Improving Transitions of Care

SUMMARY HIGHLIGHTS

Since 1995, **Universal Home Care (UHC)** has been offering greater Los Angeles (and neighboring counties) our highly-respected **"Care Coordination Program"** which bridges the unmet health needs of patients – particularly the elderly and individuals with chronic illnesses – from hospital setting to home with their own dedicated Continuum Care provider.

Patients who are cared by **UHC's** qualified medical staff experience the finest caliber of transition via our **"Care Coordination Program"** as a means to reduce hospital readmittance and designed to provide our patients with 1:1 personal care.

In essence, **UHC's** **"Care Coordination Program"** is a related, but distinct concept, which offers our patients + family caregivers the interaction of 1 provider vs. many to ensure optimal care. Every transition of care will involve coordination by **UHC's** team, which typically encompasses the assessment of the patient's needs, evaluation and implementation of the care plan.

Some facts about transitions of care:

Among hospitalized patients 65+, ***21%*** are discharged to a long-term care or other institution	Approximately ***25%*** of Medicare skilled nursing facility (SNF) residents are readmitted to the hospital
Individuals with chronic conditions—a number expected to reach 125 million in the U.S. by 2020—may see up to ***16 physicians in one year***	Between **41.9** and ***70%*** of Medicare patients admitted to the hospital for care in 2013 received services from an average of ***10 or more physicians during their stay***

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Prevention of Poor Transitions of Care

Oftentimes, the health care system fails to meet the needs of patients during transitions because care is rushed and responsibility is fragmented, with little communication across care settings and multiple providers. Survey findings by the Agency for Healthcare Research and Quality (AHRQ) on Patient Safety Culture, found that 42% of the hospitals surveyed reported that "things fall between the cracks when transferring patients from one unit to another" and "problems often occur in the exchange of information across hospital units."

Poor communication during transitions from one care setting to another can lead to confusion about the patient's condition and appropriate care, duplicative tests, inconsistent patient monitoring, medication errors, delays in diagnosis and lack of follow through on referrals. These failures create serious patient safety, quality of care, and health outcome concerns.

We need only to look at the high prevalence of hospital readmissions and medical errors to see the inadequacies of care transitions and their adverse economic implications to the health care system:

- Medication errors harm an estimated 1.5 million people each year in the United States, costing the nation at least $3.5 billion annually
- One study found that, on discharge from the hospital, 30% of patients have at least one medication discrepancy
- According to another study, one in five U.S. patients discharged to their home from the hospital experienced an adverse event within 3-weeks of discharge. Sixty percent were medication related and could have been avoided
- On average, 19.6% of Medicare fee-for-service beneficiaries who have been discharged from the hospital were readmitted within 30 days and 34% were readmitted within 90 days

Improving Transitions of Care

At **Universal Home Care (UHC)**, our multidisciplinary team of health care experts are committed to improving the quality of transitions of care. **UHC's** mission is to raise awareness about the importance of transitions in ***improving health care quality, reducing medication errors and enhancing clinical outcomes among health care professionals, patients, and family caregivers.***

As new policies, programs, and practices emerge that seek to improve care transitions, the experts at **UHC** recommend the following approaches for achieving successful transition outcomes:

- Structure the current reimbursement plan so that it compliments transitions of care
- Improve communication during transitions between providers, patients and family caregivers
- Implement electronic health records that include standardized medication reconciliation elements
- Expand the role of pharmacists in transitions of care in respect to medication reconciliation
- Establish points of accountability for sending and receiving care, particularly for hospitalists, SNFists, primary care physicians and specialists
- Increase the use of case management and professional care coordination
- Develop performance measures to encourage better transitions of care