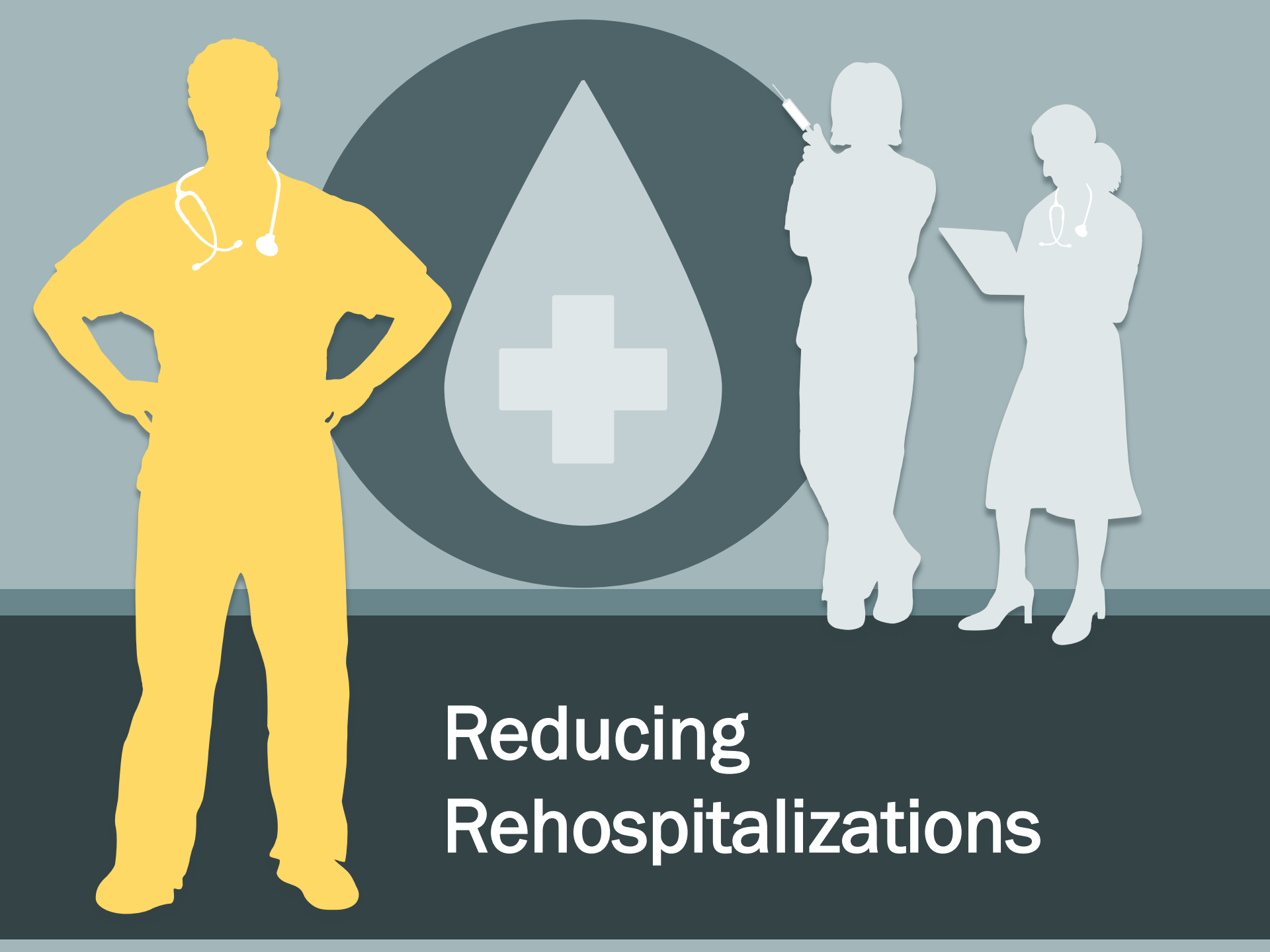

Reducing
Rehospitalizations

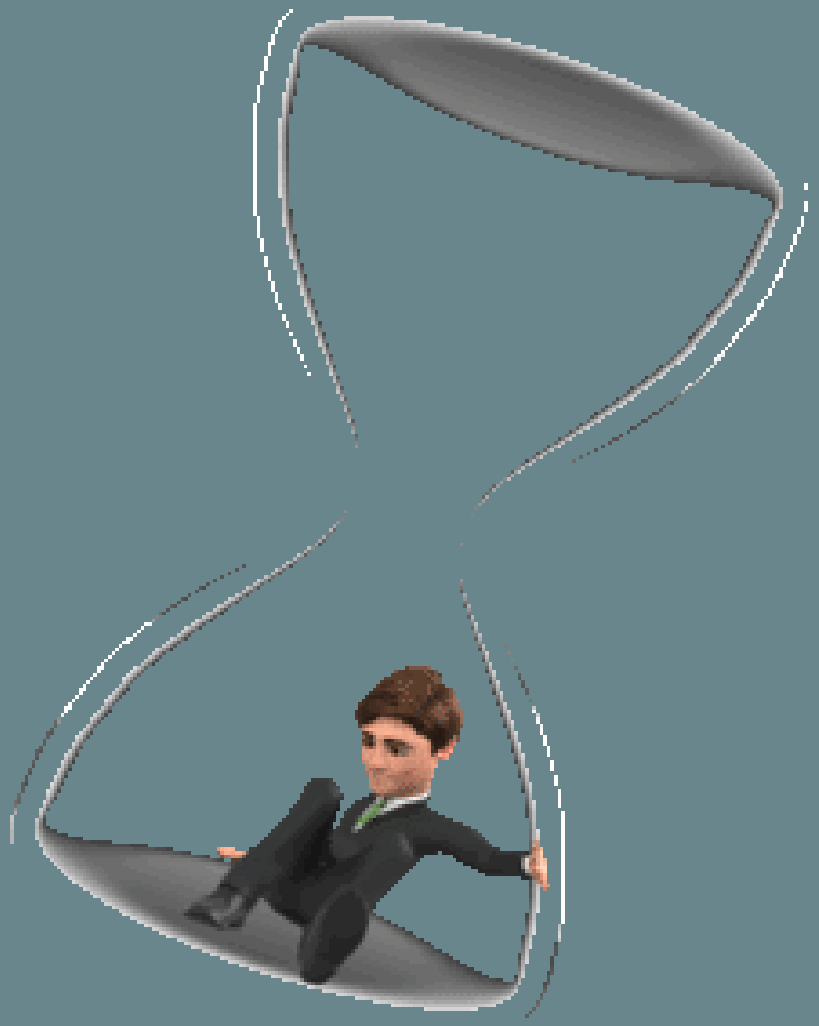
“The movement patients make between healthcare practitioners and settings as their condition and care needs change during the course of chronic or acute illness”

…Dr. Eric Coleman

What is Care Transitions?

Multiple Transitions

Critical: Hospital to home is the transition that place the patient at highest risk



Transition dysequilibrium

Transitional Care Multiple Models

Naylor/Coleman etc:
all proven effective

Key to ANY model:

- Patient Centered Care
- Evidence Based Mgmt
- Health Care Literacy
- Attention to Handover Communication

Most important:
HOSPITAL TO HOME
Ensure necessary handover components in system

Transitions of Care Standards

The American Case Management Association established national standards of practice for case management, and now broadens its scope to include the development of Transitions of Care (TOC) Standards.

The phrase **Transitions of Care (TOC)** describes a process of transferring a patient's care from one setting or level of care to another, such as from hospital to home or hospital to skilled nursing facility. These transitions are particularly vulnerable points in the healthcare continuum.

The ACMA TOC Standards provide a framework – applicable across all care settings – to implement and evaluate a process to improve care transitions.

$26 Billion

Spent on poor transitions of acute care Medicare patients per year.

Standard 1.0
Identify patients at risk for poor transitions

Standard 2.0
Complete a comprehensive assessment

Standard 3.0
Perform and communicate a medication reconciliation

Standard 4.0
Establish a dynamic care management plan that addresses all settings throughout the continuum of care

Standard 5.0
Communicate essential care transition information to key stakeholders across the continuum of care

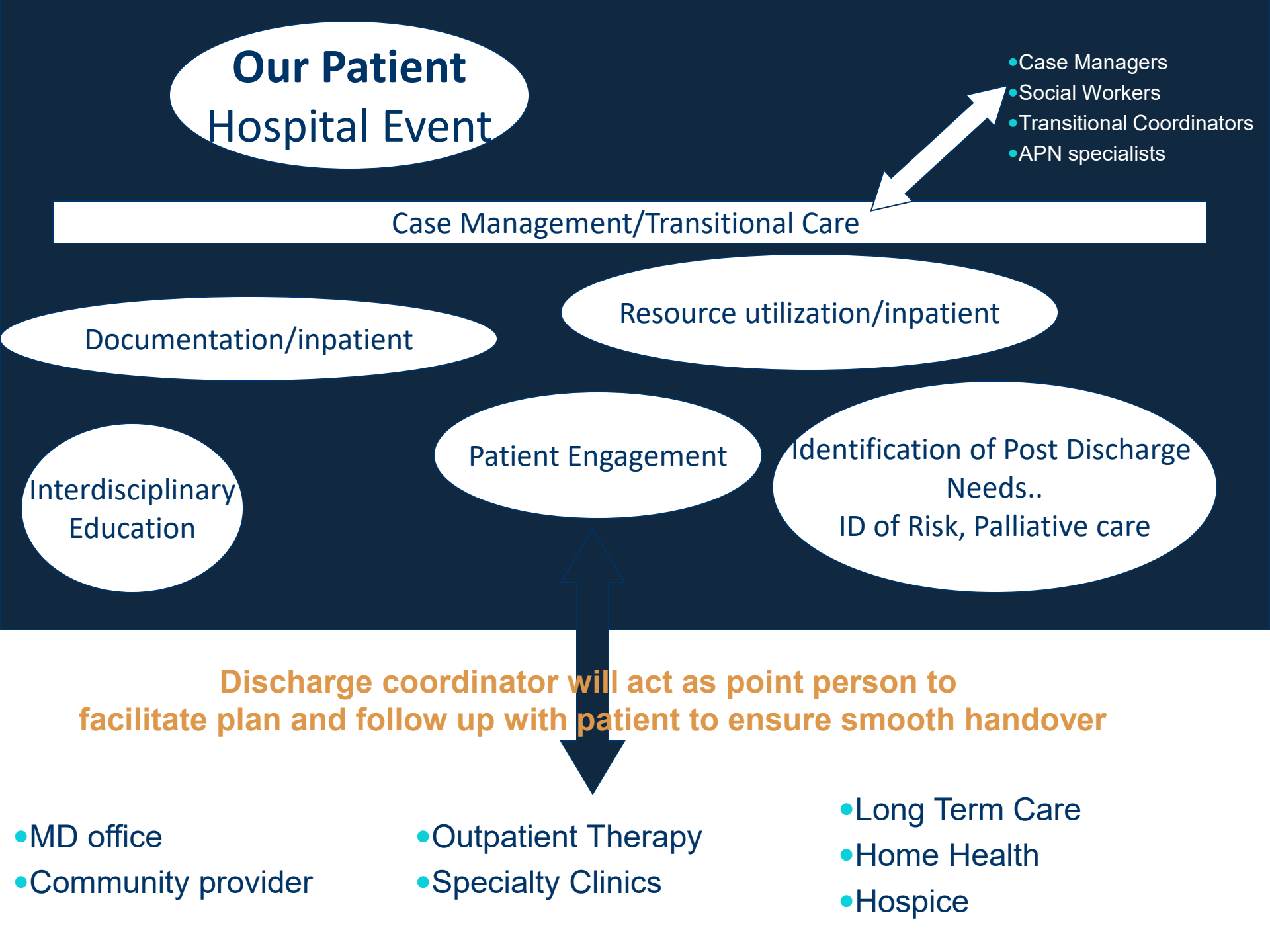
What do we have?

What do we need?

Who does the disch plan?

- With the patient or TO the patient
- Extend beyond the next level – 6 month plan

Who is the point person to navigate the patient to the next level?


Our Patient
Hospital Event
•Case Managers
•Social Workers
•Transitional Coordinators
•APN specialists
Case Management/Transitional Care
Documentation/inpatient
Resource utilization/inpatient
Interdisciplinary Education
Patient Engagement
Identification of Post Discharge Needs..
ID of Risk, Palliative care
Discharge coordinator will act as point person to facilitate plan and follow up with patient to ensure smooth handover
•MD office
•Community provider
•Outpatient Therapy
•Specialty Clinics
•Long Term Care
•Home Health
•Hospice

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Essential Components:

Effective handover to next level

Evidence based practice

Patient and family Engage-ment

Partnership between care levels and home care

The animation automatically begins.

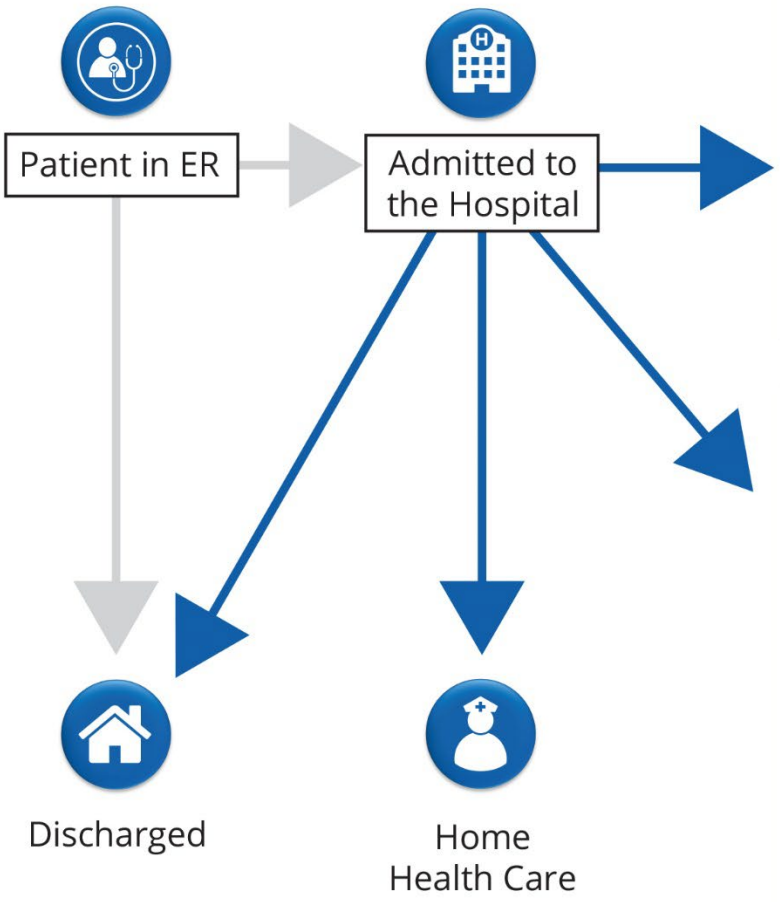
Transition of Care Needs

- Medical History/Problem list
- Medical care complications
- Medication reconciliation
- Known Psychosocial roadblocks
- Wound assessment and care
- PCP follow-up

Transition of Care: The movement of patient from one practitioner or setting to another

Transitional Care: A set of actions ensuring the coordination and continuity of care as patients transfer between locations or levels of care

Transition of Care vs Transitional Care



TRANSITIONAL MEDICINE

Outpatient Assistance

- **Independent Living Facility (ILF)**
  Patients can still live independently but have access to assistance when it is needed.
- **Assisted Living Facility (ALF)**
  ALFs provide additional assistance with prescription management and hygiene, among other types of basic care.

Inpatient Assistance

- **Skilled Nursing Facility (SNF)**
  SNFs provide 24-hour care and patients are seen anywhere from two times per month to as often as once a day.
  3 Types of SNFs:
  Long Term, Skilled Care and Palliative Care
- **Inpatient Rehab Facility (IRF)**
  Patients are closely supervised by a physician with specialized training, receive 24-hour rehabilitation nursing and daily rehab therapy.
- **Long Term Acute Care Facility (LTAC)**
  Patients are provided the highest level of care for patients with complex medical conditions and intense, specialized rehabilitation and treatment.

Transition of Care vs Transitional Care

Reducing Rehospitalizations

- Observation
- In-Patient
- Acute Rehab
- Swing Bed/SNF
- Home Health
- Chronic Care Management

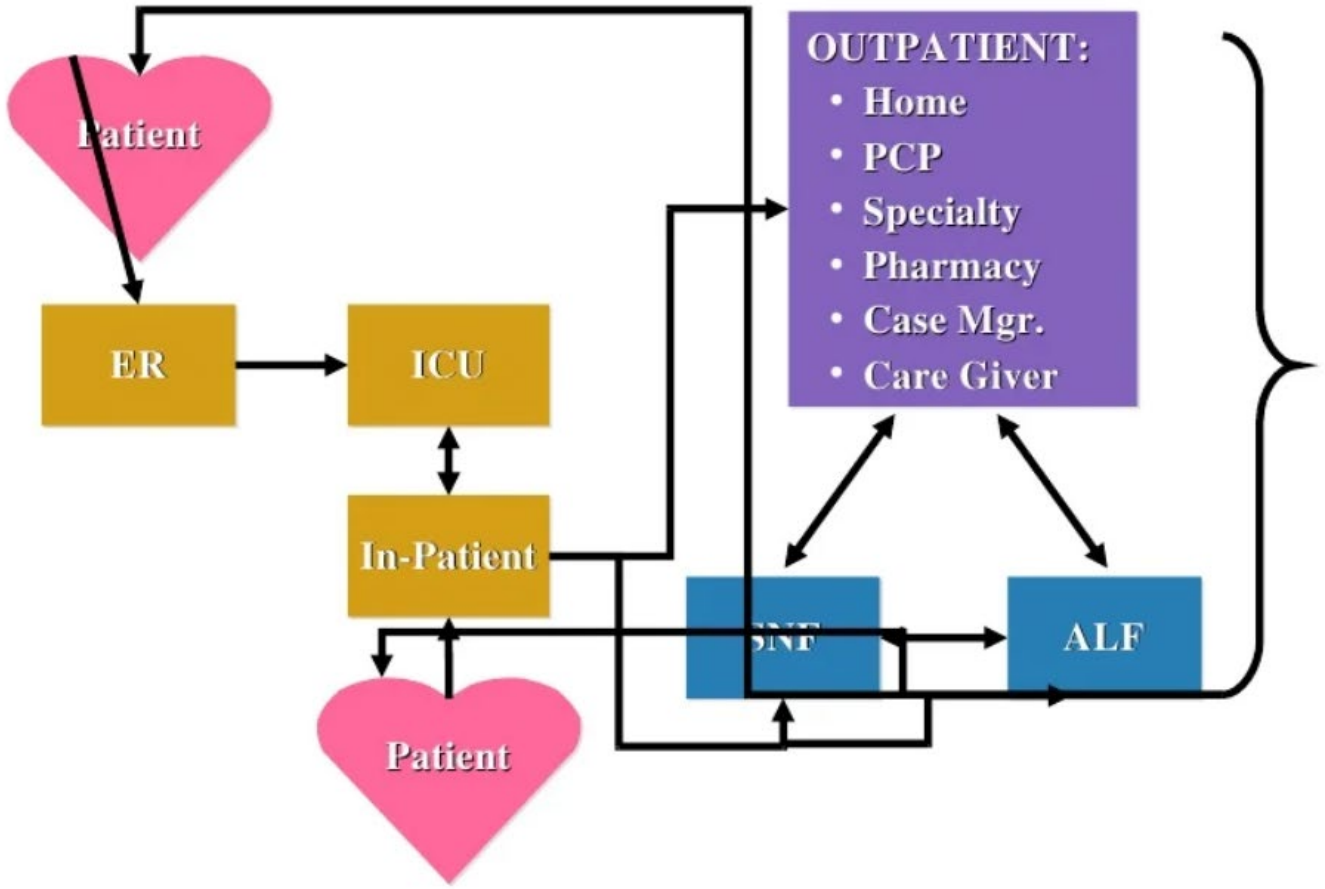
$26 Billion – spent on poor transitions of acute care Medicare patients/year

Right Care – Right Time

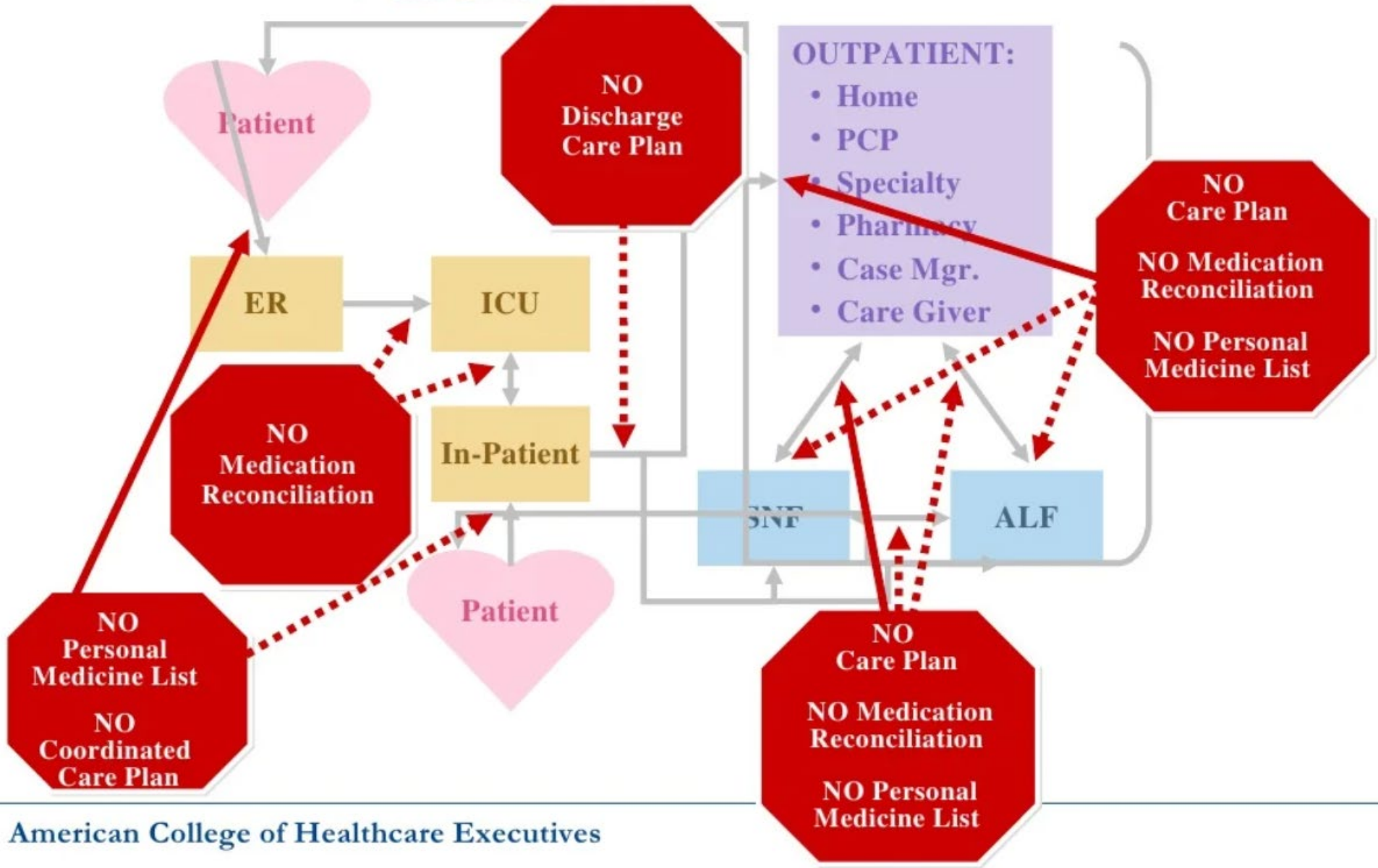
- Organizational Culture
- Differing Expectations
- Ineffective method of communicating
- Out of sync timing
- Not enough time
- Interruptions
- Inadequate staffing
- Lack of standardized procedures
- Client not included

Root Causes of Failure

Transition Issues Dramatically Impact Patient Care



Patient Care



Home Health vs Chronic Care Mgmt

Connecting patient "puzzle pieces" to maintain health, while preparing/monitoring for future events

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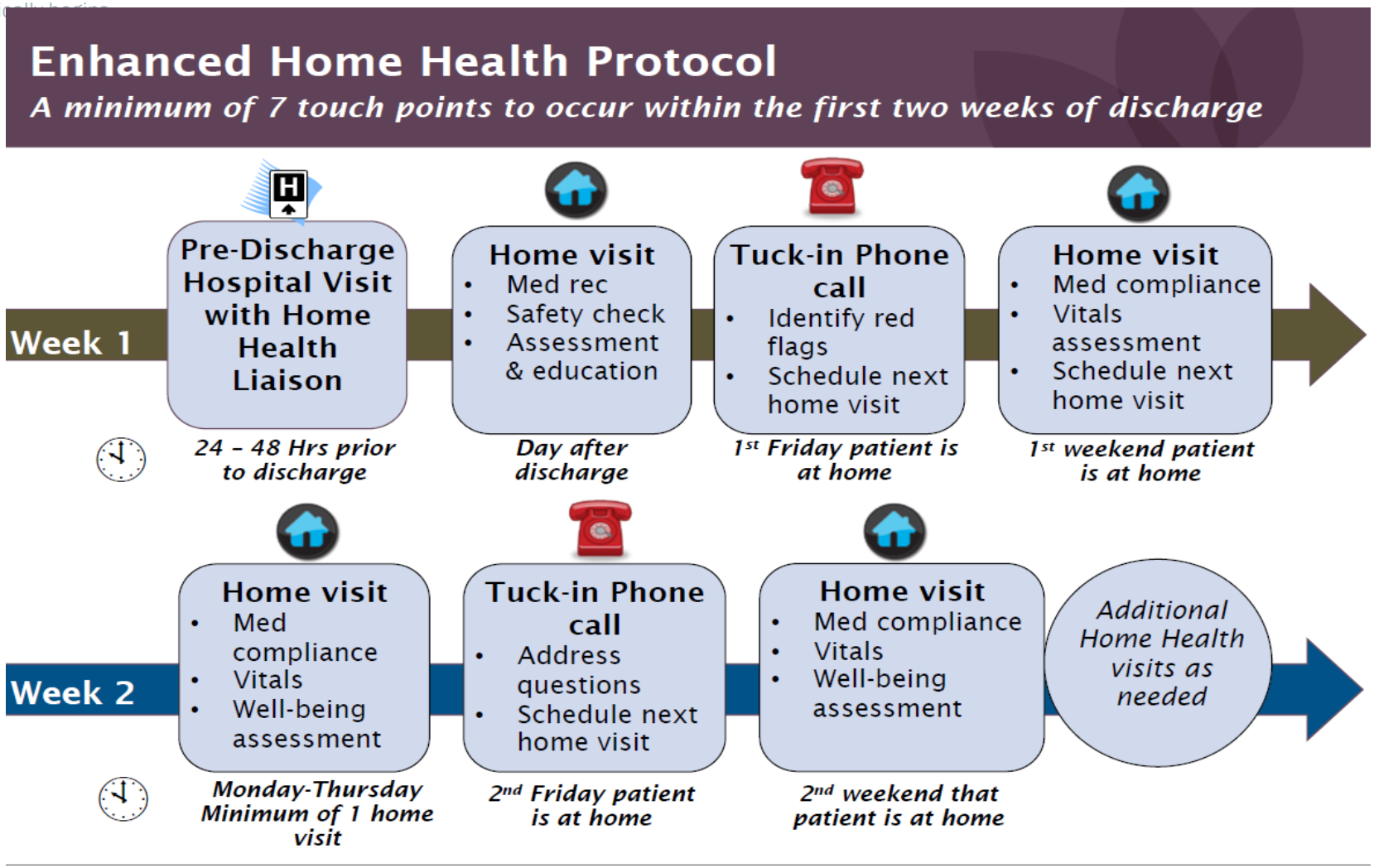

Low Tech Solutions to Reduce ACH

What are Tuck-In Phone Calls

Call to the patient shortly after admission and weekly on Thursday or Friday

- Do they have necessary supplies, medications
- Assess for Problems such as complaints of increased pain, wound issues, shortness of breath
- Reminder: Nurse on call 24 hours a day 7 days a week. Call afterhours number for concerns.

Ability to monitor cardiopulmonary status

- Blood Pressure
- Pulse
- Oxygen Saturation
- Weight

Ability to monitor Diabetes

- Blood Glucose

Remote Patient Monitoring

Chronic Care Management

Patient Centered Care

Patient Centered Care


TEAMWORK
Coming together is a beginning.
Keeping together is progress. Working together is success."
Henry Ford

Success

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Questions