In Brief

Effective Transitions between Care Settings

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Introduction

Maureen Stefanides wanted to honor her father's last wish: to die at home. She was unsuccessful. Before his passing, her father frequently transferred in and out of hospitals and nursing homes, causing needless suffering from pressure sores, recurrent infections, and malnutrition. It robbed him of his dignity and quality of life. This family caregiver's personal account captured public attention in a *New York Times* expose.[1] Unfortunately, heartbreaking accounts such as this one are heard all too often.

Unnecessary and avoidable care transitions can result in adverse outcomes, especially among older adults and people with multiple chronic conditions. Concerns about care transitions between acute and long-term services and supports (LTSS) settings have been raised since at least the 1990s. More recently, studies have emphasized the growing need to address care transitions from nursing homes to community-based settings, as well as to divert people from nursing homes.[2,3,4]

Smooth care transitions are at the core of good health care practice and person- and family-centered care. Improving effective care transitions could require coordinating nonmedical services, such as educating family caregivers, accessing appropriate community-based services, and ensuring access to transportation. Providers need to avoid unnecessary transitions and ensure smooth coordination of necessary transitions, particularly from hospitals.

What Are Care Transitions?

Care transitions occur when people move between one care setting or provider to another; for example, from home to hospital, hospital to home, or nursing home to hospital.

How Can States Measure and Improve Effective Transitions?

The second edition (2014) of the AARP *LTSS Scorecard* is an excellent tool for measuring state progress in care transitions.[5] The ability to measure care transitions is new. There were insufficient data for the first *Scorecard* (2011) to measure the extent to which LTSS is effectively coordinated or integrated with health-related services and social supports.

Six *Scorecard* indicators measure state performance on two types of transitions. The first four indicators focus on minimizing disruptive transitions between care settings. The last two indicators measure the relative success of states to transition people from nursing homes back to the community. Here are the measures and pertinent questions to answer:

1. *Nursing home residents with low care needs*— Does your state have nursing home residents with low care needs (e.g., do not require physical assistance with bed mobility, eating, using the

toilet, and transferring, and are not clinically complex or require special rehabilitation)? If your state has a relatively high proportion of nursing home residents who do not need nursing home level of care, this should be a red flag. Your state may not be taking appropriate steps to transition these residents to less restrictive environments such as assisted living or at home.

2. *Home health patients with a hospital admission*—Does your state have a high rate of hospital admissions for patients receiving home health services? If so, your state may not be implementing effective, preventive, and chronic care management or transition care when someone is returning to the community from a hospital or nursing home.

3. *Long-stay nursing home residents hospitalized within a 6-month period*—How well is your state preventing unnecessary, stressful, and costly hospitalizations of nursing home residents? Promoting evidence-based practices, including timely and effective preventive services, early treatment of acute illness, and effective management of chronic conditions, can help minimize transitions to and from nursing homes and hospitals.

4. *Nursing home residents with moderate to severe dementia with one or more potentially burdensome transitions at end of life*—Is your state minimizing burdensome hospital transitions for people with advanced illness, especially at end of life? Transitions to a hospital are "potentially burdensome" when the transition (i) occurred in the last 3 days of life; (ii) involves relocation to a different nursing home than the one in which a person resided before hospitalization; (iii) was associated with treatment for two or more hospitalizations for urinary tract infection, dehydration, or septicemia in the last 120 days of life; or (iv) included three or more hospitalizations, for any reason, in the last 90 days of life.[6] Unnecessary transitions among settings are disruptive, especially for people with dementia, and can aggravate preexisting conditions and increase the risk of medical errors. Health care

transitions in the last months of life can be burdensome and potentially of limited clinical benefit for people with advanced cognitive and functional impairment.

5. *New nursing home stays lasting 100 days or more*—What proportion of nursing home residents in your state stay 100 or more days? People who enter a nursing home and remain there for 100 or more days are far less likely to return to the community than are those with shorter stays.

6. *People with 90-plus–day nursing home stays successfully transitioning back to the community*—Is your state helping nursing home residents move back into the community? Long-stay nursing home residents and extended-stay rehab patients are at high risk of not being able to return home after such a long stay in the nursing home. In a high-performing LTSS system, states prevent excessive use of institutional settings and also develop and implement transition programs that help nursing home residents who prefer to live in the community.

Find answers to the above six questions in the *LTSS Scorecard*, located at http://www.longtermscorecard.org.

Findings and Solutions

Overall, states that rely less on nursing homes for LTSS perform better on effective transitions. The top five ranking states on the overall *Effective Transitions* dimension (Oregon, Utah, Idaho, Washington, and Vermont) had relatively low nursing home utilization rates.

States with high nursing home use were more likely to have nursing home residents with low care needs, high hospitalization rates of home health patients, and nursing home stays of 100 or more days. The bottom five ranking states (Texas, Oklahoma, Arkansas, Mississippi, and Louisiana) in the *LTSS Scorecard* did poorly across all of these indicators.

Housing, prevention of hospitalizations and nursing home admissions, end-of-life and palliative care, and home- and community-based services (HCBS) can all improve care.

- *Housing*—Access to housing is a primary barrier for people otherwise able to leave nursing homes. Having many residents with low care needs suggests that coordination with housing and social services is lacking. In addition, nursing home diversion practices may require reform to enable people with low care needs to remain in the community and receive supportive services outside of an institutional setting.

- *Prevention of hospitalizations and readmissions*—Billions of dollars are spent on avoidable hospital readmissions each year. Good care coordination that promotes preventive measures, monitoring of overall health status, early treatment of acute illness, good management of chronic illness, and family caregiver training and education can help avert unnecessary hospitalizations and readmissions, and improve quality of life.

- *End-of-life care*—Transitions at the end of life can be of limited clinical benefit for people with advanced cognitive and functional impairment, can be very costly,[7] and can indicate overly aggressive care treatment or poor care management. Nursing home residents with dementia are particularly vulnerable when they experience potentially burdensome transitions at the end of life. Such disruptive transitions can increase the risk of medical errors. People at the end of life should not be subjected to excessive hospitalizations, and they should retain choice and control over where they die. Having an advance directive can help people retain this control.

> **What Are the Top Five Ranking States for Effective Transitions?**
> 1. Oregon
> 2. Utah
> 3. Idaho
> 4. Washington
> 5. Vermont

- *Palliative care*—Providing people with relief from the symptoms, pain, and stress of a serious illness—regardless of the diagnosis—is crucial.[8] Hospitals, hospice, cancer centers, and LTSS facilities provide palliative care, but people may also receive care at home. Palliative care is unevenly distributed nationally. While 85 percent of hospitals with over 300 beds have palliative care programs, more than 75 percent of hospitals with 50 beds or fewer do not.[9] Palliative care can lead to effective transitions because communication and care coordination among providers, the person, and family are key to controlling transitions between care settings.

- *HCBS*—When a nursing home resident stays beyond roughly 60 days, his or her probability of ever leaving the nursing home is very low. Access to appropriate and affordable housing, transportation, and other supportive services such as personal care can help long-stay nursing home residents who desire to move back to the community. HCBS can make it possible for people with LTSS needs to live in the community.

Promising Practices and Initiatives

States are developing and implementing strategic plans to address concerns about inadequate nursing home diversion policies and practices as well as care fragmentation that leads to unnecessary and problematic transitions across care settings. Although the *Effective Transitions* measures in the 2014 *LTSS Scorecard* include the most current data available (2009–2012), states may have made changes to their LTSS systems that are not reflected in these measures, especially since this is a quickly

evolving field. The following are some current promising practices by states to address care transitions across settings.

Connecticut

The Centers for Medicare & Medicaid Services contracts with an organization in each state to provide quality training to state nursing homes. These entities are referred to as Quality Improvement Organizations (QIO). The Connecticut QIO started an Interventions to Reduce Acute Care Transfers (INTERACT) project involving approximately 80 nursing homes. This quality-of-care approach provides tools and best practices to nursing home and home health agency staff to reduce inappropriate transfers to hospitals.[10] Staff from these 80 nursing homes have monthly discussions to share their experiences using the various tools in the INTERACT tool kit. This is a significant intervention in nursing home practice and should lead to more careful care transitions by the participating nursing homes and hospitals.[11]

Minnesota

As the overall top-ranking state in the 2011 and 2014 *LTSS Scorecards*, the state uses an integrative communications strategy linking all LTSS users. Top-ranked states are noted for having integrated delivery systems that permit the sharing of case management and health information among multiple agencies. Approximately 1,700 Minnesota users from different agencies are on the shared system.[12] Technological innovations can make LTSS systems more efficient and help reduce fragmented care and poor care transitions.

Minnesota's Area Agencies on Aging provide crucial support to people who transition between care settings or from one home to another. Services include: home-delivered meals and grocery delivery to support nutrition, medication management services to help meet the challenges of medication compliance, transportation service to ensure follow-up with medical appointments, respite and coaching for family caregivers to support them as they give hands-on care, and homemaker services and home

modifications to create a home environment that is essential to aid recovery and maintain health.[13,14]

New York

In 2015, the New York Hospital Medical Center of Queens began a project to minimize unnecessary transitions from nursing homes by improving the technological links between 27 nursing homes and the Medical Center's participating hospitals. A key objective of this project is to ensure that nursing home staff has access to hospital patient records and hospital staff before patient transfers between the nursing home and the hospital. The Medical Center is helping all participating nursing homes join the Regional Healthix Information Organization (RHIO) for real-time exchange of information. Even though nursing homes have different electronic medical records and care protocols, information can be shared through the RHIO. The Medical Center is providing technical guidance to help the nursing homes. The Medical Center is also establishing a planning and improvement structure to formalize communication and collaboration among the nursing homes and hospitals.[15]

In addition, in 2015, under the auspices of the New York Delivery System Reform Incentive Payment (DSRIP) Program, seven Performing Provider Systems (PPS) will implement the INTERACT program.[16] A PPS generally consists of a lead hospital and its associated primary care practices, Federally Qualified Heath Centers, medical specialty practices, behavioral health and community-based organizations. Widespread adoption of this well-known care transition model by major New York institutions will lead to notable improvements in care transitions among hospitals, nursing homes, and home health agencies.[17]

Tennessee

In 2008, the Tennessee Housing Development Agency launched a free web-based housing locator service available in both English and Spanish. TNHousingSearch.org, along with a full-service bilingual call center, gives people the ability to search for rental housing regardless of

disability or financial status. The locator service was implemented in part to help people transition from institutional care to a HCBS setting.

The housing locator allows people to look for rental housing using a variety of criteria, including Section 8 and senior housing, accessibility options for people with disabilities, access to public transportation, shopping, and hospitals. The service also includes an affordability and moving cost calculator, a mapping tool, a rental checklist, and information about renter rights and responsibilities.[18]

Texas

The Regional Health Partnership in Texas is implementing palliative care and care transition programs in its hospitals and medical centers.

- University Hospital is the 496-bed acute care hospital of The University Health System. It serves as the primary teaching hospital for The University of Texas Health Science Center at San Antonio. In 2011, University Hospital began a palliative care program to train/educate approximately 400 physicians in palliative care procedures. Using intensive communication with patients and families, pain and symptom management, advanced care planning, and coordination of care, University Hospital believes that better quality of care and less usage of emergency rooms and intensive care units will result.[19]

- Guadalupe Regional Medical Center (GRMC) is a 125-bed publicly owned acute care hospital. Located in Guadalupe County, the hospital has a largely rural service area spanning six counties. Like other hospitals, GRMC recognizes gaps in care transition planning. The hospital believes that it has a higher than expected Medicaid readmission rate of chronically ill people that could be attributed to lack of symptom management and provider education, both of which could be provided through a palliative care program. GRMC began a small project in 2013 using a nurse practitioner and an interdisciplinary team to work with people and

ensure that they receive follow-up care upon hospital discharge.[20]

- JPS Hospital is a 537-bed public hospital with 43 associated ambulatory care and primary care outreach sites in Fort Worth, with a population of approximately 1.8 million residents. In late 2013, the hospital began a palliative care program to address the need for increased geriatric, LTSS, and home care resources and more care coordination. Its model uses an inpatient consultative team targeting approximately 1,200 patients over a 3-year period.[21]

Vermont

The Support and Services at Home (SASH) Program provides coordinated care to primarily help people ages 65 and older and adults with disabilities live comfortably and safely at home.[22] Now available in many communities throughout Vermont, SASH communities have a care coordinator and wellness nurse who work in partnership with a team of community providers to assist SASH participants. Participation is voluntary and free of charge. It is part of Vermont's statewide health care reform initiative called *Blueprint for Health*. Before going statewide, SASH began at the nonprofit Cathedral Square Corporation in South Burlington. Cathedral Square was concerned that frail residents in its low-income housing properties were not able to access or receive adequate supportive services, so it connected residents with community-based services and promoted coordination of health care.

The Federal Patient Protection and Affordable Care Act (ACA) of 2010

Although some of the *Effective Transitions* data predate implementation of the ACA program initiatives, many states are taking advantage of Medicaid financial incentive programs such as Money Follows the Person (MFP)[23] and the Balancing Incentive Program as a way to expand HCBS.

ACA programs have also been initiated to better coordinate care for people with chronic conditions. These care coordination programs include the

Medicare Community-Based Care Transitions Program, the Medicare Independence at Home demonstration, medical and health homes, and incentives to reduce Medicare hospital readmissions. These ACA initiatives aim to ensure that people receive recommended services, avoid unnecessary care, and receive information to better manage their conditions. Some of these initiatives also aim to improve care transitions. These care coordination and care transition programs could prevent costly hospital admissions and readmissions for high-risk Medicare beneficiaries.

Conclusion

Fragmented care delivery and poor transitions across settings are particularly stressful and vulnerable times for older adults, people with disabilities, and their family caregivers. Programs that involve support for people, medication management, improved communication, and coordination among providers have shown to be effective interventions.

Interventions that support people and their family caregivers with information and strategies to manage and coordinate care can improve quality of life, increase functional autonomy, make more efficient use of health services, and help lower costs. Care transition models that assign a transitional care manager to coordinate and monitor care and provide person and family caregiver education and support can be an effective intervention. Integrating LTSS with other services, such as housing and transportation, can also help minimize hospitalization, institutionalization, and unnecessary transitions between care settings.

States that develop strong public and private partnerships, have collaborative relationships with the health care community and supportive service providers, and focus on the needs of the whole person tend to have strong LTSS systems in place.

Resources, Available Tools and Measurements, and "How To" Guides

Managing transitions across care settings is an important component of state LTSS systems. Here are some publicly available resources that offer practical information to improve transitions between care settings:

- Alliance for Home Health Quality and Innovation—Care transitions: http://www.ahhqi.org

- Care Transition Program— http://www.caretransitions.org (some access limited to members)

- Center for Technology and Aging—Care transition toolkit: http://www.toolkit.techandaging.org/

- Institute for Healthcare Improvement— Improving transitions from hospital to community: http://www.ihi.org (some access limited to members)

- National Transitions of Care Coalition—Care transition compendium: http://www.ntocc.org (some access limited to members)

- Reducing Avoidable Admissions Effectively Campaign—http://www.rarereadmissions.org

- Collection of websites, projects, and additional resources—http://www.caretransitions.org/links.asp

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1   Nina Bernstein. "Fighting to Honor a Father's Last Wish: To Die at Home." *The New York Times on the Web*, October 25, 2014. Available at http://www.nytimes.com/2014/09/26/nyregion/family-fights-health-care-system-for-simple-request-to-die-at-home.html?_r=0,

2   Joseph G. Ouslander, MD, and Robert A. Berenson, MD. "Perspective: Reducing Unnecessary Hospitalizations of Nursing Home Residents." *The New England Journal of Medicine* 365, no. 16 (2011): 1165–1167. Available at http://www.nejm.org/doi/pdf/10.1056/NEJMp1105449.

3   Vincent Mor, Orna Intrator, Zhanlian Feng, and David C. Grabowski. "The Revolving Door of Rehospitalization from Skilled Nursing Facilities." *Health Affairs* 29, no.1 (2010): 57–64. Available at http://content.healthaffairs.org/content/29/1/57.full.html.

4   Vincent Mor, Jacqueline Zinn, Pedro Gozalo, Zhanlian Feng, Orna Intrator, and David C. Grabowski. "Prospects for Transferring Nursing Home Residents to the Community." *Health Affairs* 26, no.6 (2007): 1762–1771. Available at http://content.healthaffairs.org/content/26/6/1762.full.html.

5   Susan C. Reinhard, Enid Kassner, Ari Houser, Kathleen Ujvari, Robert Mollica, and Leslie Hendrickson, "Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers, 2nd edition," AARP

Public Policy Institute (June 2014). A copy of the *Scorecard* report and access to interactive tools to compare state scores is available on the *Scorecard* website at http://www.longtermscorecard.org.

6   See Pedro Gozalo, Joan M. Teno, Susan L. Mitchell, Jon Skinner, Julie Bynum, Denise Tyler, and Vincent Mor, "End-of-Life Transitions among Nursing Home Residents with Cognitive Issues," *New England Journal of Medicine*, September 29, 2011: 1212–1221. Available at http://www.nejm.org/doi/full/10.1056/NEJMsa1100347.

    See also Joan M. Teno, Pedro L. Gozalo, Julie P. W. Bynum, Natalie E. Leland, Susan C. Miller, Nancy E. Morden, Thomas Scupp, David C. Goodman, and Vincent Mor, "Change in End-of-Life Care for Medicare Beneficiaries," *Journal of American Medical Association,* February 6, 2013: 470–477. Available at http://jama.jamanetwork.com/article.aspx?articleid=1568250.

7   Ibid.

8   See the Center to Advance Palliative Care. Available at https://www.capc.org/payers/palliative-care-definitions/.

9   See the Center to Advance Palliative Care. Available at http://reportcard.capc.org/pdf/capc-growth-analysis-snapshot-2011.pdf.

10 For an explanation of toolkits used, see the INTERACT website. Available at https://interact2.net/.

11 Discussion with AARP and Qualidigm staff in February 2015. Qualidigm is the Connecticut QIO. For additional information about INTERACT tools, see http://www.qualidigm.org/index.php/qio-program/nursing-home/the-connecticut-nursing-home-quality-care-collaborative/interact-training-series/.

12 The particular tool used is called LinkLive. See http://www.revation.com/.

13 For more information, see the m4n, Minnesota Association of Area Agencies on Aging: Resources page. Available at http://mn4a.org/resources/.

14 For more information, see the m4n, Minnesota Association of Area Agencies on Aging: Care Transitions page. Available at http://mn4a.org/?s=transition .

15 See the DSRIP application for the New York Hospital Medical Center of Queens. Available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/. Open "Project Plan Applications" and refer to project 2.b.v.

16 The seven Performing Provider Systems are NY Hospital Medical Center Queens, Staten Island & Richmond University Hospitals, Nassau County, Stony Brook University Hospital, Erie County Medical Center, Mary Imogene Bassett, and United Hospitals (Southern Tier). See the Project 2.b.vii (Inpatient Transfer Avoidance for SNF) line item in the DSRIP Performing Provider System Project Selections table on page 6 at https://www.uhfnyc.org/assets/1301.

17 Project plans for each of the seven PPS can be found in their applications. Available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/. Open the "Project Plan Applications" link located under the name of each health care provider and look for project 2.b.vii.

18 For more information on the housing locator, see http://tnhousingsearch.org/.

19 See the Texas Health and Human Services Commission: Regional Healthcare Partnership Plan 6 document. Available at http://www.hhsc.state.tx.us/1115-docs/RHP/Plans/RHP6Plan.pdf.

20 See Texas Health Care: Transformation and Quality Improvement Program—1115 Waiver; Proposed Three-Year DSRIP Projects and select "Guadalupe Regional Medical Center—Palliative Care Group." Available at http://www.texasrhp6.com/proposed-three-year-dsrip-projects.

21 See the Texas Health and Human Services Commission: Regional Healthcare Partnership Plan 10 document. Available at http://www.hhsc.state.tx.us/1115-RHP-Plans.shtml.

22 See Support and Services at Home Vermont. Available at http://www.sashvt.org.

23 The Affordable Care Act of 2010 strengthened and expanded the MFP program, allowing more states to apply. For more information, see http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Balancing/Money-Follows-the-Person.html.

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