Effective Care Transitions to Reduce Hospital Readmissions

November 8, 2017

Anchorage, Alaska
The “vicious” cycle of readmissions

Presented at WSHA/ASHNHA Partnership for Patients Safe Table – November 8, 2017
What is Care Transitions?

• The movement of patients across settings, referred to as "care transitions," is a process that requires strong partnerships between long-term post-acute care settings like home health care and other providers such as hospitals, primary care physicians, and outpatient clinics.
Readmissions related to ineffective discharge planning and discharge process.

- Leaving the hospital can be a dangerous time for patients. Why? Changes in care settings, providers who don’t communicate well, and confusion over which medications to take upon return home can result in errors and complications.

- Discharge instructions are often confusing and conflict with previous information from other providers.

- Many people end up going back to the hospital because of these complications, confusion, or because they were not prepared to manage their own care.
Reduce Avoidable Readmissions

The Institute for Healthcare Improvement (IHI) says:

• Hospitalizations account for nearly one-third of the total $2 trillion spent on healthcare in the United States. In the majority of cases, hospitalization is necessary and appropriate. However, a substantial fraction of all hospitalizations are patients returning to the hospital soon after their previous stay. These rehospitalizations are costly, potentially harmful, and often avoidable.

Evidence suggests that the rate of avoidable rehospitalizations can be reduced by improving core discharge planning and transition processes out of the hospital; improving transitions and care coordination at the interfaces between care settings; and enhancing coaching, education, and support for patient self-management.

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Care Transitions Programs

https://partnershipforpatients.cms.gov/
## Care Transitions Programs

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<th>Title</th>
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<tr>
<td>“Care Transitions Program®” (University of Colorado)</td>
<td>During a four-week program, patients with complex care needs receive specific tools, are supported by a Transitions Coach®, and learn self-management skills to ensure their needs are met during the transition from hospital to home.</td>
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http://www.caretransitions.org/
# Care Transitions Programs

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<tr>
<td>“Project BOOST” (Society of Hospital Medicine)</td>
<td>“Better Outcomes for Older Adults through Safe Transitions,” a national initiative led by the Society of Hospital Medicine to <strong>improve the care of patients as they transition from hospital to home.</strong></td>
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http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/HTM LDisplay.cfm&CONTENTID=27659
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<td><strong>TCM Overview</strong> (Transitional Care Model)</td>
<td>The Transitional Care Model (TCM) provides comprehensive in-hospital planning and home follow-up for chronically ill high-risk older adults hospitalized for common medical and surgical conditions. The heart of the model is the <strong>Transitional Care Nurse (TCN)</strong>, who follows patients from the hospital into their homes and provides services designed to streamline plans of care, interrupt patterns of frequent acute hospital and emergency department use, and prevent health status decline. While TCM is nurse-led, it is a multidisciplinary model that includes physicians, nurses, social workers, discharge planners, pharmacists and other members of the health care team in the implementation of tested protocols with a unique focus on...</td>
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**Care Transitions Programs**

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**Title**

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The Transitional Care Model (TCM) provides comprehensive in-hospital planning and home follow-up for chronically ill high-risk older adults hospitalized for common medical and surgical conditions. The heart of the model is the **Transitional Care Nurse (TCN)**, who follows patients from the hospital into their homes and provides services designed to streamline plans of care, interrupt patterns of frequent acute hospital and emergency department use, and prevent health status decline. While TCM is nurse-led, it is a multidisciplinary model that includes physicians, nurses, social workers, discharge planners, pharmacists and other members of the health care team in the implementation of tested protocols with a unique focus on...
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<td>&quot;Medicare Demonstrations: Details for Community-Based Care Transition Program&quot; (U.S. Department of Health &amp; Human Services, Centers for Medicare &amp; Medicaid Services)</td>
<td>The Community-Based Care Transitions Program (CCTP) goals are: to reduce hospital readmissions, test sustainable funding streams for care transition services, maintain or improve quality of care, and document measurable savings to the Medicare program. The demonstration will be conducted under the authority of Section 3026 of the Affordable Care Act of 2010.</td>
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<tr>
<td><a href="https://innovation.cms.gov/initiatives/CCTP/">https://innovation.cms.gov/initiatives/CCTP/</a></td>
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<td><strong>Transition Home Program Reduces Readmissions for Heart Failure Patients</strong> (U.S. Department of Health &amp; Human Services, Agency for Healthcare Research and Quality)</td>
<td>The <strong>Transition Home for Patients with Heart Failure</strong> program at St. Luke’s Hospital in Cedar Rapids, IA, incorporates a number of components to ensure patients a safe transition to home or another health care setting. These components include enhanced assessment of post-discharge needs at admission, thorough patient and caregiver education (“teach-backs”), patient-centered communication with subsequent caregivers at handoffs, and a standardized process for post-acute care follow-up (home visit, post-discharge phone calls and outpatient classes). The program reduced the 30-day readmission rate for heart failure patients from 14 to 6 percent.</td>
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<td>“Health Care Leader Action Guide to Reduce Avoidable Readmissions” (Health Research &amp; Educational Trust)</td>
<td>This resource guide is designed to serve as a <strong>starting point for hospital leaders</strong> to assess, prioritize, implement, and monitor strategies to <strong>reduce avoidable readmissions</strong></td>
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<td><strong>Transforming Care at the Bedside” (IHI)</strong></td>
<td>Admission assessment for post-discharge needs; teaching and learning; early post-acute care follow-up; patient and family-centered handoff communication.</td>
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<td><a href="http://www.ihi.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm">http://www.ihi.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm</a></td>
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<td>“GRACE Team Care: Geriatric Resources for Assessment and Care of Elders” (Indiana University)</td>
<td>The GRACE model improves health and reduces healthcare costs by lowering hospitalization rates in high-risk seniors.</td>
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<td><a href="http://medicine.iupui.edu/iucar/research/grace/">http://medicine.iupui.edu/iucar/research/grace/</a></td>
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<td>“Project RED (Re-Engineered Discharge)” (Boston University)</td>
<td>Project Re-Engineered Discharge is a research group at Boston University Medical Center that <strong>develops and tests strategies to improve the hospital discharge process in a way that promotes patient safety and reduces rehospitalization rates.</strong> The RED (re-engineered discharge) intervention is founded on 11 discrete, mutually reinforcing components, and has been proven to reduce rehospitalizations and increase patient satisfaction.</td>
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<td><a href="http://www.bu.edu/fammed/projectred/">http://www.bu.edu/fammed/projectred/</a></td>
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The Re-Engineered Discharge

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1. Educate the patient about her or his diagnosis throughout the hospital stay.
2. Make appointments for clinician follow-up and post-discharge testing.

- Make appointments with input from the patient regarding the best time and date for the appointment.
- Coordinate appointments with physicians, testing, and other services.
- Discuss reason for and importance of physician appointments.
- Confirm that the patient knows where to go and has a plan about how to get to the appointment; review transportation options and other barriers to keeping these appointments.
3. **Discuss with the patient any tests or studies** that have been completed in the hospital and who will be responsible for following up on the results.
4. Organize post-discharge services.

• Be sure the patient understands the importance of such services.
• Make appointments that the patient can keep.
• Discuss the details of how to receive each service.
5. Confirm the Medication Plan.

• Reconcile the discharge medication regimen with that followed before the hospitalization.

• Explain what medications to take, emphasizing any changes in the regimen.

• Review each medication’s purpose, how to take each medication correctly, and important adverse effects to watch out for.

• Be sure the patient has a realistic plan for how to get the medications.
Look familiar?
6. Reconcile the discharge plan with national guidelines and critical pathways.
7. Review the appropriate steps for what to do if a problem arises.

- Inform the patient about a specific plan for how to contact the primary care provider (or coverage) and provide contact numbers for evenings and weekends.
- Inform the patient about what constitutes an emergency and what to do in cases of emergency.
8. Expedite transmission of the discharge summary to the physicians (and other services, such as the visiting nurses), accepting responsibility for the patient’s care after discharge. Including:

- the reason for hospitalization, with the specific principal diagnosis.
- significant findings, such as laboratory, radiology, and operative reports, and medication administration records.
- the procedures performed and the care, treatment, and services provided to the patient.
- the patient’s condition at discharge.
- a comprehensive and reconciled medication list (including allergy treatment).
- a list of acute medical issues, tests, and studies for which confirmed results are pending at the time of discharge and require follow-up.
- information regarding input from consultative services, including rehabilitation therapy.
9. Assess the patient’s degree of understanding by asking for an explanation of the details of the plan in her or his own words; this may require:

- removal of language and literacy barriers by utilizing professional interpreters.
- contacting family members who will share in the caregiving responsibilities.
10. Give the patient a **written discharge plan** at the time of discharge that contains

- the reason for the hospitalization.
- the discharge medications, including what medications to take, how to take them, and how to obtain them.
- instructions on what to do if the condition changes.
- coordination and planning for follow-up appointments that the patient can keep.
- coordination and planning for following up on tests and studies for which confirmed results are not available at the time of discharge.
11. Provide telephone reinforcement of the discharge plan and for problem solving two to three days after discharge.
Home Health Clinicians have a unique perspective

How can we help?
Together, we can make a difference!
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