practitioners in all care venues understand their roles and responsibilities. A feedback loop has been implemented to gather information regarding quality and member satisfaction.

Section 3

Information Needs for Managing Patients in Transition

Vignette (continued)

The sending team did not convey Mr. RJ's known intolerance to narcotics to the receiving team. During his first evening in the SNF, the pain at his incision site intensified. The SNFist on-call prescribed Oxycodone. The patient became confused. Because information was not available regarding Mr. RJ's baseline physical and cognitive function, the SNF nursing and therapy staff assumed that he had advanced dementia. His rehabilitation sessions were put on hold. He remained in bed for several days and developed a decubitus ulcer on his sacrum. It was not until his wife learned of his pain regimen and advised the SNFist of his narcotic intolerance that this medication was discontinued.

(To be continued in the next section…)

Recommendations

MCOs should:

- Define the essential data elements needed to provide high quality care to members who are transitioning across sites of care.
- Assure that the essential data elements are accurately conveyed to the receiving practitioners in a timely and accurate manner.
- Develop and maintain user-friendly information systems that facilitate practitioners' ability to access necessary data elements and communicate with one another across the continuum of care.

Statement of Problem

The transfer of timely and accurate information across settings is critical to the execution of effective care transitions. Practitioners need an understanding of the patient's goals, baseline functional status, active medical and behavioral health problems, medication regimen, family or support resources, durable medical equipment needs, and ability for self-care; otherwise, they may duplicate services, overlook important aspects of the care plan, and convey conflicting information to the patient and informal caregiver. Incomplete information transfer can result in critical errors, such as the patient returning home without life-sustaining equipment (e.g., supplemental oxygen or equipment used to suction respiratory secretions). Furthermore, a lack of understanding of the patient's functional health status, including both physical and cognitive, may result in a transfer to a care venue that does not meet the patient's needs.

Few MCOs have implemented policies and procedures or adopted technology systems to ensure that relevant patient information is transferred across settings in a uniform and timely manner. A study conducted in 2002 by the Gartner Group, an independent technology consulting firm, found that the health care industry invests less of its gross revenues in information technology than other industries (2.45 percent versus 3.94 percent) (19). For MCOs that have developed policies and procedures for information transfer, it may be difficult to apply them to members who are admitted to non-contract hospitals, something that can occur, for example, when the contract hospital is full and diverts patients to other facilities.

In addition, there is often a lack of agreement about what comprises the core clinical information that all practitioners require irrespective of setting. Typically, each institution has an intake and assessment tool that is unique to its particular setting, thus contributing to inefficiency and limiting cross-venue collaboration. Further, practitioners in one setting may not trust the accuracy of data collected in another setting and therefore may duplicate tests out of concern for legal liability. Different health care institutions also have little financial incentive to create compatible information systems, whether electronic or paper-based. Federally mandated assessment tools (e.g., MDS and OASIS) do not aid in this regard since they each have varying requirements. For example, each tool measures the ability to bathe oneself differently. Although this information may have value for regulatory purposes, it is not oriented to managing care transitions.

Proposed Solutions

MCOs need to have a Standard Operating Plan (SOP) for information flow that clearly delineates the type of data to be conveyed to the next care setting and how this information transfer will be achieved. An essential step is determining which core data elements should be included in the discharge or transfer summary in order to provide the receiving care team with a comprehensive picture of the patient's baseline health status, recent developments in his or her care, the current care plan, the patient's goals and preferences, and a summary of what occurred in the sending institution or care venue. Exhibit 3 summarizes the Workgroup's recommendations for the core data elements that need to be conveyed across the continuum of care. Next, MCOs need to determine how best to operationalize this information exchange (e.g., voicemail, e-mail, fax, electronic medical record, web-based medical record, or paper medical record).

Exhibit 3. Core Data Elements Needed across the Continuum of Care.

Domains	Information Required	Short-Term Goals*	Long-Term Goals*
Functional Status	• Baseline (ADL and IADL)** • Current		
Medical Status	• Summary of admitting problem(s) • Most pressing medical problem and prognosis • Other medical problems complicating management • Comprehensive list of current medications (including prescribed and over-the-counter) • Current list of allergies/intolerances		
Self-Care Ability	• Current ability • Educational and training needs		
Social Support	• Primary caregiver (name, relationship, phone number) • Ability/willingness to provide ongoing care • Community-level support		
Disposition	• Where was patient residing prior to episode? • Where is the patient going now? • Where will the patient go next?		
Communication	• Language • Literacy • Health beliefs		
Advance Directives	• Preferences for CPR, ventilator support, enteral/parenteral feeding, hydration, dialysis • Power of attorney		
Durable Medical Equipment	• Current needs • Vendor's name and phone		
Coverage/Benefits	• Provider network for SNFs, home health agencies, hospice, respite, and durable medical equipment		

* Goals take into account the patient's values and preferences

** ADLs = Activities of Daily Living; IADLs = Instrumental Activities of Daily Living

Information transfer can also be improved by making the sending institution accountable for ensuring that the information transfer is timely and complete, enhancing information technology, and adopting uniform care planning and assessment tools that include the core data elements described above. Standardization of such a tool would eliminate the need to re-enter data into the medical record at each setting, thereby reducing the potential for error and improving efficiency. Because providers frequently contract with multiple health plans, the development and implementation of a uniform care plan requires broad-based collaboration on behalf of practitioners, providers, and MCOs within a geographic region.

The state of Massachusetts has created a universal home health authorization form for health plans (20). This two-page form includes essential information such as the patient's current functional status, health plan information, skilled nursing needs, durable medical equipment needs, short- and long-term goals, as well as contact information for the caregiver, attending physician, and any vendors (Appendix I). Several regions within Kaiser Permanente have chosen to use the Functional Independence Measure (FIM) score as a common metric to facilitate cross-site communication among clinicians working in hospitals, SNFs, and home health care venues. Horizon Blue Cross and Blue Shield of New Jersey has created protocols for standardized information transfer. For every member who is transferred, a standard documentation template is sent to the receiving team that includes basic demographic information, prior and current functional status, short- and long-term care goals, medical and rehabilitative needs, and contact information for the sending team.

Although information technology is evolving and offers great potential for improving data transfer across settings, widespread adoption and implementation of interoperable systems is not imminent. At present, only about 10 percent of health delivery systems have implemented an electronic health record system (21). Nevertheless, MCOs can take actions to improve information transfer that do not require a large investment in a comprehensive electronic system. Practices for ensuring that information is accurately conveyed to all providers could be expanded to include other care settings. For example, nursing homes require that every medication listed on the medication administration record have both a frequency and an indication in order to reduce the likelihood of medication errors. This practice could be extended into other care settings such as hospitals, assisted living, and home health care.

Researchers have shown that patients who were recently discharged from the hospital and whose PCP received their hospital discharge summary by the first follow-up clinic were 25 percent less likely to be readmitted to the hospital (22). Sierra Health Services, Harvard Vanguard, Advocate Health Centers, the Lahey Clinic, Group Health Cooperative, and Kaiser Permanente, Colorado Region, all expect hospitalists to routinely contact PCPs or leave voice messages to alert them when their patients are being discharged and delineate the essential next steps for follow-up care, including laboratory testing and medication adjustment.

MCOs can solve some of the problems concerning information transfer by establishing common standards and expectations among contract organizations. MCOs can require their contract SNFs and home health agencies to continuously update a core data set that would follow patients across all settings. However, this approach must take into account that most providers work with multiple health plans. Therefore, MCOs within a given local community might collaborate to create a standard format for the transfer of pertinent clinical information, analogous to that employed by pharmacy benefit managers (PBMs) for transferring pharmacy data.

Recent confidentiality requirements enacted under HIPAA have created perceived barriers to information transfer among practitioners working in different health care settings. Some providers have been reluctant to transfer information out of fear of penalty, while some institutions have been observed to be "hiding behind HIPAA" in order to avoid the effort necessary to ensure that essential information is transferred (23). HIPAA regulations clearly state that appropriate information that is needed for the ongoing treatment of the patient can be shared among practitioners in different settings.

Information transfer can also be improved through the development and dissemination of related technology. For example, electronic medical records have traditionally been confined to hospital or ambulatory settings; however, these might be expanded to include a wider range of health care venues. If practitioners were able to access information obtained in other care venues, the burden of information transfer would be reduced.

Larger MCOs with a high degree of vertical integration may best be able to implement these kinds of changes, as has occurred at Kaiser Permanente, Group Health Cooperative, and PeaceHealth, an integrated delivery system located in Oregon, Washington, and Alaska. Sierra Health Services has implemented an electronic medical record that facilitates access to essential information across health care settings. For example, when a hospitalized patient enters a SNF or home health care, the system automatically and electronically populates the patient's demographic information, problems list, medications, and allergies and generates an e-mail to the sending care team to confirm that the patient and his or her health care information were successfully transferred. In addition, the primary care case manager receives an e-mail alert whenever a patient receives care in a venue other than the primary care setting (e.g., specialty clinic, emergency department, hospital, SNF, or home health). Harvard Vanguard has an electronic medical record that affords practitioners the opportunity to access a patient's information in the hospital, the ambulatory clinic, and select SNFs. At the Lahey Clinic, nurse practitioners practicing in the post-acute care setting communicate with PCPs and specialists electronically through a secured e-mail system.

MCOs can also create opportunities for members to obtain personal health information over the Internet. For example, Kaiser Permanente members have access to a "Personal Health Link" that allows them to review their recent laboratory results and prescribed medications. Group Health Cooperative offers its members the same service through "My Group Health." This type of information sharing not only facilitates information transfer among practitioners in different settings but also encourages patients to play a more active role in their health care.

Patients can also be encouraged to maintain up-to-date information on their health status, including the elements delineated in Exhibit 3 or more limited information such as a medical problem list, medications, allergies, and advanced directives. Patients could use a paper record to store the information (examples are provided as Appendix II and Appendix III) or a more technologically advanced modality such as a CD-ROM, a personal data assistant (PDA), or a “smart card” (i.e., a credit-card sized tool containing a computer chip that can store health status data). In each of these cases, concerns surrounding patient confidentiality are lessened because the patient controls the ability to share medical information. Memorial Health Services in Long Beach, California, issues free medical identification cards through its web site that can be swiped into a computer to quickly register a patient and provide “instant vital information” for emergency department physicians and nurses. As of June 2002, the hospital had issued 500,000 identification cards, and approximately 75 other hospitals have expressed interest in licensing the system (24).

Section 4

Practitioner Skill Sets and Support System

Vignette (continued)

Mrs. RJ was relieved that her husband wasn't going to be discharged directly to home. However, neither she nor her husband felt well informed about their options for receiving rehabilitation services. The care team did not invite them to participate in the formulation of the care plan, nor did they ask which of the contracted SNFs would be easiest for Mrs. RJ to visit to provide emotional support during Mr. RJ's recovery, whether their home needed modification to accommodate Mr. RJ's functional status, or whether Mrs. RJ was able and willing to function as her husband's caregiver once he came home.

(To be continued in the next section…)

Recommendations

MCOs should:

- **Improve practitioner knowledge of the services and settings available across the continuum of care to facilitate the best match between a patient's care needs and care setting.**
- **Ensure that practitioners have support systems that facilitate providing treatment, information, durable medical equipment, and other services during a patient's transition.**
- **Assure that practitioners incorporate patients' goals, preferences, and functional status into both short- and long-range care plans.**

Statement of Problem

Practitioners generally lack training on how to execute effective transfers and often do not recognize their role in transition planning. The amount of effort expended in admitting a patient is often far greater than that expended in discharging a patient, when in fact the two should be comparable. Compounding the problem is the fact that most practitioners (e.g., hospitalists, hospital discharge planners, SNF nurses, home health care nurses, care managers, PCPs) have had little exposure to sites of care other than those in which they practice and are therefore unfamiliar with the ability of the receiving institution to manage complex patients. Without such knowledge, a patient may be transferred to a receiving care team that does not have the resources or skills necessary to meet the needs of particular patients.

Only rarely does a single clinician provide ongoing care to a patient transferring from one care setting to the next. Increasingly, PCPs do not follow their patients into the hospital or a rehabilitation facility. Further, with the growing movement toward using institution-based physicians (i.e., "hospitalists" and "SNFists"), who often work in shifts, rotating on and off service, patients commonly receive care from multiple physicians in the same setting. Also, institution-based physicians often assume that a patient has a PCP who will assume care after discharge, which is not always the case.

Problems of continuity are not limited to physicians. A case manager or other professional charged with coordinating care may be unaware when one of his or her patients has accessed an emergency department or was admitted to a hospital. Although the hospital or SNF may employ its own case managers, these professionals rarely have responsibility for patients after discharge or communicate directly with other case managers, disease managers, or staff at community-based organizations involved with the patient's overall care. Thus, these patients may not have the benefit of continuity and advocacy at a time when they are acutely ill and vulnerable.

Nursing shortages further exacerbate the challenge of ensuring safe and efficient transfers. This shortage disproportionately affects post-acute and long-term care nursing facilities, which commonly experience high turnover and difficulty attracting nurses, even when they are in reasonable supply. Newly hired nursing staff members are unlikely to be familiar with the institution's transfer procedures or with the health status of any given patient residing in the facility and, thus, may not convey an accurate picture to the next set of practitioners.

Health care practitioners may also lack the necessary tools and information to function effectively. Practitioners throughout the continuum often are not familiar with how to evaluate patients with acute and chronic care needs and transmit this information across settings. This information is important for making decisions regarding the type and level of post-acute care services the patient requires. For example, the discharge summary—whether from the hospital, SNF, or home health agency nurse—commonly does not include information about the patient's prior functional status; recommendations from practitioners in various disciplines such as social work, behavioral health, occupational therapy, and physical therapy; or the informal caregiver's ability or willingness to execute the care plan. Without a frame of reference for the patient's baseline level, receiving practitioners cannot obtain a complete view of the patient's functional status.

Proposed Solutions

Practitioners require specific training to meet the needs of patients in transition. The essential skills necessary to care for these patients are summarized in Exhibit 4. Practitioners need to shift their mindset from the concept of a patient discharge towards that of a patient transfer to continuous care management. All practitioners must learn how to communicate across sites and collaborate to formulate a common care plan that incorporates different disciplines; evaluate a patient's system of social support, baseline level of function, and potential for discharge; and initiate care planning for the next setting well before the transfer occurs. As illustrated in the clinical vignette, informal caregivers are often worried about their ability to care for the patient when he or she arrives home; therefore, it is critical that hospital physicians, nurses, and discharge planners be knowledgeable about the range of post-hospital options available in the community and the level of care that each facility is capable of providing. Consistency of information from all of these professionals is essential. Finally, practitioners should know whom the patient should contact to obtain accurate information regarding benefit coverage.

Exhibit 4. Essential Skills for Practitioners.

- Establish short- and long-term goals for medical care that take into account patient preferences and the natural history of the disease process.
- Determine the specific care that the patient will require in order to achieve these goals.
- Assess the patient's ability to meet his or her self-care needs, as well as the caregiver's ability and willingness to participate in the care plan.
- Be knowledgeable of the care continuum and each facility's capability for providing care.
- Determine the care site where the patient's needs will best be served.
- Actively engage the patient and caregiver in the decision to move to a new site of care.
- Initiate the transfer plan as early as possible. Recognize that patients may have difficulty processing information and require consistent information from all practitioners and continued reinforcement.
- Incorporate knowledge of the patient's health care benefits into the design and execution of the care plan.
- Communicate the patient's goals and preferences to all health care professionals who participate in the design or execution of the plan of care.
- Communicate the patient's essential clinical and functional status information to the receiving care team.
- Remain available to members of the receiving care team should post-transfer questions or concerns arise.
- Direct the patient and caregiver to the appropriate person when questions arise about benefits.

Since there are no training programs that specifically address the management of care transitions, it behooves MCOs to initiate their own educational programs. MCOs can encourage practitioners from sending institutions to visit receiving institutions in order to gain a better appreciation for (1) their capability to deliver care and (2) the information that should be transmitted in the discharge or transfer summary. Kaiser Permanente, Colorado Region, provides an in-service program aimed at educating PCPs about the range of services provided by the Continuing Care Department as well as other resources within the health plan that support the needs of patients in transition. PCPs also receive training on how to admit patients directly to SNFs rather than first sending them to the emergency department.

Changing the practice environment may also entail eliminating transfers during times when the receiving institution is not adequately staffed to receive the patient. For example, Fontana Medical Center in Kaiser Permanente's Southern California Region avoids transferring patients from the hospital to a SNF after 5:00 p.m. because the Kaiser care manager and nurse practitioner are no longer on duty.

Inter-practitioner communication is critical for the success of care transitions. When practitioners at Sierra Health Services are presented with patients with complex care needs during hospital interdisciplinary team rounds (which include hospitalists, nurses, case managers, and discharge planners), they begin by stating the patient's age, functional status, and caregiver support system to reinforce the importance of these elements in constructing the transfer plan. At Horizon Blue Cross and Blue Shield of New Jersey, the date of a patient's discharge is estimated shortly after hospital admission in order to facilitate communication about and planning for the necessary transfer arrangements. When patients are admitted to a SNF, Horizon arranges a pre-transfer interdisciplinary conference call between the medical director and nursing staff to establish patient goals and estimate the date of discharge.

At the Fontana Medical Center in Kaiser Permanente's Southern California Region, registered nurses from both the transferring hospital and the receiving SNF review the patient's care plan via telephone prior to discharge. Once the patient has been transferred, the registered nurse in the SNF can contact the same nurse in the hospital to clarify any remaining issues. At Harvard Vanguard, the respective rounding teams from the hospital and the SNF meet to discuss pending transitions for specific high-risk patients with complex care needs. At the Lahey Clinic, clinicians from the sending care team complete a paper form that provides direction to the receiving care team (primary care or home health) regarding the patient's needs following hospital transfer. At some PACE sites, practitioners follow their patients across settings, providing greater continuity and the opportunity for enhancing inter-provider communication.[4]

Similarly, as part of Visiting Nurse Services in New York's capitated long-term care program, nurse consultants visit patients in the nursing home setting and provide continuity by following their patients into the hospital if they are admitted. Specifically, they ensure that the hospital care team has current and accurate information for the patient and provide input into the formation of the plan to transfer the patient back to the nursing home.

Group Health Cooperative has adopted several procedures to improve practitioner hand-offs for patients leaving the hospital. For example, the hospitalist retains primary responsibility as the attending physician until the SNF team evaluates the patient. Patients with complex care needs who are discharged to their homes are referred to an ambulatory care manager, and a consultative physician evaluates the patient in the primary care clinic 1-2 days after discharge. Most commonly, this physician is a hospitalist whose inpatient skills are current and who has access to discharge information.

Some MCOs have also explored tailoring specialized services and expertise to patients with the greatest potential to benefit. For example, while utilization management nurses can handle most patients, some patients may need the added training and expertise of complex care managers. Sierra Health Services has instituted several specialized care management programs for patients with complex care needs, including those with congestive heart failure, organ transplant recipients, and persons enrolled in home-based programs. The case managers in these programs have advanced training in the management of these conditions and are skilled in the use of specialized tools and protocols.

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[4] Program of All-Inclusive Care for the Elderly (PACE) integrates acute and long-term care financing to provide comprehensive health and social services to nursing-home eligible older adults.

Finally, some MCOs are exploring the addition of a new class of practitioners, referred to as "transitional care managers," using advanced practice nurses. The nurses assume responsibility for the comprehensive care of the patient in conjunction with the PCP for approximately four weeks post-discharge. They are skilled at identifying changes in health status, assessing and managing multiple complex conditions, managing medications, and collaborating with caregivers and members of interdisciplinary teams. Their responsibilities include: (1) facilitating interdisciplinary collaboration between the sending and receiving care teams; (2) serving as a single contact person who can address questions or concerns among patients and caregivers before, during, and immediately after a transfer; (3) reviewing medications for discrepancies and potential errors; (4) following up with the patient to make sure that he or she filled all prescriptions, received durable medical equipment as ordered, and made an appointment with the next practitioner; (5) empowering the patient and caregiver to be greater participants in their care; and (6) educating the patient and caregiver about the care plan (25;26). This model has been tested in patients with congestive heart failure and older adults with complex care needs and has been shown to be effective at reducing re-admissions rates, length of subsequent hospitalizations, and costs (25-29).

In a variation of this model, the aim of the transitional care manager is to enhance patient and caregiver participation in the management of care transitions and coach them on how to communicate with the multiple health professionals involved in their care. With funding provided by The Robert Wood Johnson Foundation and the John A. Hartford Foundation, this intervention is currently being tested in a randomized trial in collaboration with Kaiser Permanente, Colorado Region, and Centura Senior Life Center, which serves 5,000 Medicare patients in the Denver metropolitan area under both capitated fee-for-service reimbursement (25;29). To date, the study has shown that the hospital readmission rate among patients who receive this intervention is approximately half that of comparable patients that did not receive the intervention (29). Finally, at Neighborhood Health Plan in Boston, nurse practitioners provide around-the-clock direct care management to 30 HIV patients, including accompanying them to ambulatory visits, the hospital or SNF, and into their homes. The application of this model to older patients with complex care needs is being explored.

Section 5

Patient and Caregiver Preparation

Vignette (continued)

Throughout the entire episode, Mr. and Mrs. RJ felt uninformed and unprepared for what to expect in the subsequent phase of care. Upon returning home from the SNF, Mr. RJ's care needs overwhelmed his wife. She did not feel that she had received adequate instruction for her role as caregiver. A home health nurse visited Mr. RJ on the day following discharge from the SNF, determined that he had a urinary tract infection, and arranged for him to receive oral antibiotics. At this point, Mrs. RJ became tearful and said that she was not able to care for her husband at home. The home health nurse explained that Mr. RJ might not meet the criteria for re-admission to the SNF and, if he did not, the expenses incurred would be their responsibility.

(To be continued in the next section...)

Recommendations

MCOs should:

- Identify patients likely to require care transitions in the near future and engage them and their caregivers in pre-transition planning.
- Provide patients and caregivers with the resources and tools that will enable them to participate in the formulation of their transition care plan.
- For patients facing imminent transitions, prepare patients and caregivers for their role in the transition as soon after the date of admission as possible for non-elective admissions and before admission for elective admissions.

Statement of Problem

Patients who are transferred from the hospital and their caregivers often feel inadequately prepared for what to expect at the next care site. Frequently, they perceive that they have had little input into the decision to be transferred. They also sense that the various practitioners responsible for their care generally communicate poorly, if at all, across settings. Many believe that they have not received adequate instruction as to how to care for themselves in the next setting (e.g., managing their conditions, taking their medications), and they often regard as impractical their practitioners' expectation that informal caregivers can provide adequate care. Finally, they also feel unprepared for the emotional impact that comes from a change in health or functional status (30-34).

How well the delivery system meets patients' needs during a care transition has a significant effect upon informal caregivers. Often, because of poor communication and inefficiencies, patients and their informal caregivers must by default assume responsibility for care coordination across different settings. Not only does this unanticipated role create emotional burdens for informal caregivers, it may also cause financial strains if they are no longer able to fulfill their usual roles in the workplace or with the family.

Some patients have unrealistic expectations. They may believe that they are ready to be transferred from the health care institution to home, when in fact they are unable to take care of their basic needs. Such situations force physicians and care managers to make a difficult trade-off between patient autonomy and patient (and caregiver) safety. Discharge under this circumstance can place both the patient and the informal caregiver at risk for adverse physical and mental health outcomes. In some cultures, the family member who cares for the patient may not be the person who assists in making decisions concerning the patient's care. For example, the adult daughter may be involved in the day-to-day provision of care, but the eldest son may make the health care decisions on behalf of the patient.

Typically, formal mechanisms are not in place to ensure that patients and caregivers are involved in the development of the care plan, including the logistics of the impending transfer. The caregiver, who often plays a critical role in the execution of the care plan following the transfer, may not even be present when the plan is formulated. Even when the patient and caregiver do participate, the primary focus often concerns the details of the immediate treatment plan, leaving unaddressed whether the next steps in the treatment plan are congruent with the patient's overall prognosis and goals for care.

Patients may be unaware of the alternatives available to them for receiving or paying for care (e.g., the Veteran's Administration for those patients that are eligible, Medicaid, and community resources) or the benefits for each option. Also, patients may not be able to distinguish one care setting from another (i.e., SNF, rehabilitation facility, assisted living facility, long-term nursing home care) or understand the relationship between the type of facility and the services provided, further limiting their ability to participate in the decision to be transferred.

Discrepancies between patients' and practitioners' goals may be compounded by barriers of language, education, values, and culture. For example, patients' preferences may be compromised by practitioners' personal beliefs. Language barriers arise when the patient and provider do not share the same primary language or when practitioners use medical jargon. Finally, studies have revealed that between 30 and 40 percent of older adults lack the literacy skills necessary to function in the health care environment. For example, they may be unable to read or understand the directions on their prescription bottles or the information on an appointment slip (35).

Proposed Solutions

MCOs and practitioners have multiple opportunities to engage patients and informal caregivers in discussions that elicit their care needs and preferences. The pre-hospital admission planning process is an ideal opportunity to discuss the potential content and location of the post-hospital care experience. Alternatively, since the majority of hospital admissions are acute and unplanned, it would also be appropriate to identify patients who have advanced, chronic illness and are likely to be hospitalized and require post-acute care services within the year. These patients could be scheduled for a pre-transition planning discussion with their PCP or a care manager during a routine ambulatory visit. Patients who have recently experienced such transitions may be particularly receptive to such a discussion. These pre-transition visits are also an appropriate time to make certain that the member understands the need for documentation of advance directives as well as his or her post-hospital benefits. Such pre-transition visits might begin with a question such as:

> *You may need to go to the hospital, and when this happens you may be too weak to care for yourself at home and need time to recover. Do you have someone who could take care of you for three days or so after a hospitalization?*

At Group Health Cooperative, older members are asked this question at the time of their annual comprehensive evaluation. Members who are not able to identify a short-term caregiver are referred to a social worker or registered nurse to develop an advanced care plan that becomes part of their medical record. Kaiser Permanente, Colorado Region, has instituted an alternative model of primary care whereby health care practitioners see their older patients in a group setting (36;37). These group visits are an appropriate forum for engaging patients and caregivers in pre-transition planning.

For those patients who are admitted non-electively to the hospital, the process of discharge (transition) planning needs to be initiated early in the stay. Patients and informal caregivers should have the opportunity to express their concerns and actively participate in the formulation of the care plan. These discussions should be conducted in lay language and ideally should be initiated at the time of admission. Because of the critical role that caregivers play in executing the care plan, they must be consulted before any assumption is made regarding their ability and willingness to participate. In addition, the patient and caregiver may need time to assimilate and discuss the information provided, weigh the various options, and ask questions. At a minimum, caregivers and patients who are frail or who have complex care needs should be encouraged to ask practitioners (e.g., discharge planners, social workers, utilization management nurses, or physicians) the questions listed in Exhibit 5. Providing patients and caregivers with the opportunity to have

Exhibit 5. Patient and Caregiver Care Transition Planning Questions.

- How much of my prior abilities will I likely get back?
- What steps do I need to take to make this happen?
- How long will it take?
- Where can I go to recover? Will my stay be covered under my existing benefits?
- What resources and adaptations will it take to restore function?
- What is the anticipated time frame for me to regain function?
- Are my family members and friends expected to provide assistance? If so, how much assistance is required and for how long?

input into the care plan is one way to invite discussion regarding individual preferences or practices that may impact the transition. These dialogues also may help practitioners identify family members who should participate in decisions regarding care planning and plan implementation.

Patients and their caregivers can often be more effective participants in the planning and execution of care transitions if they acquire specific skills, analogous to the self-management skills they need to care for their medical conditions. For instance, patients can become more knowledgeable about their health care benefits and community resources (e.g., companion care and respite care). One approach for enhancing the role of the patient and caregiver is to provide them with tools that prepare them for the upcoming transfer. Several tools have been designed for this purpose. First, researchers at the University of Colorado Health Sciences Center developed the patient transfer checklist, displayed in Exhibit 6, for patients and caregivers admitted to a hospital or SNF based on input from patients and caregivers who had recently been discharged from the hospital to a SNF or home with home health services (25).

Second, the Los Angeles County Department of Community and Aging Services provided funding for the Partners in Care Foundation to create a tool to assess caregivers' capability to sustain the level of care currently provided (Appendix IV). The information gained from this tool can be used to tailor the care plan to better meet patients' needs during transitions. Third, Oxford Health Plan has added a section to its website that provides a menu of resources for caregivers, including a caregiver handbook, advice for how to make the home safer, and steps they can take to reduce the strain of caregiving. These tools empower patients and caregivers to speak up and participate in the planning process.

Sending institutions can also prepare patients for a transfer by ensuring that patients are able to assume an

Exhibit 6. Patient Transfer Checklist (25)[5].

Before I leave the care facility, the following tasks should be completed:

- I have been involved in decisions about what will take place after I leave the facility.
- I understand where I am going after I leave this facility and what will happen to me once I arrive.
- I have the name and phone number of a person I should contact if a problem arises during my transfer.
- I understand what my medications are, how to obtain them, and how to take them.
- I understand the potential side effects of my medications and whom I should call if I experience any of them.
- I understand what symptoms I need to watch out for and whom to call should I notice them.
- I understand how to keep my health problems from becoming worse.
- My doctor or nurse has answered my most important questions prior to my leaving the facility.
- My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

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[5] This and other transition-enhancing tools are available at http://www.caretransitions.org.

enhanced role in their recovery. For example, patients receiving post-acute care in Veteran's Administration facilities can participate in a medication self-administration program that allows the patient, caregiver, and practitioners to determine whether the patient will be able manage his or her medications upon returning home. A pharmacist meets with the patient to gauge his or her understanding of the medication regimen and ability to follow it. Patients who demonstrate that they are able to follow the regimen are instructed to request their medications from the dispensing nurse at the appropriate time each day. If they are able to maintain the correct schedule, they are allowed to keep their medications in their room (with appropriate safeguards to ensure that other patients are not able to access them) and take them on their own with staff oversight. After successfully completing this trial, the patient and sending team can be confident that medications will be taken appropriately after discharge.

There are instances where the hospital care team recommends that a patient receive care in a SNF, but the patient decides to go directly home instead. Both Healthcare Partners and the Lahey Clinic have protocols for dealing with this situation. The hospital care team provides patients and caregivers with training in how to manage at home and encourages them to practice what they have learned before leaving the hospital. This training includes skills such as how to transfer a patient from the bed to a chair or on and off of the toilet, how to change dressings, and how to administer medications. Following discharge, these skills are closely monitored and reinforced by home health care nurses and therapists.

For patients planning an elective admission, preparation for self-care can be initiated prior to hospital admission. For example, Keystone East, the HMO owned by Independence Blue Cross in Philadelphia, has developed a program that targets patients undergoing elective joint replacement surgery. Prior to surgery, a nurse case manager telephones the patient to assess his or her condition and schedule two distinct home visits. First, a nurse reviews the patient's physical and social needs, evaluates the safety of the home, and provides education about the patient's role in the surgery and aftercare, such as post-surgery breathing techniques. Second, a physical therapist evaluates the patient's gait and post-surgery need for durable medical equipment, and may also provide instruction on pre-surgical strengthening exercises and the use of assistive devices. Once the patient is discharged from the hospital, a case manager and physical therapist follow the patient through the recovery. A focus group of patients who participated in this program reported that their comprehensive care needs were uniformly met. Kaiser Permanente, Colorado Region, the Lahey Clinic, and HealthCare Partners offer similar programs.

Oxford Health Plan encourages members to create an "I need" list that is tailored to their specific functional (e.g., physical, cognitive, sensory) and emotional (e.g., fear of needles) needs. An Oxford nurse coaches patients in articulating their needs and encourages them to create a written list. For patients who have difficulty writing, the nurse creates the list and mails it to the patient's home. Members are encouraged to bring the "I need" list to all health care encounters. Health Partners in Minneapolis has prepared materials for patients and caregivers describing its SNF network, the criteria for selecting facilities, and what patients should expect during their stays. It has also prepared informational materials for what patients should expect when they receive rehabilitation services for select common conditions. Finally, the Medicare Conditions of Participation requirement that practitioners notify patients of an impending transfer (38) creates an opportunity to discuss the goals and specifics of an upcoming transition.

Section 6

Financial Incentives and Structural Issues

Vignette (continued)

Mrs. RJ became upset after being told that the cost of Mr. RJ's readmission to a nursing home would be at their expense. She had assumed that he was eligible to receive 100 days in the SNF, and thus far he had only spent several days there. The patient's children and friends shared Mrs. RJ's sense of outrage and, together, they appealed the decision. Although the plan's decision was upheld, considerable time, effort, and financial resources were required by both parties to resolve the matter.

Recommendations

MCOs should:

- **Ensure that financial incentives among providers are aligned to promote (1) high quality care transitions and (2) the transmission of essential data elements to practitioners involved in a patient's care across different settings.**
- **Structure their delivery systems to promote seamless transitions across care settings.**
- **Review benefit coverage and limitations with members and/or practitioners prior to a transfer and explain to members what they should expect at the next care setting(s).**

Statement of Problem

Payment mechanisms commonly lack incentives for assuring that optimal care coordination occurs across settings. Per-stay (or per-case) payment mechanisms can promote premature patient transfer without adequate focus on the patients' needs at the next setting. Yet reducing the length of stay in one setting may negatively influence care, as well as costs, in a subsequent setting. Furthermore, each additional care transition provides another opportunity for an adverse transition-related event or error to occur.

Structural barriers may also impede the provision of optimal care for patients in transition. For example, MCOs that attempt to create a continuum of care by contracting for a variety of acute and post-acute services often encounter differences among providers with respect to their mission, staffing, internal incentives, and professional cultures. These differences can contribute to poor communication, insufficient information transfer, and inadequate preparation of the patient and caregiver. Further, the continuum of care may be incomplete or lack the capability to care for certain subsets of patients, such as those who require ventilators, have antibiotic-resistant infections, or have moderate to advanced dementia. Finally, tensions may arise within an MCO between clinicians, who desire to contract with high quality facilities, and the finance department, which desires to negotiate the lowest rates.

The manner in which services are structured also impacts the provision of care. For example, under one delivery system, a patient with an infection of the bone (i.e., osteomyelitis) may be treated at home and receive intravenous antibiotics three times daily from a visiting nurse. Under another delivery system, the home health agency may not have the technical ability or requisite staffing to provide such frequent home visits requiring that the patient be admitted to a SNF. Although some degree of variation is inevitable, the MCO is responsible for adopting mechanisms to ensure that care is provided in the most appropriate setting and is of high quality. Also, the lack of a common medication formulary across settings heightens the risk for miscommunication and error as the medication regimen must be revised in each setting (39-42).

Additionally, patients may not comprehend their benefit package and their resulting financial obligation, including how that obligation varies by care setting. For example, a common misconception among patients and caregivers is that their SNF benefit covers 100 days of care, irrespective of medical necessity. In addition, some patients may choose to receive care in settings that lack adequate staff and resources (e.g., going directly home instead of to a SNF), potentially resulting in a lack of essential services and a greater risk for medication errors, fragmentation of care, and utilization of costly services.

Patients need to be aware of coverage limitations. Misunderstandings are common and can create false expectations on behalf of patients and caregivers that could potentially impact the patient's perception of the MCO in a negative way, even when no errors have been committed. In one case, for example, an MCO provided a patient with appropriate care under its benefit structure but received substantial negative publicity from the local newspaper because the patient and family were upset that uncovered services were not reimbursed. Patients or their agents may even file appeals, which can be costly to the MCO.

Proposed Solutions

During negotiations with contract facilities and providers, MCOs can create financial incentives that support information transfer. Using a "pay for performance" approach, MCOs can include specific language in contracts with hospitals, SNFs, and home health agencies regarding the types of information that need to be transferred and the time frames within which the transfer must occur. Audits can be conducted periodically to assess performance. Sierra Health Services has implemented a system wherein cell phones are used to facilitate communication between hospitalists and PCPs. Phone calls from the hospitalists to PCPs are tracked and affect hospitalists' financial compensation, which is tied to the percent of discharged patients for whom they have contacted the PCP.

In addition, MCOs can provide incentives to practitioners who meet pre-defined goals for quality indicators. Existing satisfaction tools that hospitals, SNFs, and home health care agencies currently use can be supplemented to include items related to transitional care, with incentive payments that reward specified patient ratings. For example, when HCAHPS® is implemented nationwide, hospitals will have the opportunity to supplement the standardized questions included in the survey with additional items tailored to their quality priority areas (16). Thus, providers could incorporate validated measures of care transition quality to enhance their survey (14).

MCOs can also pay for practitioners to participate in extended advance care planning visits with members and their caregivers to formulate contingency plans in the event at-risk members become physically unable to perform daily functional tasks (i.e., who would care for the patient and where would that care occur?). Advanced planning for future transitions would allow members and their caregivers to face these difficult decisions without the pressure that occurs in a time of crisis. Through its member newsletter, Horizon Blue Cross and Blue Shield of New Jersey encourages such visits with PCPs and case managers. Likewise, Harvard Vanguard conducts advance care planning visits via telephone or in face-to-face visits that count as extended office visits. Geriatric Care of Nevada provides a similar service to both MCO enrollees and Medicare fee-for-service beneficiaries.

Further, incentives serve to encourage practitioners to communicate with patients, caregivers, and the receiving health care team during transitions. At Horizon Blue Cross and Blue Shield of New Jersey, which contracts with a physician group that cares for patients in hospitals and SNFs, each attending physician is expected to prepare patients and their families for what to expect at the next setting, communicate verbally with receiving physicians, and transfer a standard set of core clinical information. The compensation package for physicians reflects their performance in these three areas.

MCOs can also adopt innovative structural approaches to improve the quality of transitional care. For example, receiving care nurses or care managers can be encouraged to meet with patients and sending care teams prior to an impending transfer. In some cases, this initial visit might occur in the emergency department or ambulatory clinic. The purpose of this "pre-transfer" visit would be to:

- conduct an initial assessment, with particular attention to whether the receiving care team has the capability to meet the patient's needs after the transfer;
- gather the essential data elements directly from the sending care team, thereby reducing the potential for errors;
- update or modify the care plan with the patient to reflect his or her care goals in the next setting;
- prepare the member and caregiver for what to expect after the transfer, including how the care will be covered by the health plan and any associated co-payments; and
- estimate the length of stay in the next setting.

The MCO could either reimburse the receiving team for this visit, selectively contract with those providers who are willing to offer such a service or build such a requirement into the contract. These visits might best be targeted to particularly complex cases, as not all patients would benefit from this approach. The benefits to the receiving provider organizations include building and maintaining business relationships and improving quality. These pre-transfer visits are commonly conducted by Hospice and PACE programs and in Canada (43). In addition, Sierra Health Services and the Lahey Clinic have implemented this requirement to some extent in their contractual arrangements with home health agencies.

MCOs can also work with their contracted facilities to ensure that the practice environment is conducive to a collaborative approach to managing patients in transition. This may entail creating new expectations for care managers and other practitioners to follow patients across sites of care. For example, a member of the receiving health care team might visit the sending institution to facilitate the transfer. Alternatively, a member of the sending team might follow a member across settings. At HealthCare Partners, hospital care managers are assigned to several SNFs and follow patients who are discharged from the hospital to a SNF for the duration of their episode in order to advocate for the member and ensure continuity of the care plan.

Communication via telephone can also be used to improve the quality of care transitions. Telephone contact after hospitalization can improve adherence to a medication regimen and attendance at follow-up appointments (44-46). MCOs can pay for a care manager to telephone patients to make sure that they have filled their medication prescriptions, understand the discharge plan, and have received any home nursing services or durable medical equipment as planned. Sierra Health Systems, PacifiCare, the Lahey Clinic, Advocate Health Centers, Kaiser Permanente, Colorado Region, and HealthCare Partners all employ ambulatory care managers charged with telephoning patients after their hospitalization to ensure that their transition back to primary care goes smoothly.

Section 7

Getting Started

For MCOs that are just beginning to address the issue of improving care transitions for their members, the solutions proposed thus far, taken as a whole, may seem daunting. This section suggests steps that MCOs can take to get started. One approach is to begin improvement efforts by selecting and focusing on only one patient population (e.g., patients with specific conditions such as stroke, hip fracture, or dementia or those who reside in particular settings such as nursing homes or assisted living facilities) and one particular type of transition (e.g., transfer from the hospital to a SNF or from the hospital to home with home care). Once the patient population and type of transition have been identified, the episode of care should be defined. This definition could be based on time (e.g., 30 days), resolution of an acute exacerbation, or completion of a particular type of transfer, such as return to independent living.

The next step is to gather preliminary data to quantify the extent of the challenge. Data collection does not need to be a lengthy process or require sophisticated statistical analysis. The data might include tracking whether the requisite information was transferred in a timely fashion, whether patient safety was compromised (i.e., by medication errors or the transfer occurred before the patient was medically stable), or the rate of recidivism within a defined time period. In addition to analyzing patterns of care, MCOs can also gauge the quality of care transitions from the perspective of their members. Patients could be telephoned after returning home and asked about their transition experience. Alternatively, items related to care transitions could be added to standard post-hospital satisfaction questionnaires. Nurses at Oxford Health Plan routinely contact members who were re-admitted to the hospital and conduct a comprehensive assessment to determine the cause of the re-admission. For example, was there a lack of caregiver support, were the post-hospital facilities unable to deliver the level of care needed, or did the patient and caregiver not know whom to call when questions arose? Based on this assessment, the nurses stratify patients as high and low risk for subsequent re-admissions, which guides the intensity of the nurses' intervention. The nurses then communicate their findings to hospital discharge planners.

A team at HealthCare Partners has initiated a workflow study to improve the quality of care transitions. After collecting data on the volume of daily transitions among its 450,000 members, HealthCare Partners determined that an average of 75 patients per day were discharged from an emergency department, 115 patients from its contracted hospitals, 8 patients from out-of-area hospitals, and 5 patients were admitted to hospice. Next, an evaluation of the time and effort that hospitalists and care managers expended executing these transitions revealed that hospitalists averaged 65 phone calls per day, hospital care managers averaged 40 phone calls, and both hospitalists and care managers were spending considerable time on clerical tasks. As a result, HealthCare Partners provided hospitalists and care managers with greater clerical support so that they could focus on higher-level professional tasks. HealthCare Partners is now measuring the impact of this additional support on hospital re-admission rates and the efficiency of its health care professionals.

Once the data have been gathered and analyzed, they can be shared with clinicians and key stakeholders to assess potential short- and long-term solutions. Ideas for practice improvement can be generated from these discussions and supplemented with the approaches proposed in this report or from other best practices resources. For example, solutions may initially focus on improving information transfer through an electronic medical record or clarifying which practitioner is accountable for the patient at different stages of the transition. Performance measurement can be an invaluable tool, particularly when opportunities arise to compare current practice with a baseline year. It also may be advantageous to "piggyback" efforts to improve care transitions with other initiatives, such as those aimed at improving patient safety, the creation of disease-specific care pathways, or other CQI activities.

Next, the extent of the problem and the proposed improvements need to be incorporated into a business case and presented to senior leadership and other key stakeholders, including medical directors, nursing directors, discharge planners, case managers, administrators of home health agencies and skilled nursing facilities, relevant community-based agencies, and consumer representatives. This first meeting should build awareness of the problem and reduce the "silo mentality" discussed in this report. To the extent possible, the costs and adverse consequences of poor care transitions need to be articulated, such as the financial costs of recidivism; frustration and dissatisfaction for members, caregivers, and clinicians; and potential litigation and negative publicity.

What follows is an alternate version of Mr. RJ's case that illustrates how his outcome may have differed had the MCO, practitioners, and caregivers involved in his care embraced the principles and practices discussed in this report.

Vignette (alternate version)

Six months prior to his hip fracture, Mr. and Mrs. RJ met with his PCP and case manager to complete an advance care plan that detailed how the couple would respond if Mr. RJ was not able to care for himself for a short period of time. Following the repair of his fractured hip and prior to his transfer to the SNF, the intake nurse from the contract SNF met with Mr. and Mrs. RJ, prepared them for what to expect during this phase of his recovery, and answered their questions about clinical care and their benefits coverage. Based on this information, Mrs. RJ was able to anticipate when Mr. RJ would be coming home and communicated this information to their son, who had already agreed to stay with the couple.

The hospital and SNF had an agreement to share clinically relevant data elements. The hospitalist contacted the SNFist to discuss Mr. RJ's care plan, review his medications, and call attention to his intolerance of narcotics. As a result, Mr. RJ did not experience an adverse drug reaction at the SNF and made exceptional progress in his rehabilitation. Following both his hospital and SNF stays, Mr. RJ's PCP received a written discharge summary and a brief call from the attending physician apprising her of the patient's interim progress, current status, and next phase of care.

With the help of his wife, his son, the home health nurse, and the home health therapist, Mr. RJ's strength and mobility continued to improve following his transfer to home. Within three months, he was enjoying himself on the golf course once again.

References

(1) Mor V, Wilcox V, Rakowski W, Hiris J. Functional transitions among the elderly: patterns, predictors, and related hospital use. Am J Public Health. 1994;84:1274-80.

(2) Covinsky KE, Palmer RM, Fortinsky RH, Counsell SR, Stewart AL, Kresevic D et al. Loss of independence in activities of daily living in older adults hospitalized with medical illnesses: increased vulnerability with age. J Amer Geriatr Soc. 2003;51:451-58.

(3) Gill TM, Williams CS, Tinetti ME. The combined effects of baseline vulnerability and acute hospital events on the development of functional dependence among community-living older persons. Journals of Gerontology Series A-Biological Sciences & Medical Sciences. 1999;54:M377-M383.

(4) Agency for Healthcare Research Quality HCUPnet. Outcomes by patient and hospital characteristics for all discharges. http://hcup.ahrq.gov/HCUPnet.asp (last accessed 4/23/02). 1999.

(5) Kramer A, Eilertsen T, Lin M, Hutt E. Effects of nurse staffing on hospital transfer quality measures for new admissions. In: Health Care Financing Administration, ed. Appropriateness of minimum nurse staffing ratios for nursing homes. Baltimore: 2000.

(6) Coleman E, Min S, Chomiak A, Kramer AM. Identifying Medicare Beneficiaries at risk for complicated post-hospital care transitions: a predictive model. Health Services Research 2004 (in press).

(7) Institute of Medicine. Crossing the quality chasm: a new health system for the 21st century. Washington, D.C.: National Academy Press; 2001.

(8) Clarfield A, Bergman H, Kane R. Fragmentation of care for frail older people—an international problem. Experience from three countries: Israel, Canada, and the United States. J Am Geriatr Soc. 2001;49:1714-21.

(9) Murtaugh C, Litke A. Transitions through postacute and long-term care settings: patterns of use and outcomes for a national cohort of elders. Med Care. 2002;40:227-36.

(10) Federal Register. Medicare program: improvements to the Medicare+Choice appeal and grievance procedures. Final rule. Rules and Regulations. 2003;68:16651-69.

(11) Joint Commission on Accreditation of Healthcare Organizations. Standards and intent statements - section 1: patient-focused functions. Hospital Accreditation Standards. 2001 ed. Oakbrook Terrace: Joint Commission on Accreditation of Healthcare Organizations; 2001: 69-156.

(12) Coleman EA. Aspen Transitional Care Conference Proceedings. http://www.uchsc.edu/hcpr/documents/AspenTransitionProceedings.pdf. 2002.

(13) Wenger NS, Young R. Quality Indicators for Continuity and Coordination of Care in Vulnerable Elders. http://www.acponline.org/sci-policy/acove/. 2003.

(14) Coleman E, Eilertsen T, Smith JD, Frank J, Thiare JN, Ward A et al. Developing and testing of a measure designed to assess the quality of care transitions (abstract). J Am Geriatr Soc. 2002;50:S7.

(15) California Health Care Foundation. Results from the Patients' Evaluation of Performance (PEP-C) Survey. http://www.chcf.org/documents/quality/PEPCTechReport.pdf. 2003.

(16) Agency for Healthcare Research and Quality RM. Measuring patient's hospital care experiences: development of a national standard. http://www.ahrq.gov/qual/hspcahps.htm. 2002.

(17) Seevak E, Kent DJ, Wagner EH. A pharmacist-based screening program of octogenerians starting new medications. Journal of Managed Care Pharmacy. 2003;9:13-18.

(18) Institute for Healthcare Improvement. Luther Midelfort Achieves Dramatic Error Reductions. http://www.ihi.org/resources/successstories/index.asp. 2003;11/09/2003.

(19) Gomolski B, on behalf of the Gartner Group. Technology expenditures for health care organizations. http://www.gartner.com/DisplayDocument?id=375084&ref=g_search. 2002.

(20) Siegel H, Preskul-Ricca, MA. Managed care and home health care: partnerships that work for patients. Home Health Care Management & Practice. 2003;15(6):470-478.

(21) Department of Health and Human Services. Transforming Healthcare Quality through Information Technology (THQIT) - Implementation Grants. Request for Applications. 2003;RFA-HS-04-011.

(22) van Walraven C, Seth R, Austin PC, Laupacis A. Effect of discharge summary availability during post-discharge visits on hospital readmission. J Gen Intern Med. 2002;17:186-92.

(23) Coleman EA, Foley C, Phillips C. Falling through the cracks: practical strategies for reducing adverse events among older patients transferring between sites of care. Annals of Long Term Care. 2003;11:33-36.

(24) Wysocki T. Emergency room overcrowding. Wall Street Journal. 2 A.D.;07/03/02.

(25) Parry C, Coleman EA, Smith JD, Frank J, Kramer AM. The care transitions intervention: a patient-centered approach to ensuring effective transfers between sites of geriatric care. Home Health Care Serv Q. 2003;22:1-14.

(26) Naylor M, Brooten D, Campbell R, Jacobsen B, Mezey M, Pauly M et al. Comprehensive discharge planning and home follow-up of hospitalized elders: a randomized clinical trial. JAMA. 1999;281:613-20.

(27) Rich M, Beckham V, Wittenberg C, Leven C, Freedland K, Carney R. A multidisciplinary intervention to prevent the readmission of elderly patients with congestive heart failure. N Engl J Med. 1995;333:1190-1195.

(28) Stewart S, Pearson S, Horowitz J. Effects of a home-based intervention among patients with congestive heart failure discharged from acute hospital care. Arch Intern Med. 2000;158:1067-72.

(29) Coleman EA, Smith JD, Frank J, Thiare JN, Ward A, Eilertsen TB et al. An interdisciplinary patient-centered approach to improving transitions across sites of geriatric care. J Am Geriatr Soc. 2002;50:S128.

(30) Coleman EA, Eilertsen TB, Smith JD, Frank J, Thiare JN, Ward A et al. Development and testing of a measure designed to assess the quality of care transitions. Int J Integrated Care [Access www.ijic.org]. 2002;vol 2.

(31) Levine C. Rough crossings: family caregivers odysseys through the health care system. New York, NY: United Hospital Fund of New York; 1998.

(32) vom Eigen K, Walker J, Edgman-Levitan S, Cleary P, Delbanco T. Carepartner experiences with hospital care. Med Care. 1999;37:33-38.

(33) Harrison A, Verhoef M. Understanding coordination of care from the consumer's perspective in a regional health system. Health Serv Res. 2002;37:1031-54.

(34) Weaver FM, Perloff L, Waters T. Patients' and caregivers' transition from hospital to home: needs and recommendations. Home Health Care Services Quarterly. 1998;17:27-48.

(35) Gazmararian JA, Baker DW, Williams MV, Parker RM, Scott TL, Green DC et al. Health literacy among Medicare enrollees in a Managed Care Organization. JAMA. 1999;281:545-51.

(36) Beck A, Scott J, Williams P, Robertson B, Jackson D, Gade G et al. A randomized trial of group outpatient visits for chronically ill older HMO members: the cooperative health care clinic. J Am Geriatr Soc. 1997;45:543-49.

(37) Coleman EA, Magid DJ, Beck A, Eilertsen TB, Conner DA, Kramer AM. Reducing emergency visits in older adults with chronic illness: a randomized controlled trial of group visits. Effective Clin Pract. 2001;4:000.

(38) Centers for Medicare and Medicaid Services. Conditions of participation: Discharge planning. Federal Register. 2001;Section 482.43:503-4.

(39) Moore C, Wisnevesky J, Williams S, McGinn T. Medical errors related to discontinuity of care from an inpatient to an outpatient setting. J Gen Intern Med. 2003;18:646-51.

(40) Beers M, Sliwkowski J, Brooks J. Compliance with medication orders among the elderly after hospital discharge. Hosp Formul. 1992;27:720-724.

(41) Agency for Health Care Quality Research. Medical errors: the scope of the problem. AHRQ. 2000.

(42) Forster A, Murff H, Peterson J, Gandhi T, Bates D. The incidence and severity of adverse events affecting patients after discharge from the hospital. Ann Intern Med. 2003;138:161-67.

(43) Hollander MJ, Prince MJ. Analysis of interfaces along the continuum of care. Victoria, B.C.: Home Care and Pharmaceuticals Division, Health Policy and Communications Branch, Health Canada; 2002.

(44) Dudas V, Bookwalter T, Kerr KM, Pantilat SZ. The impact of follow-up telephone calls to patients after hospitalization. Am J Med. 2001;111:26S-30S.

(45) Baren JM, Shofer FS, Ivey B, Reinhard S, DeGeus J, Stahmer SA et al. A randomized, controlled trial of a simple emergency department intervention to improve the rate of primary care follow-up for patients with acute asthma exacerbations. Ann Emerg Med. 2001;38:115-22.

(46) Einstadter D, Cebul R, Franta P. Effect of a nurse case manager on postdischarge follow-up. J Gen Intern Med. 1996;11:684-88.

Appendices

Appendix I

UNIVERSAL HEALTH PLAN/ HOME HEALTH AUTHORIZATION FORM

S.OC. Date: ___/___/___ **Initial:** **Reauthorization:** ___/___/___
Agency Discharge Date: ___/___/___ **MD Agrees: Y/N** **Patient Agrees: Y/N**

Patient Information

Name: ____________________
S.O.C. Address: ____________________
____
Telephone #: ____________________
DOB: ___/___/___
Homebound: Y/N Why? ____________________
Diagnosis: ____________________
Surgery: N/A ____________________

MD Information

Ordering MD: ____________________
MD Phone#: ____________________
PCP: ____________________
Date of Next MD Visit: ___/___/___

Health Plan Information

Health Plan Name: ____________________
Insurance #: ____________________
Health Plan CM: ____________________
Initial Auth#: ____________________
Telephone #: __________ Fax #: __________

Agency Information

Agency Name: ____________________
Provider Number: ____________________
Contact: ____________________
Telephone #: __________ Fax#: __________

DME/Supplies/IV/Lab

Vendor Name: ____________________

Community Resources ____________________
____

Caregiver Information

Name: ____________________
Relationship: ____________________
Type of Assistance: ____________________
Teachable/Not Teachable: ____________________
Primary Phone#: ____________________

Maternity Care N/A ☐

Delivery Date: ___/___/___Time of Delivery: ____:____
Discharge Date: ___/___/___Time of Discharge: ____:____

Current Functional Status

Cognitive	**Dress Lower Extremities**	**Bathing**	**Toileting**	**Ambulation**
☐ Alert/Oriented ☐ Impaired ☐ Disoriented	☐ Independent ☐ Requires assist ☐ Unable	☐ Independent ☐ Requires assist ☐ Unable	☐ Independent ☐ Requires assist ☐ Unable	☐ Independent ☐ Requires assist ☐ Unable

Service Request	*From*	*To*	**# Of Visits**	*Frequency*	*Auth# Visits*	Health Plan Auth #
RN						
HHA/Hrs&Visits						
PT						
OT						
ST						
MSW						
Other						

Return Communication

Comments: ____________________
____
Name: ____________________ Title: ____________________ Date: ____/____/____

Page 2

Patient Name: ____ Agency: ___________________________________

SKILLED NURSING Anticipated D/C Date: ____/____/____

Pertinent Disease Specific Data: ____

____

____

____

Home Health Aide Services: ____

Wound Care N/A	Wound 1	Wound 2	Wound 3
Location			
Appearance			
Measurement			
Drainage			
TX and Frequency			

Medications: Compliant: Y/N Teachable Patient: Y/N Med List Attached: NA/Y/N

Interventions and Educational Plan: ____

____

____

Short Term Goals: ____

____

Long Term Goals: ____

____

____

Barriers to Achieve Goals: ____

____

Signature: ________________________ Title: ________________ Department: ______________ Date: ____/____/____

OTHER SKILLED DISCIPLINES Anticipated D/C Date: ____/____/____

Please complete a separate pg. 2 when more than one skilled discipline providing care

PT __________ OT ___________ ST ___________ MSW _____________ Other _________________________

Home Health Aide Services: ____

Pertinent Disease Specific Data: ____

____

____

Interventions and Educational Plan: ____

____

Short Term Goals: ____

____

Long Term Goals: ____

____

Barriers to Achieve Goals: ____

Signature: ___________________________ Title: _____________________ Department: _____ Date: ____/____/____

Appendix II

Personal Health Record

If you have questions or concerns,
Contact (______________________)
at (_____) _____ - __________

REMEMBER
to take this record with
you to all doctor visits

The Personal Health Record of:
____

Personal Information
Address: ________________________________
Home Phone #: ____________________________
Alternate Phone #: ________________________
Birth Date: ______________________________
Hospital ID #: ____________________________
PCP Name: _______________________________
Advance Directives?: _______________________

Hospitalization Information
Admitted: ___/___/___ Discharged: ___/___/___
Reason for Hospitalization: __________________
____

Caregiver Information
Name: __________________________________
Home Phone #: ____________________________
Alternate Phone #: ________________________
Relation to Patient: ________________________

Medical History

- ☐ Arthritis
- ☐ Abnormal Heart Rhythm
- ☐ Cancer
- ☐ Diabetes
- ☐ Hardening of the Arteries
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Hip Fracture
- ☐ Lung Disease
- ☐ Medical/Surgical Back Conditions
- ☐ Pneumonia
- ☐ Stroke
- ☐ Other Diagnoses: ___________________

To better manage my health and medications, I will...

- Take this Personal Health Record with me wherever I go, including ALL doctor visits and future hospitalizations.
- Call my doctor if I have questions about my medications or if I want to change how I take my medications.
- Tell my doctors about ALL medications I am taking, including over-the-counter drugs, vitamins, and herbal formulas.
- Update my Medication Record with any changes to my medications.
- Know why I am taking each of my medications.
- Know how much, when, and for how long I am to take each medication.
- Know possible medication side effects to watch out for and what to do if I notice any.

Medication Record (sample)

Name	**Dose**	**Reason**	**New?**
Azmacort MDI	4 puffs 2 times a day	Emphysema	N
Oxygen	2 liters per minute	Emphysema	N
Triam/HCTZ	75/50 take $^{1}/_{2}$ pill once per day	Leg swelling	Y
Warfarin	5 mg once per day	Blood thinner	N
Atenolol	25 mg once per day	Blood pressure	N
Atorvastatin	10 mg at bedtime	Cholesterol	N
Multivitamin	once per day	Nutrition	N

Allergies: Penicillin ➔ Rash

Notes for my Primary Care Physician:

1. Do I need to take Triam/HCTZ even when I do not have swelling?
2. How long will I receive home health care?
3. When is my next blood draw to check the Warfarin?

Intervention Activities Checklist

Before I leave the care facility, the following tasks should be completed:

- ☐ I have been involved in decisions about what will take place after I leave the facility.
- ☐ I understand where I am going after I leave this facility and what will happen to me once I arrive.
- ☐ I have the name and phone number of a person I should contact if a problem arises during my transfer.
- ☐ I understand what my medications are, how to obtain them, and how to take them.
- ☐ I understand the potential side effects of my medications and whom to call if I experience them.
- ☐ I understand what symptoms I need to watch out for and whom to call should I notice them.
- ☐ I understand how to keep my health problems from becoming worse.
- ☐ My doctor or nurse has answered my most important questions prior to my leaving the facility.
- ☐ My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- ☐ If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

Appendix III

Confidential This document if managed by the patient. It is NOT an electronic Shared Care Plan

What is "My Shared Care Plan"?

"My Shared Care Plan" is a self-management tool that can help you keep track of what is going on with your health. Having this information with you when you visit your doctor may help you become more of a partner in your care.

"My Shared Care Plan" has been tested with more than 40 patients across Whatcom County, WA who are living with diabetes and/or heart failure. We would like to hear what you think. Visit *www.PatientPowered.org* to share your thoughts and to see what others are saying.

How can I make the most of "My Shared Care Plan"?

Fill out all of the information that you know in "My Shared Care Plan". If there are things you don't know, ask for that information from your clinic at your next visit. Bring "My Shared Care Plan" with you to all of your health care appointments. Ask your care team members (doctors, nurses, therapists, pharmacists, etc.) to look at "My Shared Care Plan" for a current picture of your health and to help you keep the information accurate, up-to-date, and complete. You can also work together to define problems, set priorities, establish goals, create treatment plans, and solve problems.

What is "Self-Management"?

Self-management means that you play a key role in managing your care. You are part of a team, along with your doctors, nurses, pharmacists and others, working together to manage your health. For more information on self-management, visit *www.PatientPowered.org.*

What are "Advanced Directives"?

Advanced Directives state your preferences for end of life decisions. These include:

- **Healthcare Advance Directives (Living Will)**: This is a legal form that does not require a lawyer. Your Living Will communicates your wishes about artificially prolonging your life if you are unable to make your wishes known.
- **Physician Order for Life Sustaining Treatment (POLST)**: This is a bright green form you and your physician must complete and sign together. These Physician's orders state your preferences for end of life medical care.
- **Durable Power of Attorney for Health Care**: This is a legal form that does not require a lawyer. This form allows you to name a person as your health care agent – someone who can make decisions about your medical care if you are unable to make the decisions for yourself.

For more information on Advanced Directives, talk to your Doctor. You can also obtain forms and information from the Washington State Medical Association 1-800-552-0612.

What are "Next Steps"?

"Next Steps" are small, short-term goals that move you in the direction of a positive lifestyle change. Share your next steps with your care team members so they can support you in reaching your goals.

How can I get another copy of "My Shared Care Plan"?

You can find this file at www.PatientPowered.org.
You can also pick up a copy of "My Shared Care Plan" at

- LifeQuest – (360) 738-6720
  3333 Squalicum Parkway Bellingham, WA 98225
- St. Joseph Hospital – Information Desk
  2901 Squalicum Parkway Bellingham, WA 98225

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Go to *TOOLS* then *UNPROTECT DOCUMENT*

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When you make changes it may shift the page headings and location of information. You can print off specific additional pages from the Website.

For more information on the Pursuing Perfection Project, please visit www.PatientPowered.org or call (360) 756-6885.

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Shared Care Plan for:

Personal Profile

Birthdate:

Phone Number:

Email Address:

I want the person working with me to know...

I have challenges with: ☐ Speech ☐ Vision ☐ Hearing ☐ Mobility ☐ Transportation ☐ Other________________
My primary language other than English is: ________________________ **Translator needed:** ☐ Yes ☐ No
Comments:

I have issues with diet: ☐ Yes ☐ No
Comments:

My religion/spirituality impacts my health care: ☐ Yes ☐ No
Comments:

I have these Advanced Directives: ☐ Living Will ☐ Physician Orders for Life Sustaining Treatment (POLST) ☐ I have granted my Healthcare Power of Attorney to ____________________________ (Name of person)
Comments:

I Live: ☐ Alone ☐ Partner/Spouse ☐ Family ☐ Assisted Living ☐ Nursing Home ☐ Other_________________________
Comments:

I learn best by: ☐ Reading ☐ Being talked to ☐ Being shown ☐ Listening to tapes ☐ Seeing pictures/videos
Comments:

I have access to the Internet: ☐ Yes ☐ No
Comments:

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Shared Care Plan for:

Goals

Long Term Goals (Example: I want to get my blood pressure under control, Go on a long trip out of town)

Goal Description

Completed Long Term Goals

Goal Description

Health Indicators (Example: blood pressure, weight, test results)

<table>
<tr><th>Indicator</th><th>Goal</th><th>Comment</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="3">Log Date: Results: Date: Results: Date: Results:</td></tr>
<tr><td></td><td></td><td></td></tr>
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<tr><td></td><td></td><td></td></tr>
<tr><td colspan="3">Log Date: Results: Date: Results: Date: Results:</td></tr>
</table>

Confidential This document if managed by the patient. It is NOT an electronic Shared Care Plan

Shared Care Plan for:

Next Steps

I Am Concerned About:

- ☐ My ability to manage my chronic condition
- ☐ Financial
- ☐ Access to health care
- ☐ Emotional
- ☐ Family issues
- ☐ Spiritual support
- ☐ Thinking or memory problems
- ☐ End of life issues
- ☐ Other ____________________

Comments:

Next Steps: (Actions you will take to reach your long term goals and health indicators goals)

Date	Next Steps Taken

Completed Steps: (Celebrate your successes here)

Confidential This document if managed by the patient. It is NOT an electronic Shared Care Plan

Shared Care Plan for:

Care Team

Emergency Contact Person: ____

Emergency Contact Phone #: ____

My Care Team – Direct Care (doctors, nurses, family members, caregivers, other health professionals)

Next Appt.	
Name	
Phone #	
Fax #	
Role	
Comments	

My Care Team – Support (pharmacies, therapy clinics, home health agencies, other support people)

Next Appt.	
Name	
Phone #	
Fax #	
Role	
Comments	

Shared Care Plan for:

Diagnoses

My Chronic Diagnoses

Diagnosis	Description	Start Date	End Date	Diagnosed By	Comments

Confidential This document if managed by the patient. It is NOT an electronic Shared Care Plan

Shared Care Plan for:

Active Medications

Medications (Medications you have been prescribed to take)

Start Date	RX By	Generic (Brand) Name & Strength	Directions	Reason I take this	Time of day taken				
					OTC	B	L	D	N
					❑	❑	❑	❑	❑
Comments:									
					❑	❑	❑	❑	❑
Comments:									
					❑	❑	❑	❑	❑
Comments:									
					❑	❑	❑	❑	❑
Comments:									
					❑	❑	❑	❑	❑
Comments:									
					❑	❑	❑	❑	❑
Comments:									
					❑	❑	❑	❑	❑
Comments:									

Other Medications or Supplements I choose to take

Start Date	RX By	Generic (Brand) Name & Strength	Directions	Reason I take this	Time of day taken				
					OTC	B	L	D	N
					❑	❑	❑	❑	❑
					❑	❑	❑	❑	❑
					❑	❑	❑	❑	❑
					❑	❑	❑	❑	❑

Discontinued Medications

Discontinued Medications

Start Date	DC Date	RX By	Generic (Brand) Name & Strength	Directions	Why I took this	Status	Reactions

Reactions

Allergies / Intolerances

Substance	Date Occurred	Type	Documented By	Reaction

Contraindications (Medications that do not work for you or shouldn't be taken with other medications or your diagnoses)

Substance	Reason	Documented By

Appendix IV

Caregiver Assessment Instrument

Date of Assessment:______________________

Section I – Background Information

Name of Caregiver:

Relationship to Care Recipient:

Address:

Phone: (Primary) (Secondary)

Name of Secondary Caregiver:
(other family member or friend who helps you, if any)

Relationship to Care Recipient:

Address:

Phone: (Primary) (Secondary)

II. How long have you been providing care for your relative(s)?

- ☐ Less than one year
- ☐ 1 – 2 years
- ☐ 3 – 5 years
- ☐ 6 – 10 years
- ☐ 11 years or more
- ☐ Other

III. What is your current living situation?

- ☐ I live alone, but I go to care recipient's residence to regularly provide care.
- ☐ I live with my family (spouse/children), but I go to care recipient's residence to regularly provide care.
- ☐ Spouse of care recipient, we live in same home.
- ☐ I live in care recipient's home.
- ☐ Care recipient lives with me in my home.
- ☐ I am a long distance caregiver (I do not live near care recipient, but still provide care).
- ☐ Other situation (please specify):

IV. What is your current employment status (outside of the home)?

- ☐ Currently employed full-time (over 35 hours per week)
- ☐ Currently employed part-time (less than 35 hours per week)
- ☐ Retired
- ☐ On disability (temporary or long-term)
- ☐ Leave of absence (such as family/medical leave)
- ☐ Not regularly employed for pay

In your own words, what is the illness or disability of the person you are caring for?

Please list people you currently know who you could rely on for emotional and/or practical support such as friends, family, and neighbors:

Name	**Relationship**	**Phone**

Section II - Needs Assessment

Please indicate the type of help you need or are currently receiving to help you in your caregiving role.

Do you currently need assistance with caregiving? ☐ Yes ☐ No
If yes, in your own words, can you tell me what assistance you feel you need right now?

I'm now going to list some types of help caregivers typically need or receive. Please let me know if you receive this type of help, and if so, how you receive it.

Type of Help	**Yes?**	**No?**	**If Yes, How Received?**
Day Care (for family member)			
Housekeeping Assistance			
In-Home Nursing Care			
Managing Finances			
Legal Assistance			
Meals			
Personal Care of Relative			
Respite Care			
Shopping/Errands			
Transportation			
Support Group			
Social Work/Case Management			
Other: (specify)			
Other: (specify)			

Section III – Mental Health

V. Choose the best answer for how you felt over the past week (7 days)

Question	**Yes?**	**No?**
1. Are you basically satisfied with your life?		
2. Have you dropped many of your activities and interests?		
3. Do you feel that your life is empty?		
4. Do you often get bored?		
5. Are you in good spirits most of the time?		
6. Are you afraid that something bad is going to happen to you?		
7. Do you feel happy most of the time?		
8. Do you often feel helpless?		
9. Do you prefer to stay at home, rather than going out and doing new things?		
10. Do you feel you have more problems with memory than most?		
11. Do you think it is wonderful to be alive now?		
12. Do you feel pretty worthless the way you are now?		
13. Do you feel full of energy?		
14. Do you feel that your situation is hopeless?		
15. Do you think that most people are better off than you are?		

Section IV - Caregiver Strain Index

I am going to read a list of things that other people have found to be difficult after somebody comes home from the hospital or is in need of care. Would you please tell me if any of these apply to you (respond yes or no)?

Question	**Yes?**	**No?**
1. Sleep is disturbed (e.g., because ________ is in and out of bed or wanders around at night).		
2. It is inconvenient (e.g., because helping takes so much time or it's a long drive over to help).		
3. It is a physical strain (e.g., because of lifting in and out of a chair or the effort or concentration required)		
4. It is confining (e.g., helping restricts free time or I cannot go visiting).		
5. There have been family adjustments (e.g., because helping has disrupted routines or there has been no privacy)?		
6. There have been changes in personal plans (e.g., I had to turn down a job or could not go on a vacation).		
7. There have been other demands on my time (e.g., from other family members).		
8. There have been emotional adjustments (e.g., because of severe arguments).		
9. Some behavior is upsetting to me (e.g., incontinence, ___________ has trouble remembering, or ___________ accuses people of taking things).		
10. It is upsetting to find ___________ has changed so much for his/her former self (e.g., he/she is a different person than he/she used to be).		
11. There have been work adjustments (e.g., because of having to take time off).		
12. It is a financial strain.		
13. I am feeling completely overwhelmed (e.g., because of worry about concerns about how I will manage).		

Section V – Additional Caregiver Background Information

Gender of Caregiver: ☐ Male ☐ Female

Age of Caregiver: ___________ **Age of Care Recipient:** ___________

Are you currently caring for more than one person? ☐ Yes ☐ No

Do you currently drive your own care? ☐ Yes ☐ No
If not, who helps you with transportation? ____

Martial Status of Caregiver: ☐ Single, never married ☐ Married ☐ Widowed
☐ Divorced ☐ Cohabitating (living with partner, but not married)

Which ethnic group do you most closely identify with?
☐ Asian ☐ Anglo/White ☐ Black/African American ☐ Hispanic Origin (of any race)
☐ Native American Indian ☐ Native Hawaiian/Other Pacific Islander ☐ Other________________________________

Section VI – Overall Assessment Observations:

(Additional assessment information obtained for care planning, interventions, and follow-up)