MiCMRC Self-Study Module

Transitions of Care

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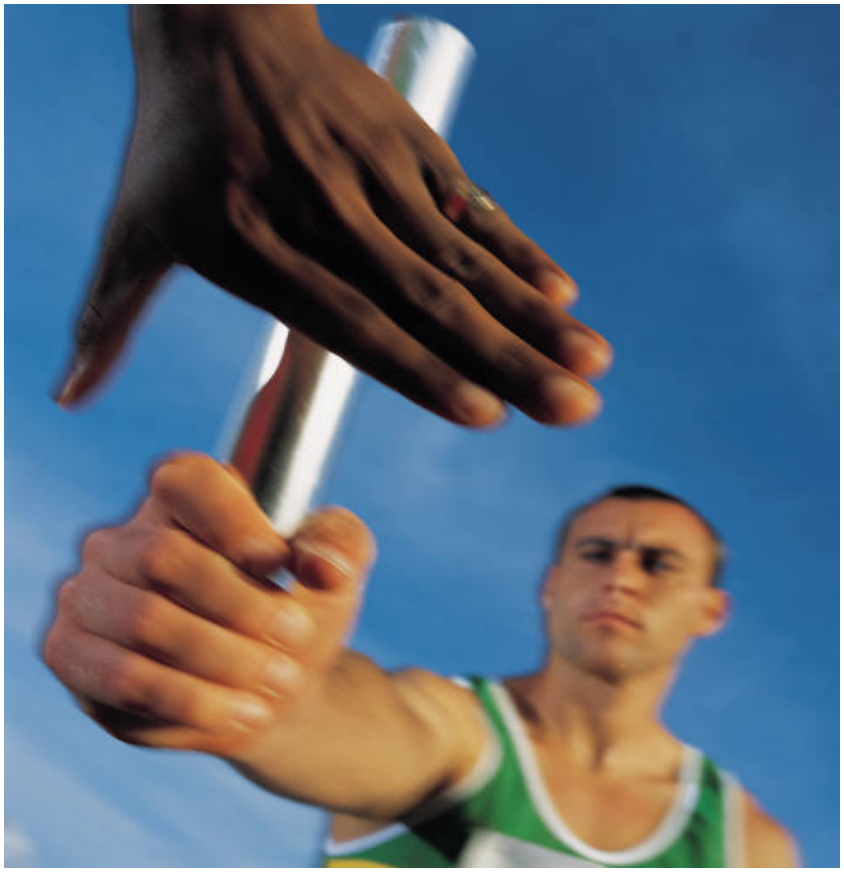
The Michigan Care Management Resource Center

Transitions of Care Objectives

- Identify key elements of a smooth transition of care
- Describe real time patient information to share with the next provider of care
- Post hospitalization, describe characteristics of a high risk patient

Transitions of Care



Transitional Care

- Care involved when a patient/client leaves one care setting (i.e. hospital, nursing home, assisted living facility, SNF, primary care physician, home health, or specialist) and moves to another.
- Specifically, they can occur:
  - Within settings; e.g., primary care to specialty care, or intensive care unit (ICU) to ward.
  - Between settings; e.g., hospital to sub-acute care, or ambulatory clinic to senior center.
  - Across health states; e.g., curative care to palliative care or hospice, or personal residence to assisted living.
  - Between providers; e.g., generalist to a specialist practitioner, or acute care provider to a palliative care specialist

https://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf

Transitions of Care

- Transitions of care are a set of actions designed to ensure coordination and continuity. They should be based on a comprehensive care plan and the availability of well-trained practitioners who have current information about the patient's treatment goals, preferences, and health or clinical status.
- They include logistical arrangements and education of patient and family, as well as coordination among the health professionals involved in the transition.

Transitional Care Example

- For example, in the course of an acute exacerbation of an illness, a patient might receive care from a PCP or specialist in an outpatient setting, then transition to a hospital physician and nursing team during an inpatient admission before moving on to yet another care team at a skilled nursing facility. Finally, the patient might return home, where he or she would receive care from a visiting nurse. Each of these shifts from care providers and settings is defined as a care transition.

(www.caretransitions.org)

Rehospitalizatons - What happens?

- 20 percent of US hospitalizations are rehospitalizations within 30 days of discharge
- Up to 76 percent of rehospitalizations occurring within 30 days in the Medicare population are potentially avoidable (MedPAC)
- One-quarter to one-third of these patients return to the hospital due to complications that could have been prevented

Goals for Smooth Transition

- Provide the patient a safe, successful transition from one provider to the next
- Patient's and/or family's experience and satisfaction with care received
- Provider's experience and satisfaction with the quality of interaction and collaboration among providers involved in care transitions.
- Health care utilization and costs (e.g., readmissions, etc.).
- Health outcomes consistent with patient's wishes (e.g., functional status, clinical status, medical errors, and continuity of care).

Root Cause of Ineffective Transitions

- Communication breakdown
  - Expectations differ between senders and receivers of patients in transition
  - Culture does not promote successful hand-off (e.g., lack of teamwork and respect)
  - Inadequate amount of time provided for successful hand-off
  - Lack of standardized procedures in conducting successful hand-off, e.g. use of SBAR (situation, background, assessment, recommendation)

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Root Cause of Ineffective Transitions

- Patient education breakdowns
  - Patients or family/friend caregivers receive conflicting recommendations, confusing medication regimens, and unclear instructions about follow-up care.
  - Patients and caregivers are sometimes excluded from the planning related to the transition process.
  - Patients may lack a sufficient understanding of the medical condition or the plan of care or lack the knowledge or skills to do so

https://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf

Root Cause of Ineffective Transitions

- Accountability breakdowns
  - No physician or clinical entity that takes responsibility to assure that the patient's health care is coordinated, especially when multiple specialists are involved
  - Fail to coordinate care or communicate effectively, which creates confusion for the patient.
  - Primary care providers are sometimes not identified by name
  - Limited discharge planning and risk assessment.
  - Steps are not taken to assure that sufficient knowledge and resources will be available

Typical failures following discharge from the hospital

- Medication errors
- Poor discharge instructions
- No follow-up appointment
- A follow-up appointment that is scheduled too long after hospitalization
- Poor outpatient management
- Lack of social support
- Patient confusion about self-care instructions and medications
- Patient lack of adherence to medications, therapies, and daily weights
- Key therapies not initiated in the hospital

Typical failures following discharge from the hospital

- PCP does not have the patient records at time of follow up visit
- Outpatient physician may have difficult contacting hospital based physician
- Office practice team is not aware of barriers for the patient keeping their apt
- Patients don't know whom or when to call if their condition worsens;
- Outpatient physician does not coordinate care with case managers or other community-based providers such as home health care nurses;
- Patients may not fully understand the importance of the first post-hospital visit; and
- Patients have only a partial understanding of what they need to do and why despite the use of methods to engage them during their hospital stays in learning about their care

Transitions of Care Interventions:

Care Managers

Care Managers Role in Transition of Care

- Find your hospital admit and discharge list
  - Patients discharged from hospital
  - Note: may also include patients –
    - ED visits, urgent care
    - Admit or discharge from SNF, LTAC, Long term etc.
- Determine patient eligibility
- Conduct TOC intervention
  - Patient eligibility list - participating Health Plans
  - Determine patient population your practice is targeting

Care Managers Role in Transitions of Care

- Identify patients at risk for readmission
    - Hospitalization history
    - Degree of patient/caregiver self care confidence

- Prioritize patients based on risk of re- hospitalization
    - Prioritize daily TOC by starting with highest risk patients

Care Management of Patients with Complex Health Care Needs

The most effective care management programs for patients with complex health care needs are those targeting the transition from hospital to home.

- Hospitalization is an indicator of patients that may benefit from complex care management
- Hospitalization is a major life event, patient may be motivated to address health issues
- Often at times of transition, quality and access deteriorate

*http://www.rwjf.org/files/research/52372caremgt.rpt.revised.pdf

Post Hospitalizations: Prioritization of High Risk Patients based on Risk of readmission

High-Risk Patients	Moderate-Risk Patients	Low-Risk Patients
Patient has been admitted two or more times in the past year. Patient is unable to Teach Back, or the patient or family caregiver has a low degree of confidence to carry out self-care at home.	Patient has been admitted once in the past year. Patient or family caregiver has a moderate degree of confidence to carry out self care at home, based on Teach Back results	Patient has had no other hospital admissions in the past year. Patient or family caregiver has high degree of confidence and can Teach Back how to carry out self care at home.

Transitions of Care
ADT

- Notifications of Admissions, Discharges, and Transfers

Patients transition from one provider or healthcare setting to another as the patients' health care needs require. These transitions trigger Electronic Health Records to generate Admit-Discharge-Transfer (ADT) notifications that identify the patient along with important details that provide insight to an extremely complex set of care decisions being made by care teams, families and the patient.

Post Discharge Phone Call from PCP Office

- Ensures that patients are contacted by someone they know and with whom they have a relationship
- Opportunity to adjust the risk assessment received from the hospital
- Establishes accountability of the practice for the patient
- Ensures continuity in the patient education process

Goal of Post Discharge Phone Call

- Provide customized, real-time critical information to the next care provider(s)
  - Practitioners need an understanding of
    - the patient's goals
    - baseline functional status
    - active medical and behavioral health problems
    - medication regimen
    - family or support resources
    - durable medical equipment needs
    - ability and confidence for self-care

http://www.ihi.org/knowledge/Knowledge%20Center%20Assets/ceb3e69a-2007-460a-8999-e12c2013b5e6/TCABHowtoGuideIdealTransitionHomeHFJun08.doc

Transitions of Care:
Care Management follow up visit

Patient population: Eligible patients

- Post hospitalization follow up phone call visit by care manager
  - within 24-48 hours
- Review patient discharge summary
- Medication reconciliation
- Assess care giver support
- Assess patient's medical status
- Elicit patient concerns and questions

Transitions of Care:
Care Manager Follow up visit (cont.)

- As needed, follow up appt. with PCP
- As needed, patient has follow up appt. with Specialists scheduled
- Assess barriers to keeping follow up appointments
- DME – what is in home, what is needed
- Coordination of care
  - Specialists, HHA, SNF, Long Term Acute Care (LTACH), Acute rehabilitation
  - Tests, labs – schedule, follow up
- Identify team members that have responsibility for aspects of follow- up

Prior to Post Hospitalization PCP follow up visit

- Address patient concerns and questions
- Emphasize with patient/caregiver importance of the follow up PCP visit
- Clarify outstanding issues with sending physician
- Care team coordinates care: call HHA RN, notify PCP of updates

Prior to Post Hospitalization PCP follow up visit

- Collaborate with patient on self management support; perform teach back
- Explain warning signs and how to respond; have patient teach back
- Provide instruction on how to seek after hours care both emergent and non-emergent

Transition of Care

References

- **How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations**

- http://www.ihi.org/knowledge/Pages/Tools/HowtoGuideImprovingTransitionsHospitaltoOfficePracticeReduceRehospitalizations.aspx

Michigan Care Management Resource Center Website micmrc.org

Care Management 101 is a web based self study opportunity

- a suggested road map of staged content for the new Care Manager
- may be utilized to create customized curriculum for self-study based on the CM's self-assessment
  - Care managers may identify their areas of strengths and gaps
  - Review CM 101 content to select recorded webinars, tools, resources

Access Care Management 101: www.micmrc.org

Access your specific program information

View CE approved Webinars

Share your success as a care manager and practice team

View best practice stories and tools

View multiple webinars on various clinical topics

Michigan Care Management Resource Center Website micmrc.org

Topics for Care Managers Include:

- Advance Care Planning
- Palliative Care
- Pediatrics
- Medication Management
- Transitions of Care
- Patient Centered Medical Home & Team Based Care
- Chronic Conditions
- Quality and Population Health Management
- Elderly Population
- Behavioral Health

Thank You!

- Questions?
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