The Role of Long-term–Care Facilities in Transitions of Care

The Burden of Chronic Disease

In the United States, the traditional model of healthcare delivery is divided into discrete episodes of care. Patients frequently move between multiple settings and providers without a dedicated person or team assuming responsibility for maintaining quality of care or managing the transitions-of-care process.\(^1\)

Without a single point linking healthcare systems and providers, the efficiency of care coordination during a transition is reduced. This lack of effective coordination can have serious consequences, many of which can likely be reduced or avoided.\(^1,2\)

These consequences include

- **Gaps in quality of care due to\(^2\)**
  - Lack of patient education and patients who don’t adequately understand their condition at discharge
  - Inadequate communication and medical follow-up among providers between sites of care
  - Medication issues

- **Exponential increases in healthcare costs as a result of\(^2,3\)**
  - Duplicate therapy
  - Readmissions
  - Adverse drug events

The situation is compounded by the fact that patients with multiple chronic conditions use health services at higher rates than other patients. Because of poor coordination of care, these patients often receive duplicate testing, conflicting treatment advice, and prescriptions that are contraindicated. These factors seem to play a role in the correlation between the growing number of chronic conditions and the increasing percentage of preventable hospitalizations and readmissions.\(^2,4\)

CHRONIC DISEASE STATISTICS

- Projections show that there will be a substantial increase in the number of chronic disease cases over the next 20 years as a result of the aging of the US population\(^5\)
- In 2004, healthcare spending for people with chronic conditions was nearly 6 times higher than for people without chronic conditions\(^4\)
Standards for Improving Transitions of Care

In 2009, the Transitions of Care Consensus Conference (TOCCC) developed and published standards-of-care recommendations for managing transitions of care between inpatient and outpatient settings. After developing a set of core principles, the TOCCC proposed the following standards:

- **Coordinating clinicians** to ensure timely communication between a facility and receiving provider (e.g., phone, fax, electronic health record [EHR])
- **Care plans/transition records** to provide minimal data that should always be part of a transition record
- **Communication infrastructure** that provides secure, private, and HIPAA-compliant communications that are accessible to patients and treating practitioners
- **Transition responsibility** for patient care maintained by sending provider or location until receiving provider or location confirms transfer and assumption of responsibility is complete
- **Timeliness** to ensure that factors for timely feedback and feed-forward of information between providers are in place
- **Community standards** that use national standards and processes that institutions must adopt for transitions-of-care accountability to promote effective transitions
- **Measurement utilizing** national standards, processes, and metrics that institutions must adopt for transitions-of-care accountability leading to continuous improvement of the transition process

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Effective Transitions of Care Involve All Healthcare Stakeholders

Although the traditional focus has been on hospital transitions, transitions of care affect all healthcare stakeholders. Care delivery requires a division of labor, which results in multiple healthcare professionals taking part in the care of a single patient. Care transitions occur any time a patient moves between care settings or environments, or transfers from the responsibility of one healthcare professional to another. Therefore, effective collaboration among all healthcare stakeholders is essential to help:

- Reduce medication errors
- Maximize compliance
- Ensure appropriate continuity of care

The US government has allocated almost $1 trillion as part of the 2010 healthcare reform legislation for projects and initiatives aimed at improving overall quality and coordination of care. These efforts include:

- Reducing avoidable hospital readmissions through enhanced transitions of care
- Broadening the use of health information technology (HIT) that will facilitate provider communication
Primary Care Providers (PCPs)

PCPs are often the first point of contact for patients and provide comprehensive and continuous medical care.  

### PCP Responsibilities

- Provide patients with contact information and appointment time frames
- Explain to patients the reasons for and expectations and goals of the visit
- Tailor patient education discussion and materials to match the patient's health literacy level
- Order necessary studies that would help facilitate the visit
- Maintain and transfer accurate and up-to-date patient records
- Consult with the next provider on prereferral work-up, when ordering additional services outside practice guidelines, and as needed after transfer is complete

### PCPs INCLUDE

- Physicians
- Physician assistants
- Nurses
- Nurse practitioners

Case Managers

Case managers coordinate continuity of care and facilitate communication regarding all aspects of a patient's treatment plan between the patient, his or her caregivers, and the healthcare team.

### Case Manager Responsibilities

- Ensure that a member of the healthcare team takes responsibility for patient transitions
- Facilitate the timely communication and exchange of information between care providers
- Expedite access to care and advocate for patient and caregiver needs
- Design a comprehensive care plan that is focused on the patient and caregivers
- Collect and analyze outcomes data to help determine the care plan’s success and if any corrective action is required
- Closely monitor and manage the patient’s plan of care, progress, and outcomes to help avoid treatment problems and delays
- Provide patient and caregiver education
- Tailor patient education discussion and materials to match the patient's health literacy level
- Conduct timely patient follow-up to prevent exacerbations that can lead to emergency room visits or hospitalizations
Clinical Pharmacists

Clinical pharmacists provide consultative services that foster appropriate, evidence-based medication selection and coordinate medication management across the care continuum.\textsuperscript{13,14}

Clinical Pharmacist Responsibilities

- Provide drug information to other healthcare providers and patients\textsuperscript{13,15}
- Help develop treatment protocols\textsuperscript{13}
- Implement treatment protocols under collaborative practice agreements\textsuperscript{13}
- Review medications ordered from multiple providers\textsuperscript{14}
- Resolve potential medication conflicts in therapy\textsuperscript{15}
- Monitor therapeutic responses, including laboratory test results\textsuperscript{13}
- Continuously assess for and manage adverse drug reactions\textsuperscript{13}
- Reconcile medications as patients move across the care continuum\textsuperscript{13}
- Provide patient and caregiver education and medication counseling\textsuperscript{13}
- Tailor patient education discussion and materials to match the patient’s health literacy level\textsuperscript{10}

Key Programs and Initiatives

US policy agencies and healthcare societies are increasing their support for research and initiatives designed to help establish transitions-of-care best practices.

Some programs and projects currently under way to improve transitions of care within the US healthcare system include

- **HIT initiatives** – projects centered on developing and integrating technology that enables healthcare providers to maintain, store, and share patient medical information via electronic medical records and EHRs\textsuperscript{16,17}
- **Accountable care organizations** – partnerships between local entities and providers that are held accountable for reducing costs and improving quality of care\textsuperscript{18,19}
- **Project Better Outcomes for Older Adults through Safe Transitions (BOOST)** – a national initiative led by the Society of Hospital Medicine, the project is a comprehensive tool kit for improving transitions of care in hospitals\textsuperscript{20,21}
- **Project Re-Engineered Discharge (RED)** – led by a research group at Boston Medical Center that develops and tests strategies for improving hospital discharge processes\textsuperscript{20}
- **The National Transitions of Care Coalition (NTOCC)** – a coalition of more than 30 associations and organizations dedicated to addressing the issues and challenges surrounding transitions of care\textsuperscript{22}
References


