CONTINUITY OF CARE AND THE GERIATRIC PATIENT

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Topics

■ Definition of “continuity of care” (COC)
■ Types of care continuity
■ Patient-related impact of COC
■ Physician-related impact of COC
■ What COC means for the older adult
■ Factors that disrupt continuity
■ Discharge Planning
■ The Patient-Centered Medical Home
Definition

- What **IS** “Continuity of Care?” (COC)
  - Many definitions
  - Little consensus

- Impact on patient outcomes is well-documented in many studies
Definition

AAFP (COC is a defining feature of FM)

- COC is the process by which the patient and the physician are cooperatively involved in ongoing health care management toward the goal of high quality, cost-effective medical care
- Rooted in a long-term patient physician partnership
- Facilitated by a physician-led, team-based approach to health care.

AAFP 1983, 2009
Definition

- Internal Medicine
  - A sustained partnership over time between a clinician and patient is considered a fundamental component of primary care. This longitudinal relationship ideally leads to a bond between clinician and patient, characterized by trust and a sense of responsibility.
  - Institute of Medicine: a core attribute of primary care

JGIM; March 2005
Types of Care Continuity

Dimensions of Continuity

- Informational
- Longitudinal (chronologic)
- Interpersonal
- Geographic
- Interdisciplinary (team-based)
- Family

Saultz; AnnFamMed: Sept. 2003
Types of Care Continuity

- Informational continuity
  - Each provider of care for a patient has access to comprehensive data about the previous health care encounters, even if the patient is seen by different providers in different locations. However, having access to or knowledge about a patient’s medical history does not imply that a patient-physician relationship exists.
Types of Care Continuity

- **Longitudinal continuity**
  - Health care interaction is ongoing in the same location, with the same medical record, and the same health care professionals; there is a resulting growing knowledge of the patient by those providing care. The extended pattern of visits, however, does not imply anything about the nature of the relationship between patient and provider.
Types of Care Continuity

- Interpersonal continuity
  - A special type of longitudinal continuity that is associated with an ongoing personal relationship between the patient and healthcare provider that is distinguished by personal trust and responsibility
Types of Care Continuity

- Geographic continuity
  - A form of care continuity that is provided with no regard to the location of the patient (office, home, hospital, nursing home, etc.). There is increasingly more literature on this type of continuity as hospitalist programs have increased in number in many large hospitals.
Types of Care Continuity

- Interdisciplinary (team-based) continuity
  - A form of patient care that allows previous knowledge of the patient to be used or present even which a wide range of services spanning the traditional medical specialties is required.
Types of Care Continuity

- Family continuity

A system of care wherein all family members receive care from providers who have knowledge of the health problems of other family members.
Types of Care Continuity

- COC can best be defined as a “hierarchical concept”:
  - Interpersonal continuity
  - Longitudinal continuity
  - Informational continuity
How do we measure continuity??

Measurement techniques are “multiple”
- Formulas using visit-based measures only
  - Continuity of Care Index
  - Usual Provider Continuity Index
- Some instruments require an assigned provider, some don’t

ANSWER: There are multiple models, tools, and techniques, that measure outcomes which are generally limited to only one type of continuity. Researchers have not identified a method to measure the full spectrum of COC.

Saultz; AnnFamMed Sept. 2003
How do we measure continuity??

- Example: a study is designed to evaluate longitudinal care patterns, but it will probably offer little or no information about the nature of the physician-patient relationship (interpersonal continuity).

- Research into continuity also remains limited by the diverse definitions and methodology of measurement.
Positive Impacts of Care Continuity (for the patient)

- Higher overall patient satisfaction
- Fewer hospitalizations
- Fewer emergency room visits
- Improved receipt of preventive services
- Increased knowledge and trust between patient and physician
- Rational referral decisions
Positive Impacts of Care Continuity (for the patient)

- Reduction in iatrogenic harm
- Lower costs
- More appropriate end of life care
- Substantial reductions in long-term mortality
Difficulties of Care Continuity (for the physician)

- Complacency
- Heightened sense of responsibility
  - Increased worry
  - Friction between work and personal life
  - Boundary issues
  - Patient dependency
  - Grief
- Dealing with difficult patients
- Physician stress and burnout
So what does COC have to do with the older adult patient?

- The times have long past when one physician, with the help of a nurse, provided all of the health care a person needed.
- Now, older adults might receive care from doctors, nurses, nurse practitioners, physician assistants, pharmacists, dietitians, physical and/or occupational therapists, social workers, and nurses’ aides.
- In many cases, they may also have more than one doctor specializing in care of one problem or one organ system.
Older adults are also more likely to move from one place of care to another (including a doctor’s office or rehabilitation facility)

The long-term care continuum. Arrows indicate transitions in care. Dotted lines indicate continuing care retirement community.
What COC means for the older adult

In the “ideal” world, all providers of a patient’s health care (and the patient) should communicate and work together to coordinate care as a patient moves from one health care environment to the other.

Under these preferred conditions, transitions would occur smoothly without disrupting care.
What COC means for the older adult

- Truthfully, and unfortunately, it is not always easy to accomplish these ideals because the health care system in the United States is complicated and fragmented.

- Patients have so many health care providers that they don’t know which practitioner to ask which question and are often left to fend for themselves, “feeling like a stone rolling downhill, having no control over what is happening or where they will end up.”

Merck Manual of Health and Aging 2009
Ever-present threats to continuity

- Managed care networks with shifting patient eligibility and physician membership
- Continued growth of specialists (fewer medical students entering primary care residency training programs)
- The hospitalist movement
- Transitions between care settings, especially at the end of life (62% of pts experience 1 or more transitions during the last 3 months of life*)

*Van den Block.; JAMA 298(14): 2007
In 1998, 54% of internal medicine residents planned careers in primary care vs specialty medicine; by 2005, that number decreased by more than 50% to just around 20% going to primary care.

Stoeckle Ctr for Primary Care Innovation; MGH, Boston, MA. 2009
NEJM 355(9): 2006
Factors that disrupt continuity

- Having multiple practitioners
  - One or more may not have up-to-date, accurate information about care provided or recommended by other practitioners
  - One practitioner might not be acquainted with who the other practitioners are and may not think to contact them
  - Information about the patient’s care may be miscommunicated or misunderstood
Factors that disrupt continuity

- Having multiple practitioners
  - The patient, family member, or caregiver might report an important detail to one practitioner or not to another
  - The sum of all of these events can result in the prescribing of inappropriate drugs or other unnecessary treatments
  - In some cases, diagnostic tests may be needlessly repeated

Merck Manual of Health & Aging 2009
Factors that disrupt continuity

- Different practitioners may have different opinions about a person’s health care
- Lack of transportation
- Lack of health insurance
- Health care system rules
  - Government (Medicaid, Medicare)
  - Insurance companies
Factors that disrupt continuity

- Transition from outpatient setting to hospital

  - Retrospective cohort study of 3,020,770 hospital admissions between 1996 – 2006 using enrollment and claims data for a 5% national sample of Medicare beneficiaries > 66 years

  - Main outcome: percentage of pts who were seen during hospitalization by any outpatient physician they had visited in the year before hospitalization or by their PCP

  Sharma, et al; JAMA: April 22/29, 2009
Factors that disrupt continuity

Results

Pts visited by at least one physician seen in outpatient setting

1996  50.5%  44.3%
2006  39.8%  31.8%

Sharma, et al; JAMA: April 22/29, 2009
Factors that disrupt continuity

- Greater absolute decreases in continuity with any outpatient physician occurred
  - in patients admitted on weekends
  - for patients admitted to an academic institution
  - elderly residents of large metropolitan areas and New England
  - in hospitals having increased involvement of hospitalists (1/3 decrease in continuity of care)

Sharma, et al; JAMA: April 22/29, 2009
Factors that disrupt continuity

- However, this study also identified benefits of hospitalist care purporting greater efficiency in both hospital and outpatient care.

- It also revealed that the oldest patients and those with multiple comorbid conditions were more likely to have continuity with both their outpatient physicians and PCP’s during hospitalization (which is assessed as an appropriate adjustment for the most vulnerable patients).
Factors that disrupt continuity

- Other researchers conclude:
  - that the evolution of hospitalists, and the subsequent division of labor in the health care spectrum, is a source of inherent discontinuity between acute hospitalization and community management.
  - that it is the lack of coordination of care at discharge and other modifiable factors that contribute to poor outcomes after discharge and hospital readmission rates.

Kripalani: JAMA, Feb. 28, 2007
Van Walraven; JGIM, June 2004
Factors that disrupt continuity

- Deficits in communication and information transfer between hospital-based and community-based primary care physicians (PCP) are substantial and ubiquitous.
- Urgent improvements are needed in processes for transferring information to PCPs at hospital discharge (including physician providers at long-term care facilities)

Kripalani: JAMA, Feb. 28, 2007
Factors that disrupt continuity

- Research is revealing that poor information transfer and discontinuity are associated with lower quality of care on follow-up and adverse clinical outcomes.

- Many patients are being seen in follow-up by their PCPs after hospitalization who have no knowledge of previously pending test results or results of tests that were done during hospitalization.

Kripalani: JAMA, Feb. 28, 2007
Case

- 86 y.o. female is admitted to the hospital from the emergency department (ED). During the inpatient stay, she was not seen by her PCP since he no longer provided inpatient care. Instead, the hospitalist group took the baton from the ED.

1. Did the hospitalists know her?

   NO
Case

2. Did they have a special relationship with her? **NO**

3. When did they see her? **LATER**

4. How long did her 89 y.o. husband have to wait to talk with someone who could tell him what they had found and what the treatment plan was? **A LONG TIME**
5. When was the specialist called in to relieve her problems? **Much later**
6. When did the procedure get done? **Much later still**
7. By the way, did the PCP ever come by as a courtesy call? **NO**
Case

- The patient is transferred to a rehabilitation center after hospitalization and is assigned yet another provider. The medications had to be brought from home or, if given in the hospital, it was required that prescriptions be written by the doctor who initiated them in the hospital, not by the PCP (which her husband learned from the PCP’s nurse after sitting in the waiting room for 45 minutes).
What happened to continuity of care?

- Is it a concept that is dissolving as a result of specialization and technological advances?
- Are we taking steps to allow safe and efficient transition of our patients to other providers? Other care facilities? Are there any…….

Solutions?
Advice/Recommendations?
Answers?
Consider this……

- A patient may need to see several types of health care practitioners in order to receive the best quality care.
- Interdisciplinary care consists of a group of practitioners working together to provide the care that a patient needs.
- As soon as the patient is admitted, all members of the interdisciplinary team should participate in discharge planning.
Consider this……

- A recent longitudinal qualitative study demonstrated the presence of feelings of abandonment at the transition to “end of life care” were associated with loss of continuity and lack of closure of therapeutic relationships.
- This occurs often as patients transition to hospice care.
- The same feelings occurred with lack of closure for patients and families at or near the time of death.

Back, A.L. Arch Intern Med 2009; 169
Discharge Planning

- Physicians, nurses, social workers, case managers, physical and occupational therapists should all collaborate to determine when discharge is safe and which setting is most appropriate.
- The process should begin within 24 hours of admission
Discharge Planning: HOME

- Provide patients, family members, or caregivers with training to provide care
  - giving medications
  - implementing treatments
  - monitoring recovery
  - write down detailed instructions about follow-up appointments and drug schedules

- Provide contact information for PCP or other provider to be contacted should questions or problems arise
Discharge Planning: HOME

- Being conscientious about taking these steps produces many favorable outcomes for the patient:
  - Shortens the hospital stay
  - Decreases the likelihood of readmission
  - Identifies less expensive care alternatives
  - Facilitates placement of equipment in the patient’s home (i.e. hospital bed, oxygen, DME supplies)
  - Increases patient satisfaction
  - Might prevent nursing home placement
Discharge Planning: HOME

- RCT: The Care Transitions Intervention
  - Methods: 712 community dwelling adults 65 years or older, with 1 or more of 11 selected conditions either received the “intervention” or no intervention. Patients with dementia were excluded unless they had a proxy who was willing to participate.

Coleman, D. Arch Intern Med. 166: Sept. 25, 2006
Discharge Planning: HOME

RCT : The Care Transitions Intervention

Methods: The “intervention” consisted of 4 pillars

- Assistance with medication self-management
- A patient-centered record owned and maintained by the patient to facilitate cross-site information transfer
- Timely follow-up with primary or specialty care
- A list of “red flags” indicative of a worsening condition with instructions on how to respond

Coleman, D. Arch Intern Med. 166: Sept. 25, 2006
Discharge Planning: HOME

- RCT : The Care Transitions Intervention
  - Methods: The interventions were operationalized by possession of a personal health record and a series of visits and telephone calls with a transition coach.

  Designed to encourage older patients and their caregivers to take on a more active role during care transitions, to facilitate care coordination and continuity across settings, and to insure that needs were being met in all care settings.

Coleman, D. Arch Intern Med. 166: Sept. 25, 2006
Discharge Planning: HOME

- RCT: The Care Transitions Intervention
- Outcome Measures:
  - Primary - rate of nonelective rehospitalization at 30, 90, and 180 days after discharge from the index hospital stay.
  - Secondary – rate of rehospitalization for the same condition that prompted the index hospitalization.

Coleman, D. Arch Intern Med. 166: Sept. 25, 2006
Discharge Planning: HOME

- RCT: The Care Transitions Intervention

  - Results:
    - Intervention pts had lower rehospitalization rates at 30 days and 90 days than controls
    - Intervention pts had lower rehospitalization rates for the same condition that prompted the index hospitalization at 90 days and 180 days vs controls
    - Mean hospitalization costs were lower for intervention pts vs controls at 180 days

  Coleman, D. Arch Intern Med. 166: Sept. 25, 2006
When pts are discharged to a nursing home, other hospital, or rehab facility, it is recommended that a written summary be sent with the patient and a copy faxed to the receiving institution.

It is helpful when the hospital nurse calls the receiving institution to review the information shortly before transfer.
Unfortunately, physicians rarely have a one-on-one conversation before transfer and rarely does a discharge summary accompany pts who are transferred to nursing homes.

The discharge summary is a vital tool for communication and information transfer.
Discharge Planning: Nursing Home

- Current JCAHO performance standard mandates that the d/c summary be completed within 30 days of discharge; but this is insufficient from a patient safety perspective and does not meet the needs of providers who see these patients sooner.

- One study showed a greater risk of hospital readmission among pts treated in follow-up by a physician did not receive a discharge summary.

Kripalani: JAMA, Feb. 28, 2007
Discharge Planning: Nursing Home

The discharge summary should document pertinent information including:

- Cognitive and functional status
- Current medications and time the last doses were given; duration of antibiotic therapy and number of doses remaining
- Drug allergies
- Resuscitation status (DNR, DNI)
- F/U appointments (date, location, time, name of MD)
- Studies and results of tests completed during hospitalization
- Pending lab and test results
- Names and phone numbers of family contacts
Discharge Planning: Nursing Home

- To promote patient safety during transitions of care, timeliness, accuracy, and relevance of discharge communications must be improved.
- One option is to give the patient a copy of the most pertinent information in a brief d/c note.
- The use of a combination of technology and paper-based information might help to overcome some of the barriers to effective discharge communication.
And finally….The Patient-Centered Medical Home (PC-MH)

- The medical home concept was initially introduced by the American Academy of Pediatrics in 1967, referring to a central location for archiving a child’s medical record.

- The AAP expanded this concept to include certain operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.
And finally….The Patient-Centered Medical Home (PC-MH)

- The PC-MH is an approach to providing comprehensive primary care for children, youth, and adults in a health care setting facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family.

- Implementation of the PC-MH concept has taken place in many areas across the U.S. and in some cases, with corporate collaboration (IBM, Boeing, and the AAFP).
Research has demonstrated that having a medical home was associated with:

- less difficulty accessing care after hours
- improved flow of information across providers
- increased patient satisfaction
- fewer duplicate tests
- lower rates of medical errors
- fewer unmet health needs
- overall improved health related outcomes
And finally….The Patient-Centered Medical Home (PC-MH)

- Is this the answer to reviving and sustaining continuity of care?
- We will only know over time whether the PC-MH movement will bring these waning values back into the primary care of medicine.
Summary

- COC of care has many definitions and little consensus on its meaning.
- There are several different dimensions of COC, but interpersonal continuity is the strongest predictor of positive physician and patient outcomes.
- Maintaining COC with patients through different health care settings facilitates documented positive outcomes for patients.
Summary

- The negative impact of COC on physicians should not be ignored; interventions should be practiced to offset undesirable outcomes.
- The older adult population more frequently transitions from one health care setting to another.
- All providers of health care to older adults need to take a more pro-active role in assuring that information transfer is accurate and comprehensive as patients move from one setting to another.
Summary

- If you can’t speak with the physician provider who will be responsible for care in the next setting, or if you can’t send a complete discharge summary, take a few minutes to write a brief discharge note.
- Advice: Don’t rush through the medication reconciliation process.
Summary

- Whenever possible, try to visit your patients in the hospital and show interest in their well-being, even when admitted to the care of a hospitalist; likewise, hospitalists should communicate with the PCP.
- Call or visit patients and families when they transition to hospice care or other end-of-life care. Take steps to avoid development of feelings of abandonment.
Summary

- Keep in mind there are many positive outcomes for elderly patients when they receive high quality CONTINUITY OF CARE.
References

- Sharma, G., et al. Continuity of Outpatient and Inpatient Care by Primary Care Physicians for Hospitalized Older Adults. JAMA 301(16): 1671-1680; April 22/29, 2009
References

- Care for Older Adults: less continuity from home to hospital. Nursing, July 2009