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 key elements of medication management
- Describe elements of evidence-based transitional care models
- Identify successful models for advanced illness planning
Transitions into Office Practices
How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations

Support for the How-to Guide was provided by a grant from The Commonwealth Fund.

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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 on-going care plan to other team members
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.
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
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
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
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
Self-management Support and Medication Reconciliation

Review the patient’s medication lists:

- Is it easy for patient or family caregiver to know each medication and reason for taking it?

- Is it “red stop sign” clear to patient and family which meds are discontinued?

- Can patient or family caregiver identify medications that should NOT be taken?

- Are changes from the previous list highlighted – what does that mean to the patient or caregiver?

- Are both generic and brand names included to help stop duplications?
Resources for Creating User-friendly Medication Lists

How to Create a Pill Card

For more information, please visit the patient safety and errors section at:
http://www.ahrq.gov/

Iowa Healthcare Collaborative (IHC) Med Card

For more information, please visit:
http://www.ihconline.org/aspx/consumerresources.aspx#MedCard_Anchor
# How to Create a Pill Card (AHRQ)

<table>
<thead>
<tr>
<th>Name</th>
<th>Used For</th>
<th>Instructions</th>
<th>Morning</th>
<th>Afternoon</th>
<th>Evening</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simvastatin 20mg</td>
<td>Cholesterol</td>
<td>Take 1 pill at night</td>
<td><img src="image" alt="Sun" /></td>
<td><img src="image" alt="Cloud" /></td>
<td><img src="image" alt="Sunset" /></td>
<td><img src="image" alt="Moon" /></td>
</tr>
<tr>
<td>Furosemide 20mg</td>
<td>Fluid</td>
<td>Take 2 pills in the morning and 2 pills in the evening</td>
<td><img src="image" alt="Sun" /></td>
<td><img src="image" alt="Cloud" /></td>
<td><img src="image" alt="Sunset" /></td>
<td><img src="image" alt="Moon" /></td>
</tr>
<tr>
<td>Insulin 70/30</td>
<td>Diabetes (Sugar)</td>
<td>Inject 24 units before breakfast and 12 units before dinner</td>
<td><img src="image" alt="Insulin" /></td>
<td><img src="image" alt="Insulin" /></td>
<td><img src="image" alt="Insulin" /></td>
<td><img src="image" alt="Insulin" /></td>
</tr>
</tbody>
</table>

Name: Sarah Smith
Pharmacy phone number: 123-456-7890
Date Created: 12/15/07
Medication Management: A Common Element of both Office Practice & Home Health
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.
The medication list should include clear instructions for how the patient should take each medication.

Reinforce when pre-hospital medications should be continued with the same instructions.

Highlight changes in the dose or frequency compared with pre-hospital instructions.

Identify pre-hospital medications that the patient should discontinue (a “red stop sign” to indicate when a medication should be stopped can be helpful).
Helpful Tips for Patients & Families

- Look for ways to simplify the medication regime.
- Identify medication schedules that are unrealistic in a home setting and propose a more realistic schedule.
- Use Teach Back to reinforce what the patient should take.
- Help the patient and family caregivers understand the importance of taking their list to all appointments and ensuring it is updated in real time.
Transitional Care Models
IHI’s Framework: Improving Care Transitions

- Transition from Hospital to Home or other Care Setting
- Transition to Community Care Settings and Better Models of Care
- Supplemental Care for High-Risk Patients

Key Design Elements:
- Patient and Family Engagement
- Cross-Continuum Team Collaboration
- Health Information Exchange and Shared Care Plans
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

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Hospital Visit

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

A Valued Partner in the Community: Your Local Area Agency on Aging

- Available in nearly every community in the US
- AAAs work directly with the older adult’s family to improve planning; providing additional services including transportation, in-home care services and case management; and providing or paying for home modification
- To find local resources please visit:
  - http://www.n4a.org/caretransitions
  - http://www.aoa.gov/AoA_programs/Tools_Resources/Care_Transitions.aspx
Advanced Illness Planning
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.
HAVE YOU HAD THE CONVERSATION?

Help get it out in the open. When it comes to end of life, I want mine to be...

261 people have spoken. Join them.

WHAT
it's all about

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.

Everyone has a story

"At that point I decided not only to honor my mother’s wishes, but also to give her the best possible death.”

HOW
to get started

Explore our Starter Kit for tools and tips to help you have the conversation.

WHY
it’s important

Explore Starter Kit

Read more

Processor 4.0

Everyone has a story

Have you had the conversation with a loved one? Or do you wish you had the chance? We want to hear about it.}

SHARE MY STORY

CONNECT WITH US:

SHARE YOUR SUPPORT

The Conversation Project depends on foundation grants, corporate sponsorships, and individual contributions to support its work. Please consider a gift to honor a loved one's memory.

DONATE NOW

The Conversation Project

In collaboration with The Conversation Project, a non-profit organization that promotes open communication about the values of life, death and care.

the conversation project
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)
Consumer Awareness About Palliative Care

How knowledgeable, if at all, are you about palliative care?

*Data from a Public Opinion Strategies national survey of 800 adults age 18+ conducted June 5-8, 2011.*
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

- Patients with an advance care plan
- Document in chart - Care team aware of wishes
- Care consistent with directive

National information: Research in Action, AHRQ, Issue #12, March 2003

Advanced Illness Planning: Honoring Choices Minnesota

- 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”
What has been your experience?
What can you teach us?