Managing Care Transitions between Acute and Long Term Care

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Pain Points

• Medication reconciliation
• Discharge needs assessment & planning
• Care coordination & post-acute services
• Communication & handoffs
• Patient & caregiver engagement and support
• Advanced serious illness / complex cases
• Equipment
Promising Practices

Project RED: Re-engineered Discharge

• Designed and tested at Boston University Medical Center as an project of the Agency for Healthcare Research and Quality – toolkit available online

• Includes comprehensive discharge planning, discharge education, and post-discharge patient follow-up

• Discharge preparation workbook and many forms in English and Spanish such as simple med lists
Promising Practices

Project RED: Re-engineered Discharge

• Texas Experience - Nacogdoches Medical Center

• Exemplar describes:
  • Teach-back method for patient meds
  • Follow-up calls to patients within days of DC
  • Scheduled doctors' appointments for patients
  • Transportation to appts as needed
  • Educated staff at skilled nursing facilities
Promising Practices

BOOST: Better Outcomes for Older adults through Safe Transitions

• Initiative led by the Society of Hospital Medicine to improve the care of patients as they transition from hospital to home.

• Emphasizes a patient-centered approach & engagement

• Focuses on identifying risk of re-admission and specific interventions to mitigate potential adverse events

• Improves information flow between hospital and outpatient providers and H-CAHPS scores related to DC.
Promising Practices

BOOST: 8 P’s Risk of Adverse Events post DC

1. Problems with medications (> 10 meds, high risk)
2. Psychological (depression)
3. Principal diagnosis (guidelines)
4. Physical limitations (deconditioning, frailty)
5. Poor health literacy (unable to teach-back)
6. Patient support (social isolation, PCP)
7. Prior hospitalization (non-elective in prior 6 mos.)
8. Palliative care (identify pts who would benefit)
Promising Practices

• Transitional care

“a set of actions designed to ensure the continuation and continuity of healthcare as patients transfer between different locations or different levels of care.”

• Based on comprehensive care plan & well-trained practitioners with current information about the patient’s goals, preferences, and clinical status

• Includes logistics, patient & family education, and coordination among healthcare professionals

• Decades of research shows reduced readmissions and improved outcomes
Promising Practices

Transitional Care Bundle – 7 Essential Interventions

1. Medication Management
2. Transition Planning
3. Patient and Family Engagement
4. Information Transfer
5. Follow-up Care
6. Healthcare Provider Engagement
7. Shared Accountability across Providers & Organizations
Promising Practices

PArTNER: PATient Navigator to rEduce Readmissions

- PCORI funded transitional care model that is specifically targeted to Minority-Serving Institutions (MSIs).
- Increased support to patients and caregivers at the hospital through the transition home to reduce readmission rates and patient anxiety.
- Community health worker acts as a patient navigator, visits in hospital and at home & peer telephone support.
- Designed in collaboration of patients and caregivers to address their specific needs.
Promising Practices

PArTNER: PATient Navigator to rEduce Readmissions
Promising Practices

Medical Orders for Scope of Treatment (MOST) forms for Palliative Care patients going to skilled nursing facilities

Follows the national POLST paradigm – Physician Orders for Life-Sustaining Treatment

Operationalizes advance directive documents
Resources

• Project RED Toolkit

• BOOST – Institute for Clinical Systems Improvement
  https://www.icsi.org/_asset/x4glet/BoostPPT.pdf

• National Transitions of Care Coalition
  http://www.ntocc.org/ Resources for patients, providers, policymakers, and evaluation software for quality improvement
Resources

• PATient Navigator to rEduce Readmissions
  https://www.pcori.org/research-results/2013/patient-navigator-reduce-readmissions-partner-study

• MOST/POLST
  http://www.coalitionqec.org/polstmost.html
  http://polst.org
Questions / Discussion

What’s on your mind about managing transitions from acute to long term care?