Easing the Transition From Hospital to Home

Melissa Knopper, Contributing Writer

On a recent day, a team of nurse practitioners from the University of Pennsylvania (UPenn) School of Nursing stopped by to visit an 80-year-old patient. She had just been discharged from the hospital, with a sheaf of prescriptions in her hand.

While visiting the patient in her home, less than 24 hours after discharge, the NPs discovered the woman had filled all but one of her prescriptions. Apparently, the pharmacy had told the woman that her insurance would not cover that medication.

So she simply didn’t fill it, even though it was an important pain medication that would ease her recovery. The NPs called the woman’s doctor and agreed on a different pain medication that would be covered, and the woman started taking it right away.

“Had we not been there, this lady would have taken most of her pills, but not this one,” says Kathleen McCauley, PhD, RN, ACNS-BC, FAAN, FAHA, an associate dean at UPenn. “She would have sat home, and her symptoms would have gotten worse and worse until she had to return to the hospital.”

SAVING MONEY, REDUCING STRESS

McCauley and the NPs are part of a long-term research project at UPenn, which focuses on keeping elderly patients out of the hospital. The concept is known as transitional care, and it has become an important part of President Obama’s health care reform plan. Prevention of hospital readmissions among Medicare patients alone could save nearly $20 billion per year, according to estimates recently published in the New England Journal of Medicine.

“Any change a patient makes—from a physician’s office to home, or from the hospital to a nursing home—those are all transitions, and those transitions don’t go very well,” says Kenneth Thorpe, PhD, chair of the Health Policy and Management Department at Emory University’s Rollins School of Public Health. “In fact, 20% of Medicare patients are readmitted within 30 days.”

Thorpe, who has been advising Washington lawmakers on ways to cut health care costs, estimates that communities could cut readmissions at least in half and save billions of dollars if they put transitional care teams, such as the UPenn group, in place.

Besides helping the local and national economy, transitional care teams can make a difference on a more personal level. Patients and families must deal with so many complex drugs and devices, from blood glucose monitors to oxygen machines and nebulizers that “it becomes a full-time job,” says Chileen Eze, BS, RN, who works for Rocky Mountain Home Health in Grand Junction, Colorado. “And they just don’t have the energy to do it, because they feel terrible.”

NPs and PAs will play a key role as this type of care comes to the forefront, experts predict, because they are team players with excellent communication skills and a broad knowledge base. “A big part of what the clinician has to do is go negotiate with the health care system on behalf of the patient,” McCauley says. “It takes tremendous sophistication and people skills.”

Mary Lou Stevens, PA-C, a hospitalist at St. Mary’s Hospital in Grand Junction, Colorado, loves her work, helping patients move successfully from hospital to home (or to a nursing home or hospice facility). “It’s a wonderful job,” she says. “It’s intellectually challenging, and I do think it’s a very good fit for a PA.”
Stevens says PAs are generally good at communicating and navigating the health care system on behalf of patients—basically seeing the big picture. In her case, Stevens became a PA after 25 years in nursing (primarily in oncology). “In this job, you are professionally growing all the time,” she says. “And it’s very satisfying.”

MODELS OF GOOD CARE
McCauley and her colleagues have been studying the “Naylor model” of transitional care—named for Mary Naylor, PhD, FAAN, RN, Director of UPenn’s New Courtland Center for Transitions and Health—in large clinical trials for 15 years. Now, they are sending advanced practice nurses and clinical nurse specialists out into the field to test the system in the real world. They are working through large existing health plans, such as Kaiser Permanente in California.

Most of the advanced practice nurses in the program have a strong background in acute care, home care, or both. Others have a specialty in gerontology.

Their first step is to study a series of online training modules, so they can brush up on diabetes, for example, or heart failure. “Next, we pair them with experienced transitional care nurses and key physicians who understand the model,” McCauley explains. “Over time, we gradually get them to be more and more independent.”

The NPs and other clinicians in the program have a conference call every week, during which they discuss their cases. The program has built up a network of key medical experts that the transitional care teams can tap into when they run into a challenge. “We’ve gotten this network of resource people together,” McCauley says, “so they have a support system.”

Eze’s home health agency is part of a health care co-op in Grand Junction, called Rocky Mountain Health Plans. As part of their daily responsibilities, designated staff from hospitals and home health agencies share notes about which patients are in the hospital and which are coming home soon. As a result, clinicians like Eze are at a patient’s bedside, working on the transition to home before the person has even left the hospital.

“That’s one big key here in Grand Junction,” she explains. “The moment they get hospitalized and it looks like they need home care, we try to target that patient and get services in place. That’s one good link right there, and it’s a very unique one.”

During his August visit to Grand Junction for a health reform town hall meeting, President Obama praised Eze’s community for keeping more people out of the hospital by providing excellent transitional care—and cutting costs in the process.

Stevens says the physicians who created the hospitalist program at St. Mary’s in Grand Junction put a special emphasis on communication and coordination of care. For example, they have a very thorough discharge plan for each patient and they get all of the caregivers together to talk with the patient and family before the person leaves the hospital. (For more on the hospitalist side of the story, see Hoppel AM. Hospitalists: ensuring quality care. Clinician Reviews. 2009;19[8]:cover, 36-38.)

The physicians who run the program care a lot about the community, Stevens says, so they set the right tone and expect a high standard of care. “They do the right thing for the patient, for the right reasons,” she adds.

GOALS AND ROLES
One of the important lessons McCauley and her colleagues teach nurses learning to provide transitional care is to tap into a patient’s goals to motivate them to make big lifestyle changes. “This is all about coaching and helping the patients to clarify their goals,” she says.

For example, McCauley remembers a heart failure patient who was very obese and had not left the second floor of her apartment for years. All it took was one important question from an NP: “What is your goal?” It turns out the woman had a strong desire to go to church. So the NP worked with her, setting up diet and exercise programs in her home and generally giving moral support. “She got her moving and that lady actually made it to church,” McCauley recalls triumphantly. “The whole thing was driven by the patient’s goals.”

Other times, aging patients will fiercely protect their privacy. McCauley remembers one nurse
who got around this by knocking on the door and saying he was there to visit the lady's dog. "He came in, made nice with the dog, and then did everything he needed for her," McCauley recalls.

Clinicians working in transitional care also must spend more of their time working with family caregivers. For example, there was one case in which the patient had a well-meaning son—but the transitional care team soon discovered that he had a mental illness that prevented him from being a dependable caregiver. So they brought in other home care resources to make sure the patient was taking the correct medications.

Another part of the job is being a watchdog when insurance companies mandate patients' discharges before they are ready. Eze has seen this before. "We'll look at them and say we can't accept them [for transitional care] because they are too unstable," she says. "These are the sicker people they would never have sent out of the hospital 15 years ago."

LONG-TERM IMPACT
Health reform experts such as Emory's Thorpe predict transitional care will become more common across the country in the next few years, as long as health plans and hospitals are willing to pay for the extra staff required. Some of the current hot spots for transitional care include UPenn, Grand Junction, and the Care Transitions Program at the University of Colorado Medical School in Denver.

Policy analysts from AARP currently are pushing for a Medicare program that will cut reimbursement rates to hospitals that readmit patients within 30 days. Other bills requiring transitional care programs are pending in Congress and may even be folded into President Obama's health reform plan.

So it's an exciting time for this new field, McCauley says. The question is, will decision makers think for the short term or the long term? Thorpe estimates it would take an initial investment of $25 to $30 billion to put teams of clinicians in place to provide transitional care for the entire Medicare program. On the other hand, that investment would pay for itself within the first year. And it would bring significant savings for every year after that, according to the NEJM article.

"We've got to pay attention to these transitions," McCauley says. "Because this kind of revolving door—from hospital to home back to hospital—is bad for patients, it's bad for hospitals, and it's bad for health care in general."