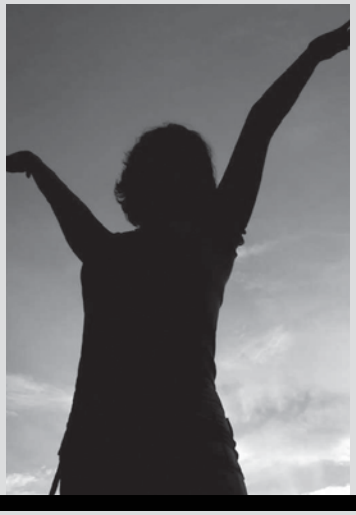

READINGS

A SELECTION OF TEN READINGS ON TOPICS RELATED TO TRANSITIONAL CARE

A SELECTION OF TEN READINGS ON TOPICS RELATED TO TRANSITIONAL CARE

Selection of readings made by A/Prof Goh Lee Gan

READING 1 – EFFECTIVENESS OF A TRANSITIONAL HOME CARE PROGRAM IN REDUCING ACUTE HOSPITAL UTILIZATION: A QUASI-EXPERIMENTAL STUDY

Low LL (1), Vasanwala FF, Ng LB, et al. Effectiveness of a transitional home care program in reducing acute hospital utilization: a quasi-experimental study. BMC Health Serv Res. 2015 Mar 14;15:100. doi: 10.1186/s12913-015-0750-2. PubMed PMID: 25888830; PubMed Central PMCID: PMC4377016.

URL: http://www-ncbi-nlm-nih-gov. /pmc/articles/PMC4377016/pdf/12913_2015_Article_750.pdf – Free full text

Author information:
(1) Department of Family Medicine and Continuing Care, Academia, Level 4 Singapore General Hospital, Singapore, 169856, Singapore. low.lian.leng@sgh.com.sg.

ABSTRACT

BACKGROUND: Improving healthcare utilization is essential as health systems around the world grapple with the escalating demands for acute hospital resources. Evidence suggests that transitional care programs are effective to improve utilization of healthcare. However, the evidence for transitional care programs that enhance the home medical care model and provide multi-disciplinary patient-centered care is not well established. We evaluated if a transitional home care program operated by the Singapore General Hospital was effective in reducing acute hospital utilization.

METHODS: We performed a quasi-experimental study using a pre-post design to evaluate the effectiveness of a transitional home care program in reducing hospital admissions and emergency department attendances of medically complex patients enrolled into the program in a tertiary hospital in Singapore. Patients received a comprehensive needs assessment performed by the physician and a nurse case manager in the home setting, followed by an individualized care plan that included medical and nursing care, patient education and coordination of care with hospital specialists and community services. Primary study outcomes were emergency department attendances and hospital admissions to all hospitals. These were extracted from hospital administrative data and national health records. Wilcoxon Signed Ranks Test was used for assess differences in pre and post continuous data.

RESULTS: Overall, 262 patients were enrolled into the program and 259 were analyzed. Patients had a 51.6% and 52.8% reduction in hospital admissions in the three-month and six-month post enrollment, respectively. Similarly, a 47.1% and 48.2% reduction was observed for emergency department attendances in the three and six months post enrollment, respectively. The average difference in per patient hospital bed days in the pre- and post-enrollment periods were 12.05 days and 20.03 days at the 3-month and 6-month periods, respectively.

CONCLUSIONS: Patients enrolled in the transitional home care program had significantly lower acute hospital utilization through the reduction of emergency department attendances and hospital admissions. A comprehensive assessment of patients' medical and social needs in the home setting and formulation of an individualized care plan optimized post-discharge care for medically complex patients.

PMCID: PMC4377016 PMID: 25888830 [PubMed - in process]

READING 2 – EFFECTIVENESS OF A NATIONAL PROGRAMME IN REDUCING ACUTE CARE

Wee SL (1), Loke CK, Liang C, et al. Effectiveness of a national transitional care program in reducing acute care use. J Am Geriatr Soc. 2014 Apr;62(4):747-53. doi: 10.1111/jgs.12750. Epub 2014 Mar 17. PubMed PMID: 24635373.

URL http://onlinelibrary.wiley.com/doi/10.1111/jgs.12750/epdf

Author information:
(1) Agency for Integrated Care, Singapore, Singapore; Duke-National University of Singapore Graduate Medical School, Singapore, Singapore.

This study evaluated the effectiveness of a national transitional care program for elderly adults with complex care needs and limited social support. The Aged Care Transition (ACTION) Program was designed to improve coordination and continuity of care and reduce rehospitalizations and visits to emergency departments (EDs). Dedicated care coordinators provided coaching to help individuals and families understand the individuals' conditions, effectively articulate their preferences, and enable self-management and care planning. Participants were individuals aged 65 and older hospitalized and enrolled from five public general hospitals in Singapore between February 2009 and July 2010 (N = 4,132). The coordinators worked with participants during hospitalization and followed up with telephone calls and home visits for 1 to 2 months after discharge and coordinated placements with appropriate community service providers. Unplanned rehospitalization and ED visit (up to 6 months after discharge) rates were compared with those of a comparator group of individuals who did not receive care coordination using propensity score-based weighting. Participant and caregiver surveys on quality of life and self-rated health were also administered. Recipients of the ACTION program had fewer unplanned rehospitalizations and ED visits after discharge. Propensity score-adjusted odds ratios of participants versus control for number of unplanned rehospitalization and ED visits were 0.5 (95% confidence interval (CI) = 0.5-0.6) and 0.81 (95% CI = 0.72-0.90) 30 days after discharge and 0.6 (95% CI = 0.6-0.7) and 0.90 (95% CI = 0.82-0.99) 180 days after discharge. Quality of life and self-rated health were better 4 to 6 weeks after discharge than 1 week after discharge. These findings confirm the effectiveness of the ACTION program in improving the transition of vulnerable older adults from hospital to community. Such transitional care should be considered as an integral part of care integration.

PMID: 24635373 [PubMed - indexed for MEDLINE]

READING 3 – TRANSITONAL CARE INTERVENTIONS PREVENT HOSPITAL READMISSIONS FOR ADULTS WITH CHRONIC ILLNESSES

Verhaegh KJ (1), MacNeil-Vroomen JL, Eslami S, et al. Transitional care interventions prevent hospital readmissions for adults with chronic illnesses. Health Aff (Millwood). 2014 Sep;33(9):1531-9. doi: 10.1377/hlthaff.2014.0160. PubMed PMID: 25201657.

URL: http://content.healthaffairs.org/content/33/9/1531.full.pdf+html

Author information:
(1)Kim J. Verhaegh (k.j.verhaegh@amc.uva.nl) is a PhD student in the Departments of Internal Medicine and Geriatrics at the Amsterdam Medical Centre, in the Netherlands.

Transitional care interventions aim to improve care transitions from hospital to home and to reduce hospital readmissions for chronically ill patients. The objective of our study was to examine if these interventions were associated with a reduction of readmission rates in the short (30 days or less), intermediate (31-180 days), and long terms (181-365 days). We systematically reviewed twenty-six randomized controlled trials conducted in a variety of countries whose results were published in the period January 1, 1980-May 29, 2013. Our analysis showed that transitional care was effective in reducing all-cause intermediate-term and long-term readmissions. Only high-intensity interventions seemed to be effective in reducing short-term readmissions. Our findings suggest that to reduce short-term readmissions, transitional care should consist of high-intensity interventions that include care coordination by a nurse, communication between the primary care provider and the hospital, and a home visit within three days after discharge.
Project HOPE—The People-to-People Health Foundation, Inc. PMID: 25201657 [PubMed - in process]

READING 4 – QUALITY CARE OUTCOMES FOLLOWING TRANSITIONAL CARE INTERVENTIONS FOR OLDER PEOPLE FROM HOSPITAL TO HOME: A SYSTEMATIC REVIEW

Allen J, Hutchinson AM, Brown R, Livingston PM. Quality care outcomes following transitional care interventions for older people from hospital to home: a systematic review. BMC Health Serv Res. 2014 Aug 15;14:346. doi: 10.1186/1472-6963-14-346. PubMed PMID: 25128468; PubMed Central PMCID: PMC4147161.

URL: http://www-ncbi-nlm-nih-gov. /pmc/articles/PMC4147161/pdf/12913_2014_Article_3453.pdf – free full text

Author information:
(1) Deakin University, School of Nursing and Midwifery, 221 Burwood Hwy, Burwood 3125, Vic, Australia. jacqui.allen@deakin.edu.au.

ABSTRACT

BACKGROUND: Provision of high quality transitional care is a challenge for health care providers in many western countries. This systematic review was conducted to (1) identify and synthesise research, using randomised control trial designs, on the quality of transitional care interventions compared with standard hospital discharge for older people with chronic illnesses, and (2) make recommendations for research and practice.

METHODS: Eight databases were searched; CINAHL, Psychinfo, Medline, Proquest, Academic Search Complete, Masterfile Premier, SocIndex, Humanities and Social Sciences Collection, in addition to the Cochrane Collaboration, Joanna Briggs Institute and Google Scholar. Results were screened to identify peer reviewed journal articles reporting analysis of quality indicator outcomes in relation to a transitional care intervention involving discharge care in hospital and follow-up support in the home. Studies were limited to those published between January 1990 and May 2013. Study participants included people 60 years of age or older living in their own homes who were undergoing care transitions from hospital to home. Data relating to study characteristics and research findings were extracted from the included articles. Two reviewers independently assessed studies for risk of bias.

RESULTS: Twelve articles met the inclusion criteria. Transitional care interventions reported in most studies reduced re-hospitalizations, with the exception of general practitioner and primary care nurse models. All 12 studies included outcome measures of re-hospitalization and length of stay indicating a quality focus on effectiveness, efficiency, and safety/risk. Patient satisfaction was assessed in six of the 12 studies and was mostly found to be high. Other outcomes reflecting person and family centred care were limited including those pertaining to the patient and carer experience, carer burden and support, and emotional support for older people and their carers. Limited outcome measures were reported reflecting timeliness, equity, efficiencies for community providers, and symptom management.

CONCLUSIONS: Gaps in the evidence base were apparent in the quality domains of timeliness, equity, efficiencies for community providers, effectiveness/symptom management, and domains of person and family centred care. Further research that involves the person and their family/caregiver in transitional care interventions is needed.

PMCID: PMC4147161 PMID: 25128468 [PubMed - in process]

READING 5 – EVALUATION OF A PRIMARY CARE-BASED POST-DISCHARGE PHONE CALL PROGRAM

Tang N, Fujimoto J, Karliner L. Evaluation of a primary care-based post-discharge phone call program: keeping the primary care practice at the center of post-hospitalization care transition. J Gen Intern Med. 2014 Nov;29(11):1513-8. doi: 10.1007/s11606-014-2942-6. Epub 2014 Jul 24. PubMed PMID:25055997; PubMed Central PMCID: PMC4238210.

URL: http://link.springer.com/article/10.1007%2Fs11606-014-2942-6

Author information:
(1) Division of General Internal Medicine, Department of Medicine, University of California San Francisco, San Francisco, CA, USA.

Comment in
J Gen Intern Med. 2014 Nov;29(11):1532.

BACKGROUND: The post-hospitalization period is a precarious time for patients. Post-discharge nurse telephone call programs aiming to prevent unnecessary readmissions have had mixed results.
OBJECTIVE: Describe a primary-care based program to identify and address problems arising after hospital discharge.
DESIGN: A quality improvement program embedding registered nurses in a primary care practice to call patients within 72 h of hospital discharge and route problems within the practice for real-time resolution.
PARTICIPANTS: Adult patients with a primary care provider in the general internal medicine practice at the University of California San Francisco who were discharged home from the Medicine service.
MAIN MEASURES: Patients reached directly by phone had a 'full-scripted encounter;' those reached only by voice-mail had a 'message-scripted encounter;' those not reached despite multiple attempts had a 'missed encounter.' Among patients with full-scripted encounters, we identified and cataloged problems arising after hospital discharge and measured the proportion of calls in which a problem was uncovered. For the different encounter types, we compared follow-up appointment attendance and 30-day readmission rates.
KEY RESULTS: Of 790 eligible discharges, 486 had a full-scripted, 229 a message-scripted and 75 a missed encounter. Among the 486 full-scripted encounters, nurses uncovered at least one problem in 371 (76 %) discharges, 25 % of which (n = 94) included new symptoms, and 47 % (n = 173) included medication issues. Discharges with full-scripted and message-scripted encounters were associated with higher follow-up appointment attendance rates compared with those with missed encounters (60.1 %, 58.5 %, 38.5 % respectively p = 0.004). There was no significant difference in 30-day readmission rates (12.8 %, 14.8 %, 14.7 %; p = 0.72).
CONCLUSIONS: Our results suggest that centering a post-discharge phone call program within the primary care practice improves post-hospital care by identifying clinical and care-coordination problems early. With the new Medicare transitional care payment, such programs could become an important, self-sustaining part of the patient-centered medical home.
PMCID: PMC4238210 [Available on 2015-11-01] PMID: 25055997 [PubMed - in process]

READING 6 – TRANSITIONAL CARE INTERVENTIONS TO PREVENT READMISSIONS FOR PERSONS WITH HEART FAILURE: A SYSTEMATIC REVIEW AND META-ANALYSIS

Feltner C, Jones CD, Cené CW, et al. Transitional care interventions to prevent readmissions for persons with heart failure: a systematic review and meta-analysis. Ann Intern Med. 2014 Jun 3;160(11):774-84. doi: 10.7326/M14-0083. Review. PubMed PMID: 24862840.

URL: http://annals.org/article.aspx?articleid=1874735

ABSTRACT

BACKGROUND: Nearly 25% of patients hospitalized with heart failure (HF) are readmitted within 30 days.
PURPOSE: To assess the efficacy, comparative effectiveness, and harms of transitional care interventions to reduce readmission and mortality rates for adults hospitalized with HF.
DATA SOURCES: MEDLINE, Cochrane Library, CINAHL, ClinicalTrials.gov, and World Health Organization International Clinical Trials Registry Platform (1 January 1990 to late October 2013).
STUDY SELECTION: Two reviewers independently selected randomized, controlled trials published in English reporting a readmission or mortality rate within 6 months of an index hospitalization.
DATA EXTRACTION: One reviewer extracted data, and another checked accuracy. Two reviewers assessed risk of bias and graded strength of evidence (SOE).
DATA SYNTHESIS: Forty-seven trials were included. Most enrolled adults with moderate to severe HF and a mean age of 70 years. Few trials reported 30-day readmission rates. At 30 days, a high-intensity home-visiting program reduced all-cause readmission and the composite end point (all-cause readmission or death; low SOE). Over 3 to 6 months, home-visiting programs and multidisciplinary heart failure (MDS-HF) clinic interventions reduced all-cause readmission (high SOE). Home-visiting programs reduced HF-specific readmission and the composite end point (moderate SOE). Structured telephone support (STS) interventions reduced HF-specific readmission (high SOE) but not all-cause readmissions

(moderate SOE). Home-visiting programs, MDS-HF clinics, and STS interventions produced a mortality benefit. Neither telemonitoring nor primarily educational interventions reduced readmission or mortality rates.

LIMITATIONS: Few trials reported 30-day readmission rates. Usual care was heterogeneous and sometimes not adequately described. CONCLUSION: Home-visiting programs and MDS-HF clinics reduced all-cause readmission and mortality; STS reduced HF-specific readmission and mortality. These interventions should receive the greatest consideration by systems or providers seeking to implement transitional care interventions for persons with HF.
PRIMARY FUNDING SOURCE: Agency for Healthcare Research and Quality.
PMID: 24862840 [PubMed - indexed for MEDLINE]

READING 7 – FEASIBILITY AND EVALUATION OF A PILOT COMMUNITY HEALTH WORKER INTERVENTION TO REDUCE HOSPITAL READMISSIONS

Burns ME (1), Galbraith AA, Ross-Degnan D, Balaban RB. Feasibility and evaluation of a pilot community health worker intervention to reduce hospital readmissions. Int J Qual Health Care. 2014 Aug;26(4):358-65. doi: 10.1093/intqhc/mzu046. Epub 2014 Apr 16. PubMed PMID: 24744082.

URL: http://intqhc.oxfordjournals.org/content/26/4/358.long

Author information:
(1) Department of Population Health Sciences, University of Wisconsin-Madison, 610 North Walnut Street, Madison WI 53726, USA.

ABSTRACT

OBJECTIVE: To pilot-test the feasibility and preliminary effect of a community health worker (CHW) intervention to reduce hospital readmissions. DESIGN: Patient-level randomized quality improvement intervention.
SETTING: An academic medical center serving a predominantly low-income population in the Boston, Massachusetts area and 10 affiliated primary care practices. PARTICIPANTS: Medical service patients with an in-network primary care physician who were discharged to home (n = 423) and had one of five risk factors for readmission within 30 days.
INTERVENTION: Inpatient introductory visit and weekly post-discharge telephonic support for 4 weeks to assist patient in coordinating medical visits, obtaining and using medications, and in self-management.
MAIN OUTCOME MEASURES: Number of completed CHW contacts; CHW-reported barriers and facilitators to assisting patients; primary care, emergency department and inpatient care use.
RESULTS: Roughly 70% of patients received at least one post-discharge CHW call; only 38% of patients received at least four calls as intended. Hospital readmission rates were lower among CHW patients (15.4%) compared with usual care (17.9%); the difference was not statistically significant.
CONCLUSION: Under performance-based payment systems, identifying cost-effective solutions for reducing hospital readmissions will be crucial to the economic survival of all hospitals, especially safety-net systems. This pilot study suggests that with appropriate supportive infrastructure, hospital-based CHWs may represent a feasible strategy for improving transitional care among vulnerable populations. An ongoing, randomized, controlled trial of a CHW intervention, developed according to the lessons of this pilot, will provide further insight into the utility of this approach to reducing readmissions.
 PMID: 24744082.

READING 8 – A CONCEPTUAL FRAMEWORK FOR EVALUATING THE CONCEPTUALIZATION, IMPLEMENTATION AND PERFORMANCE OF TRANSITIONAL CARE PROGRAMMES

Wee SL (1), Vrijhoef HJ. A conceptual framework for evaluating the conceptualization, implementation and performance of transitional care programmes. J Eval Clin Pract. 2015 Apr;21(2):221-8. doi: 10.1111/jep.12292. Epub 2014 Dec 11. PubMed PMID: 25494718

URL: http://onlinelibrary.wiley.com/doi/10.1111/jep.12292/epdf - payment required

Author information:
(1) Geriatric Education and Research Institute, Alexandra Health, Singapore;

ABSTRACT

Developed health systems want to avoid unnecessary hospital admissions by addressing the needs of chronically ill older adults throughout acute episodes of illness. Transitional care (TC) is a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location, of which the main outcome of interest is avoiding hospital readmission. Implementation of TC is complex because it entails different actions to put multiple care components into practice, with various degrees of flexibility of adapting the intervention. Furthermore, the outcome involves behaviour change required by those delivering or receiving the intervention. Although there are examples of promising interventions, the possible variations in conceptualization and implementation present a real challenge for the adaptation of efficacious TC interventions from trial to 'real-world' settings. There is a lack of a theoretical basis or explicit logic model for why adapted interventions should work. This study provides conceptual approaches for the implementation and evaluation of TC programmes. It describes a framework of (1) conceptualization - with respect to the components in an intervention and the population of interest; (2) manner and context of implementation; and (3) evaluation - how these processes of implementation impact health outcomes.
 PMID: 25494718

READING 9 – INCORPORATING PRINCIPLES FROM GERIATRIC MEDICINE TO IMPROVE CARE TRANSITIONS FOR PATIENTS WITH COMPLEX NEEDS.

Arbaje AI, (1) Kansagara DL, Salanitro AH, Englander HL, Kripalani S, Jencks SF, Lindquist LA. Regardless of age: Incorporating principles from geriatric medicine to improve care transitions for patients with complex needs. J Gen Intern Med. 2014 Jun;29(6):932-9. doi: 10.1007/s11606-013-2729-1. PubMed PMID: 24557511; PubMed Central PMCID: PMC4026496.

URL: http://link.springer.com/article/10.1007%2Fs11606-013-2729-1

Author information:
(1) Division of Geriatric Medicine and Gerontology, Department of Medicine, Johns Hopkins University, Mason F. Lord Building, Center Tower, 5200 Eastern Avenue, 7th Floor, Baltimore, MD, 21224, USA, aarbaje@jhmi.edu.

ABSTRACT

With its focus on holistic approaches to patient care, caregiver support, and delivery system redesign, geriatrics has advanced our understanding of optimal care during transitions. This article provides a framework for incorporating geriatrics principles into care transition activities by discussing the following elements: (1) identifying factors that make transitions more complex, (2) engaging care "receivers" and tailoring home care to meet patient needs, (3) building "recovery plans" into transitional care, (4) predicting and avoiding preventable readmissions, and (5) adopting a palliative approach, when appropriate, that optimizes patient and family goals of care. The article concludes with a discussion of practical aspects of designing, implementing, and evaluating care transitions programs for those with complex care needs, as well as implications for public policy.
PMCID: PMC4026496 [Available on 2015-06-01] PMID: 24557511 [PubMed - indexed for MEDLINE]

READING 10 – REDUCING HOSPITAL READMISSION RATES: CURRENT STRATEGIES AND FUTURE DIRECTIONS

Kripalani S (1), Theobald CN, Anctil B, Vasilevskis EE. Reducing hospital readmission rates: current strategies and future directions. Annu Rev Med.2014;65:471-85. doi: 10.1146/annurev-med-022613-090415. Epub 2013 Oct 21. Review. PubMed PMID: 24160939; PubMed Central PMCID: PMC4104507.

URL: http://www-ncbi-nlm-nih-gov/pmc/articles/PMC4104507/pdf/nihms595272.pdf – Free full text

Author information:
(1) Department of Medicine, Vanderbilt University, Nashville, Tennessee 37232; email: sunil.kripalani@vanderbilt.edu , cecelia.theobald@vanderbilt.edu , ed.vasilevskis@vanderbilt.edu , cecelia.theobald@vanderbilt.edu.

ABSTRACT

New financial penalties for institutions with high readmission rates have intensified efforts to reduce rehospitalization. Several interventions that involve multiple components (e.g., patient needs assessment, medication reconciliation, patient education, arranging timely outpatient appointments, and providing telephone follow-up) have successfully reduced readmission rates for patients discharged to home. The effect of interventions on readmission rates is related to the number of components implemented; single-component interventions are unlikely to reduce readmissions significantly. For patients discharged to postacute care facilities, multicomponent interventions have reduced readmissions through enhanced communication, medication safety, advanced care planning, and enhanced training to manage medical conditions that commonly precipitate readmission. To help hospitals direct resources and services to patients with greater likelihood of readmission, risk-stratification methods are available. Future work should better define the roles of home-based services, information technology, mental health care, caregiver support, community partnerships, and new transitional care personnel.
PMCID: PMC4104507 PMID: 24160939 [PubMed - indexed for MEDLINE]