Session Objectives

Participants will be able to:

- Describe the role of office practices and home health care in improving care transitions after patients are discharged from the hospital
- Describe elements of evidence-based transitional care models
- Describe various models for providing intensive care management for high-risk patients
- Identify successful models for advanced illness planning
Transitions into Office Practices

Evidence for Post Hospital F/U is Mixed

- Hernandez et al reported that patients with HF who were discharged from hospitals with lower rates of follow-up visits had a higher 30-day readmissions
- Kaiser Southern California found that older patients were 3 times more likely readmitted if they did not attend post-hospital follow-up
- Multi center VA study — those with post hospital visits had higher rates of readmission
- Mayo clinic study no difference in 30-day readmissions between those with and without a follow-up visits
Key Changes for Improving Transitions to the Clinical Office Practice

- Ensure timely and appropriate care following a hospitalization
- Prior to the visit: Prepare patient and clinical team
- During the visit: Review or initiate care plan
- At the conclusion of the visit: Communicate and coordinate ongoing care plan to other team members
CareMore Health Plan and Medical Group

- Post-hospital follow-up performed by hospitalists
- Hospitalists are profiled based on their readmission rates and are given 30-day readmission rate targets
- The hospitalists are financially rewarded when these targets are met or exceeded
- As a result, they are keenly engaged in post-hospital care and assume a major role in decision making about the timing and mode of post-hospital care

Capitol District Physicians’ Health Plan

- Provides financial incentives for primary care physicians to see their patients within 7 business days of discharge
- If accomplished, the practice may bill at the highest evaluation and management code level for a follow-up visit (99215) and receives a $150 bonus payment
- This program, coupled with a telephone assessment performed by a case manager, reduced 30-day readmission rates from 14 percent to 6 percent
Laying the Groundwork

• Meet with hospitalists to redesign summary
  – Action oriented
  – If/then statements
  – Mode and timeliness of communication
• Create access for hospital follow-up visits
Prior to the Visit

- Review discharge summary
- Clarify outstanding questions
- Reminder call to patient or family caregiver
- Stress importance of visit & address barriers
- Remind to bring medication lists and all meds
- Provide instructions for after-hours care

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During the Visit

- Ask the patient to explain his/her goals for visit and what factors contributed to hospital admission
- Perform medication reconciliation
- Instruct patient in self-management
- Explain warning signs and how to respond
- Provide instructions for seeking after-hours care

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At the Conclusion of the Visit

- Print reconciled, dated, medication list and provide a copy to the patient, family caregiver, home health care nurse
- Communicate revisions to the care plan to family caregivers, home health care nurses
- Ensure that the next appointment is made

Transitions into Home Health Care
Key Changes for First Home Health Care Visit Post-discharge

1. Meet the patient, family caregivers, and inpatient caregivers in the hospital and review transition home plan

2. Assess the patient, initiate plan of care, and reinforce patient self-management at first post-discharge home health care visit

3. Engage, coordinate, and communicate with the full clinical team
Reconcile and Manage Medications

- Within 24 hours of discharge, reconcile medications with discharge instructions with patients and family caregivers
- Verify that the patient has the needed medications and family caregivers are able to reliably obtain medications
- Check all medications and include herbal remedies, trial medications, over-the-counter medications, old medications, and physician administered medications such as injections

Self-management Support

- Identify key learners and discuss their goals for the transition
- Engage patients and family caregivers in early symptom identification and actions to take if needed
- Verify through Teach Back the patient’s and family caregivers’ understanding of the current medication list, what medications have been stopped, when medications need to be taken
- Assist the patient and family caregivers in problem solving any barriers to obtaining and taking the medications as prescribed
- Prepare patient and family caregivers for their first medical appointment by helping them identify their questions and assuring their medication list is current
IHI’s Framework:

**Improving Care Transitions**

- Transition from Hospital to Home or other Care Setting
- Supplemental Care for High-Risk Patients
- Transition to Community Care Settings and Better Models of Care
- The Transitional Care Model (TCM)

Key Design Elements:

- Patient and Family Engagement
- Cross-Continuum Team Collaboration
- Health Information Exchange and Shared Care Plans

Transitional Care Models
Key Elements of The Care Transitions Intervention®

- Adaptable to wide variety of care settings
- One home visit, three phone calls over 30 days
- “Transition Coach” is the vehicle to build skills, confidence and provide tools to support self-care
  - Model behavior for how to handle common problems
  - Practice or role-play next encounter or visit
  - Elicit patient’s health related goal
  - Create a “gold standard” medication list

Hospital Visit

- Introduce the Program and explain how it will feel different
- Introduce the Personal Health Record
- Schedule home visit (with family caregiver)

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Home Visit

- Patient identifies a 30-day health related goal
- Transition Coach models the behavior for how to resolve discrepancies, respond to red flags, and obtain a timely follow-up appointment
- Patient and Transition Coach practice or role-play next encounter(s)
- Patient identifies 2-3 questions for next encounter

Three Phone Calls

- Follow-up on active coaching issues
- Review the Four Pillars
- Estimate progress made in activation
- Ensure that patients needs are being met
Key Findings of The Care Transitions Intervention®

- Significant reduction in 30-day hospital readmits
- Significant reduction in 90-day and 180-day readmits (sustained effect of coaching)
- Net cost savings of $300,000 for 350 pts/12 mo
- Adopted by over 900 leading health care organizations in 42 states nationwide
- Please visit www.caretransitions.org

The Transitional Care Model (TCM)

The Transitional Care Model (TCM)

- Nurse Practitioners provide inpatient assessment
- NPs review medications and goals
- Design and coordinate care with patients and providers
- Attend first post-discharge MD office visit
- Direct home health care for 1-3 months
- Conduct home intervals
- Results:
  - Decreased the total number of readmissions at 6 months by 36% (37% v. 20% \(p<0.001\))
  - Decreased average total cost of care by 39%


Unique Features of the TCM

Care is delivered and coordinated…

...by same nurse
...across settings
...7 days per week
...using evidence-based protocol
...with focus on long-term outcomes

In RCTs, the TCM Has Consistently…

- Increased time to first readmission
- Decreased total 30 day all-cause readmissions
- Increased patient satisfaction
- Improved physical function and quality of life*
- Decreased total health care costs


Intensive Care Management
• Nurse Practitioners and Care Managers develop and manage personalized care plans
  – Coordinate multiple services
  – Help facilitate better communication between physicians, institutions, patients and their families
  – Help ensure effective integration of treatments
• Four levels of care, with each level involving different priorities and focus of care provided by the NP or CM
• Results:
  – Reduced hospitalizations by 45% with no change in mortality
  – Reduced emergency room visits by 50%

The Data Tells Us...

60% of people say that making sure their family is not burdened by tough decisions is “extremely important”
56% have not communicated their end-of-life wishes

80% of people say that if seriously ill, they would want to talk to their doctor about end-of-life care
7% report having had an end-of-life conversation with their doctor

82% of people say it’s important to put their wishes in writing
23% have actually done it

Source: Survey of Californians by the California HealthCare Foundation (2012)

Our Aim

The goal of The Conversation Project is to ensure that everyone’s end-of-life wishes are expressed and respected.
Get Involved!

- Explore the website
- Review the Conversation Starter Kit and share it with a friend or family member
- Enter your story
- Sign up to receive our monthly newsletter (email: conversationproject@ihi.org)
Advanced Illness Planning: Respecting Choices

- Created at Gundersen Lutheran in LaCrosse, WI
- Consider Advanced Care Planning (ACP) as a system and determine how to ensure patients and health professionals optimally interact across all care settings
- “The ultimate goal is to make sure that patients receive just the treatment they want based on truly informed decisions and to avoid over or under-treatment”
Gundersen Lutheran’s Advanced Care Planning

Results of our program compared to national average

- Started by the Twin Cities Medical Society based on Gundersen’s Respecting Choices program
- 3 part framework:
  - Develop infrastructures that encourage patient-centered planning
  - Train health professionals to encourage and facilitate advanced care planning
  - Engage and educate the community on advanced care planning
- Received support from 3 health plans
- Developed robust community engagement strategy “to demystify, to inspire, to model, to support, to prepare”