Guidelines Target Long-Term Care Transitions

Timely communication of adequate clinical data is instrumental to safe transitions.

BY SHERRY BOSCHERT

FROM THE ANNUAL MEETING OF THE AMERICAN MEDICAL DIRECTORS ASSOCIATION

LONG BEACH, CALIF. — New clinical practice guidelines for the first time provide principles and tools for safely transitioning long-term care patients from one care setting to another.

The 99-page online document for physicians and other health care professionals is not a "how to" guide but a distillation of key steps in better care transitions, Dr. James E. Lett II said at the meeting.

He said that, when he tries to talk to long-term care professionals about good transitions of care, the common response is, "We already do that."

"I hate this phrase, and I hear it so many times," said Dr. Lett of the California Department of Corrections and Rehabilitation, Sacramento. "Usually, what they have is a series of preprinted forms with no accountability for who fills them out or how they're completed."

Transitions of care, as currently practiced, result in nearly one-fifth of Medicare beneficiaries discharged from hospitals being rehospitalized within 30 days. Studies suggest that 90% of these readmissions are unplanned and 13% are potentially avoidable, which the Centers for Medicare and Medicaid Services has estimated costs an extra $12 billion per year, Dr. Lett said. He chaired the interdisciplinary working group that created the new clinical practice guidelines "Transitions of Care in the Long-Term Care Continuum" for the American Medical Directors Association, with participants from the American Medical Association, the American Geriatrics Society, and other organizations.

One foundation of the guidelines is that a care transition should be a patient-centered activity. "You don't shoehorn a patient into your transition process. You build the transition process around the patient," Dr. Lett said. Information moves with the patient. The patient and his or her family participate in decisions. The needs of the patient predominate, and advance directives should be available at each site of care.

Another central concept is that medication reconciliation must occur with every transition at both the sending and receiving sites of care.

Good transitions of care are "the ultimate interdisciplinary team activity," with every member of the care team involved, accountable, and responsive, Dr. Lett said. Caregivers from the sending site must maintain responsibility for a patient, or at least be available, until caregivers at the receiving site can assume management of the person's care.

"No longer can we expect in this complex, fractionated world that the receiving site will have all they need and the patient will do well," Dr. Lett said.

Timely communication of adequate clinical data is instrumental to safe transitions, he added. The new guidelines include a universal transfer form that can be modified by individual institutions. Tables and appendices cover the essential elements in medication reconciliation, provide sample policies, suggest a pretransition checklist and information that emergency medical services transport may request, and review myths and facts about HIPAA as it applies to transitions of care.

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DR. LETT

Dr. Lett reviewed the basic steps for implementing a care-transition program:

► Clinicians should be ready for surveillance and monitoring of a status change in both planned and unplanned transitions.

► Interdisciplinary team members must communicate with each other and with the patient and/or family to determine the most appropriate care transition. An advance directive also should be discussed.

► In a planned transition, the sending facility communicates with the receiving facility, which receives patient information prior to the patient's arrival. Lists and sample forms in the guidelines can help you plan.

► Patients can have an acute change of condition and need an unplanned transfer to an emergency department at any time. Keep the necessary forms available at all hours.

► When a patient is being transferred to another care site by emergency medical services, make sure the handoff is documented. Dr. Lett described one case of a patient with dementia and stroke who was "lost" after the emergency medical services transport team said it delivered the patient to a room and left the transfer paperwork on a dresser.

► When a patient's condition improves to the point that a planned transfer to his or her community home is appropriate, clinicians in the sending facility should address pending tests or other imminent needs of the patient.

► When a patient is nearing the end of life, a planned transition to solely comfort care is appropriate. Make sure any needed equipment is available and don't forget medication reconciliation.

► After a patient is physically handed over to the receiving setting of care in a planned transition, "you need to convey recommendations on next steps" and do medication reconciliation.

► If a patient is discharged to his or her community home in a planned transition, make sure you address the availability of transportation, the affordability of medications in the new setting, and

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handed over and that essential patient information has been received. "You must expect that the other side will verify this with you, and if they don't, you push it."

► In both planned and unplanned transitions, the sending facility follows up to confirm and document that the patient has successfully transitioned to the new setting of care.

► Monitor a facility's performance in managing care transitions. "You can't improve what you can't measure," Dr. Lett said. "Being able to say, 'We've been monitoring, and we didn't receive a history and physical 53% of the time' is a different discussion than saying, 'You never sent us a history and physical.' "

An appendix in the guidelines lists quality indicators and performance measures for care transitions. ■

Disclosures: *Dr. Lett disclosed having no relevant conflicts of interest. Sanofi-Aventis helped fund distribution of the guidelines, which are available at www.amda.com/tools/clinical/TOCCPG/index.html.*

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