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ADVANCES IN GERIATRICS

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Improving Care Transitions from Hospital to Home

The transition from hospital to home is for many older adults a perilous period. The changeover often leaves patients vulnerable to medication discrepancies, and one in five suffers an adverse event. Studies have shown that patients with post-discharge medication discrepancies are twice as likely to be readmitted within 30 days. There had to be a better way to transition patients safely home, which is just what physicians in the Division of Geriatrics and Palliative Medicine at NewYork-Presbyterian/Weill Cornell Medical Center set out to do more than a decade ago.

"When I finished my fellowship in clinical geriatrics at Weill Cornell in 2007 and then joined the faculty, my practice was largely outpatient care," says geriatrician **Sharda D. Ramsaroop, MD**. "We realized there were many people getting discharged from either rehabilitation centers or the Hospital with little to no follow-up and who were falling through the cracks."

In making follow-up visits after a patient's discharge from the Hospital, Dr. Ramsaroop discovered a number of patients had medication discrepancies. "During their follow-up visits, we would spend the majority of the visit focusing solely on the patient's medications – 15 minutes or longer – to see if they were close to what we thought they were taking. We found about 65 percent of people would have at least one medication discrepancy compared to what was listed in their Hospital discharge records."

The reasons for this varied from person to person, says Dr. Ramsaroop. "Some of it was attributable to discharge instructions that did not quite match what was in the final discharge note from the Hospital. Sometimes the patient thought they didn't need the medications and would just stop taking them. In other cases, the caregiver didn't quite understand the instructions. There were a host of reasons."

During this period, the emphasis on care transitions was beginning to spread nationally. Dr. Ramsaroop, under the mentorship of **Eugenia L. Siegler, MD**, and **M. Cary Reid, PhD, MD**,

Dr. Sharda D. Ramsaroop

and together with her Weill Cornell colleagues developed a post-discharge clinic at NewYork-Presbyterian's Irving Sherwood Wright Center on Aging, which provides both primary care and geriatric consultation to older adults in an outpatient setting. The aims of the clinic were to ensure that patients discharged from the Hospital have access to timely, comprehensive, and multidisciplinary post-hospital care; to reduce hospital readmissions; and to ultimately disseminate a model of transitional care throughout NewYork-Presbyterian.

In developing the post-discharge clinic, the Weill Cornell team conducted focus groups with members of different disciplines, including internal medicine residents, physician assistants, and nurses within the Hospital to determine their knowledge and attitudes about hospital discharge. "They described the discharge process as chaotic, confusing, and frustrating, most often because of time constraints and difficulty ensuring communication amongst all providers involved in the discharge process," says Dr. Ramsaroop. "Their suggestions for improvement in the process included designating a 'transitionalist' for patient

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A Focus on Faculty

In the Division of Geriatric Medicine and Aging at NewYork-Presbyterian/Columbia, **Nana A. Makalatia, MD**, **Bindhu Thomas, MD**, and **Xiaoshuang Nancy Yin, MD,** are caring for the older adult population at NewYork-Presbyterian Allen Hospital, which serves northern Manhattan, Riverdale, and communities in the Bronx and Westchester. In addition, they are providing geriatric teaching and educational experiences for medical trainees and serving the geriatrics needs of the Hospital and medical school.

Nana A. Makalatia, MD

Born in the Republic of Georgia, **Dr. Nana A. Makalatia** came to the United States 19 years ago after earning her medical degree at Tbilisi State Medical University. Completing residency training in internal medicine at Lutheran Medical Center in Brooklyn, she then joined Berkshire Medical Center in Pittsfield, Massachusetts, as a hospitalist, an experience that prompted her to specialize in geriatric medicine. "It was surprising how many geriatric patients I had at that time, and I thought this age group was something I needed to know more about," she says. Dr. Makalatia then went on to pursue a fellowship in geriatrics at NYU Langone Medical Center. "That training opened up my eyes to the many issues and challenges that confront older individuals. It gave me a sense of what to look for, how to assess these patients, and in particular, I learned that I needed to listen better."

Dr. Nana A. Makalatia

Returning to Massachusetts, Dr. Makalatia practiced primarily in rural communities and compares that experience to now caring for patients at NewYork-Presbyterian Allen Hospital as different "as night and day."

"The services for and the understanding of this population lag behind in rural areas," she says. "Here, we have a much greater ability to help people with home health aides, therapy, and community resources. In addition, the advanced communications systems shared by our facilities and practices make it extremely efficient in accessing our patients' records quickly to understand their medical history."

Dr. Makalatia believes there needs to be greater understanding of the aging process and why some individuals live to advanced years independent and functional and others decline rapidly. "We need to recognize the physiology of many of the issues that are so prominent in the geriatric population," she says.

Clear communication between physicians and patients on difficult subjects is also critical, adds Dr. Makalatia. "For example, physicians need to be able to discuss advance directives with their patients to understand what their wishes are and how they want to live out their lives. I find that patients are very receptive to those discussions – it is all in how you approach it."

Bindhu Thomas, MD

After earning her medical degree at Fatima College of Medicine, Philippines, **Dr. Bindhu Thomas** completed a family medicine residency as well as a geriatric medicine fellowship at the University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Hospital. Dr. Thomas is also certified in Hospice and Palliative Medicine. "As a family medicine trained physician, my practice ranged from delivering babies to seeing geriatric patients," says Dr. Thomas. "During residency I had more satisfaction caring for older adults, which pushed me towards pursuing training in geriatrics."

Dr. Bindhu Thomas

A geriatrician with NewYork-Presbyterian Allen Hospital for the past 10 years, Dr. Thomas appreciates the additional time allotted to seeing new patients. "Most physicians know that evaluating and caring for a geriatric patient presents certain challenges, but unless one actually practices in the field, it is difficult to truly understand," she says. "It takes time for our patients to get into the examining room and settle down and then to examine them and get to the bottom of the problem. It generally takes three times longer to answer one question of an older patient compared with younger patients."

Medication reconciliation is a particularly important issue to address, says Dr. Thomas. "Our older patients are usually seeing other specialty physicians who often prescribe medicines on top of what we have prescribed," she says. "When the patients return to us for care they frequently are on new medicines and we try to figure out when the medication we had prescribed was stopped and why. A large portion of our visit is used to explain why they are taking each medicine and what to anticipate. We are also educating their family and many times their home attendants. In those cases, we then call the family to update them."

Dr. Thomas values being part of a team of geriatricians. "There is no other way in geriatrics to work but as a team," she says, noting that nurse practitioners, medical assistants, and office personnel are also key members in their practice. "We are proud to be part of Columbia doctors providing geriatric care to our patients," adds Dr. Thomas. "As we grow and face the challenges of this patient population, we hope to continue to do so in a kind and complete manner."

Xiaoshuang Nancy Yin, MD

Dr. Nancy Yin earned her MD at Beijing Medical University, where she practiced for several years. In 1990, she came to NewYork-Presbyterian/Columbia to complete a research fellowship, followed by a residency in internal medicine at St. Luke's-Roosevelt Hospital Center. She then went on to pursue a fellowship in geriatrics at NewYork-Presbyterian/Weill Cornell Medical Center.

Dr. Xiaoshuang Nancy Yin

"During my residency in internal medicine I could see how hard it was for the elderly and their families to navigate health care and to be able to put together a care plan," says Dr. Yin. "I thought that it would be great for me to have the extra training and knowledge to apply with any elderly patient with specialty needs. I wanted to become a geriatrician so I could provide much better care for elderly patients."

For the past eight years, Dr. Yin, who is also board certified in Hospice and Palliative Medicine, has been addressing the multiple health challenges the elderly face. "In addition to medical issues, many people have cognitive impairment and do not have enough social or family support," she says. "That is a huge difference in this age group compared to a regular general medicine practice. When the patient asks a question, you have the answers ready, but if they are also hard of hearing it takes a longer time to explain."

Medication compliance is another hurdle for many older patients. "In general medicine, an adult patient might take two, four, or even five medications and they know the dosage," says Dr. Yin. "Our elderly patients may be on as many as 10 medications and that poses a big problem. It's easy to prescribe the medication, but it's very hard to make sure the patient is filling the prescription and then taking it according to your instructions. So, much of our time is spent trying to make sure they are filling the prescriptions regularly and taking them correctly. In addition, often people see multiple doctors and end up having medications that interact with each other. Or they might take the same medication with a different brand name and double the dose. These are the issues we have to deal with every day."

Coming to NewYork-Presbyterian/Columbia, says Dr. Yin, has allowed her to "practice the best medicine I can. Here at the geriatric practice we do what's best for our patients, including calling the patient and family after work to try to save them a trip to the Hospital. Imagine how difficult it is for someone who is 95 years old to make an office visit, so we do what we can to make it easier for them."

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Sharing Expertise: NewYork-Presbyterian/Columbia Welcomes Chilean Doctor for Observership

Alejandra Silva, MD, a Chilean doctor doing her medical residency in geriatrics at the Universidad de Santiago de Chile, spent a month as an observer at NewYork-Presbyterian Allen Hospital under the guidance of **Evelyn C. Granieri, MD,** Chief of the Division of Geriatric Medicine and Aging at NewYork-Presbyterian/Columbia.

During her observership, Dr. Silva accompanied the geriatrics team during home visits, medical consultations, and Hospital rounds. She also participated in Journal Club, a weekly review of the latest publications on geriatrics, where she presented a recent paper on frailty and sarcopenia. Dr. Silva also spoke at a community senior center in Manhattan and visited the Hebrew Home at Riverdale.

Dr. Alejandra Silva

"My time at NewYork-Presbyterian Allen Hospital was an extremely rewarding and enlightening experience," says Dr. Silva. "The geriatrics team has exceptional expertise and shared with me not only the latest research in the field but, most importantly, how to relate and work with elderly patients."

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Improving Care Transitions from Hospital to Home

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and caregiver education and calling on a clinical pharmacist for medication reconciliation."

A dedicated geriatrics consult team now follows all of the Wright Center's patients who are admitted to the Hospital and notes when they will need a follow-up appointment. All discharged patients – whose average age is 84 years old – are seen within two weeks of discharge.

Prior to the 45-minute follow-up visit, the team reviews discharge summaries, clarifying information as needed. "At least half of the patient's visit, and sometimes the whole visit, is spent discussing medications, including both prescription and over-the-counter medications, such as Tylenol," explains Dr. Ramsaroop. "We review the medication list from the Hospital discharge summary with the patient and compare it with the patient's pill bottles, lists, or their own report of medications being taken."

Pharmacies and caregivers are contacted as needed to compile an accurate patient medication list, and staff use the Medication Discrepancy Tool to categorize and reconcile discrepancies, entering all information into a single database.

"The visit also includes a physician assessment and a discussion of health-related goals, self-management, and psychosocial needs," says Dr. Ramsaroop. A social worker is available to address any psychosocial and home care requirements.

"All of the discharge summaries are automatically entered into the Hospital's electronic health record system, which has made a huge difference in managing our older patients," adds Dr. Ramsaroop. "The social work notes will tell us, for example, if the individual requires a visiting nurse or home physical therapy or a home health aide. The electronic health record also allows us to immediately send progress notes to the primary care physician and specialists within our healthcare system."

According to Dr. Ramsaroop, patients have been very receptive to the follow-up program. "In the beginning they would ask, 'Why do I have to come back? I just left the hospital.' Now it's easier to convince people that they really do need to come in and that there are things that we can do to help them," she says. "The program has grown from seeing two to three patients a month to an average of 30 patients a month, with a total of 400 patient visits to date. There is so much we can do to help meet the needs of these vulnerable patients – especially the homebound population – with access to home care and community resources."

"The transitional care program at Weill Cornell is an important stepping stone for the future," adds Dr. Ramsaroop. "It has been a valuable opportunity to teach medical residents and geriatric fellows about the importance of care transitions for older adults. Transitional care is now nationally recognized as an important area of medicine. The Centers for Medicare and Medicaid Services has developed incentives for physicians to include care transitions into their practice. The program at Weill Cornell will continue to expand and work to provide the necessary care for older adults as they transition through the system."

For More Information
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