Transitions of Care

The Key to Successful Care Coordination
Objectives:

• Learn why care transitions are more important than ever in the changing healthcare environment
• Learn key ingredients for a successful transitions program
• Recognize and overcome common barriers to successful transitions
Care Transition Goals

- **Improve patient safety** by improving patient’s preparedness for self care after discharge.
- **Reduce overall cost of health care utilization** by reducing readmissions and post discharge emergency department visits.
- **Improve patient outcomes and satisfaction**
- **Improve transitions of care across the continuum of healthcare providers and locations**
Care Transitions Definition

• Transitional care is defined as 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. Representative locations include hospitals, nursing homes, the patient’s home, primary and specialty care offices, and long-term care / sub-acute facilities.

• Transitional care is based on a comprehensive plan of care and the availability of health care practitioners who are well-trained in chronic care and have current information about the patient’s goals, preferences, and clinical status.

• Transitional Care includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition. Transitional care, which encompasses both the sending and the receiving aspects of the transfer, is essential for persons with complex care needs.
Developing a Transitions Program

• Address many of the contributing factors to unplanned hospital readmission

• Provide access to care within 24-72 hours post discharge
  • Assessment
  • Red Flags
  • Medication Reconciliation
  • Schedule PCP and specialist appointments
  • Coaching

• Improved bi-directional communication with the PCP
  • Post hospital exchange of discharge plan
  • ED avoidance

• Expand offerings of evidence-based models for self care

• Leverage Data to Manage Complex Disease

• Develop standardized transfer tools, processes and quality monitoring
  • Standardized discharge sheet and communication

• Redesign and standardize patient flow/discharge planning from hospital
The Role of the Transitions Care Manager

• The Transitional Care Manager ensures the coordination and continuity of health care as patients transfer between locations or different levels of care. Locations include hospitals, sub-acute and post-acute nursing facilities, the patient's home, primary and specialty care offices, and long-term care facilities. This includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition. Transitional care, both the sending and the receiving aspects of the transfer, is essential for persons with complex care needs.
Primary Drivers of Transitions Success

- Risk Stratification and Identification
- Self Management Skills
- Coordination of Care Across the Continuum
- Adequate Follow up and Community Resources
Risk Stratification and Identification

• Use a risk of readmission assessment tool and validate it using your institution’s data.
• Adopt an enhanced admission assessment.
• Make readmission risk assessments easy for all to access and utilize.
• Coordinate care using a multi-disciplinary team including doctors, nurses, hospital case management, pharmacists, physical therapists, occupational therapists, nutritionists, and respiratory therapists.
• Include the patient’s primary caregiver as a member of the healthcare team.
Risk Continued

• Find out if the patient has a caregiver and who the caregiver is.

• Communicate who the primary caregiver is to the members of the patient’s health care team, e.g. use a whiteboard, record important information in a standard, visible, and accessible site in the medical chart.

• Discuss with patients their palliative care and end-of-life treatment wishes.

• Design interventions to match identified needs based on risk.
Self Management Skills

- Obtain an accurate home medication history from the patient and/or primary caregiver at admission.
- Educate patients/caregivers before discharge regarding all medications prescribed, the purpose of these medications, the means of obtaining them, and the instructions for taking them.
- Evaluate patient’s “level of activation” or engagement in self-management and consider implementing motivational interviewing and activation-based coaching approaches.
- Provide clearly written medication instructions using health literacy concepts and culturally appropriate training materials.
• Develop patient-centered educational tools that employ health literacy concepts to teach patients about their diagnosis and symptoms.

• Use patient simulation.

• Train clinical staff on Teach-back using role play, and observe their technique in the field.

• Validate patient and caregiver understanding of discharge instructions?
Coordination of Care Across the Continuum

• Evaluate best practices, resources and established tools
• Determine which models will work in your organization.
• Engage IT support for completing plans of care.
• Determine where key information is to be stored and how it will be compiled to complete plans of care.
• Obtain accurate information about patients’ primary care physicians at the time of admission.
• Send completed discharge summaries to patients’ primary care physicians within 48 hours of discharge.
Coordination Continued

• Use of a concise, standardized discharge transfer form.
• Perform warm hand offs between hospital, ambulatory care and next provider of care.
• Assign clear accountability for medication reconciliation and perform reconciliation at each transition of care; consider a home visit to educate patients/caregivers about their medications and to reconcile the medications in the patients’ homes.
Adequate Follow up and Community Resources

• Prior to leaving the hospital, determine what post-discharge resources and appointments will be needed, and ensure they are addressed in the after-care plan.
• Work with patients and care providers to determine any barriers to making and attending follow-up appointment(s).
• Work with patients and caregivers to determine any barriers to other follow-up requirements such as medications, special diet, transportation needs, etc.
• In addition to these hospital-driven elements, additional benefits have been demonstrated with post-discharge interventions such as: post-discharge phone calls, home visits, home health referrals, etc. Those patients who have the highest risk of readmission may also benefit from more intensive community resources and support.
Lessons Learned:

• Collaboration between acute and post acute providers
• Collaboration between Hospital case management and Ambulatory Care Management
• Breaking up silos
• The need for individualized care and follow up plans that move with patients longitudinally over time
• Resource education
"The greatest opportunities for improving care transitions center around improving communication, building cross-setting relationships, and redesigning our workflow."

~ Eric A. Coleman, MD, MPH