NTOCC
NATIONAL TRANSITIONS OF CARE COALITION

National Transitions of Care Coalition: Reducing Avoidable Hospital Readmissions

SPEAKERS

Jackie Vance, RNC, BSN, CDONA/LTC, FACDONA, IP-BC, ASCOM, CDP, LBBP
Senior Director of Clinical Innovations and Education
Mission Health Communities

Cheri, Lattimer, RN, BSN
Executive Director, National Transitions of Care Coalition (NTOCC)

Objectives

Identify the barriers to ensuring safe transitions between the various levels of care that contribute to avoidable readmissions

Discuss the traits of building a strong team culture to support quality transitions of care

Review the key interventions for developing a transition plan and improving communication and risk identification

Identify the available resources to assist with developing and improving transitions of care and reducing avoidable hospital readmissions

- There was an important job to be done, and **Everybody** was sure that **Somebody** would do it.
- **Anybody** could have done it, but **Nobody** did it.…
- *Everybody* blamed **Somebody** when **Nobody** did what **Anybod**y could have done.

– *Anonymous*

The Best Transition is one that never happens

– James E. Lett III, MD, CMD, Past President and Past Transition of Care Committee Chair-AMDA- The Society of Post-Acute and Long-Term Care Medicine

Preventing Transitions at the Post-Acute Level

- Why is transition planning essential in the post-acute level?
  - Patients with a SNF stay who we transitioned to acute care (unplanned) were almost twice as likely to experience a patient safety event (PSE) resulting in permanent harm, compared to those who did not have a recent SNF stay
  - Patients with recent SNF stays were 1.9 times more likely to experience a PSE that caused permanent harm while accounting for age, sex, race, and hospital type.
  - Patients with recent SNF stays had an average LOS of 6.6 days; 1.1 days longer than patients without recent SNF stays

BFCC NCORC Annual Preventability Report to CMS - 2023

~~Transfer~~ Trauma

- Transfers are common from SNF to hospital however, adverse events and complications upon transitions from SNF to hospital are common too[1]
- Transition from SNF to hospital expose patients to many risks[1], including delirium, undernutrition, serious infections, skin breakdown, and adverse drug reactions[2].

1. Creditor M. Hazards of hospitalization of the elderly. Ann Int Med 1993;118:219–223
2. Hutt E et al. Precipitants of emergency room visits and acute hospitalization in short-stay Medicare nursing home patients. J Am Geriatr Soc 2002;50:223–229

Transitions at the Post-Acute Level

- Studies show that approximately 24–29 percent of patients discharged from SNFs were readmitted within 30 days.[1-3]
- Transitional care of patients being discharged from SNFs present challenges because these patients are older, have multiple health conditions, often experience multiple transitions within a short period, and require continuing healthcare and social support.

1. Weerahandi, H., Bao, H., Herrin, J., Dharmarajan, K., Ross, J. S., Jones, S., & Horwitz, L. I. (2020). Home health care after skilled nursing facility discharge following heart failure hospitalization. *Journal of the American Geriatrics Society, 68*(1), 96–102. https://doi.org/10.1111/jgs.16179.
2. Singh, S., Eguchi, M., Min, S. J., & Fischer, S. (2020). Outcomes of patients with cancer discharged to a skilled nursing facility after acute care hospitalization. *Journal of the National Comprehensive Cancer Network: JNCCN, 18*(7), 856–865. https://doi.org/10.6004/jnccn.2020.7534.
3. Weerahandi, H., Li, L., Bao, H., Herrin, J., Dharmarajan, K., Ross, J. S., Kim, K. L., Jones, S., & Horwitz, L. I. (2019). Risk of readmission after discharge from skilled nursing facilities following heart failure hospitalization: A retrospective

Silos and Poor Communication

- Many care teams continue to work in a siloed environment rather than integrating the workflow into coordinating care across the continuum of care
- Multidisciplinary teams need improved communication among the team members and their patients and family caregivers

Break Down the Barriers

1. System level barriers
2. Practitioner level barriers
3. Patient level barriers

System

Universal health information exchange systems designed to facilitate timely transfer of patient information across care settings do not exist

Existing computerized record systems are often incompatible with one another

Financial incentives to promote transitional care, collaboration across sites, and accountability are lacking

E.g., confusing reimbursement for care coordination, health plans have incentives to prescribe or substitute medications according to their own formularies

Practitioner

A single clinician rarely provides continuous care for a patient across care settings

Exacerbating the problem, clinicians caring for the same patient in different care settings do not communicate patient information to one another

Clinicians may consult multiple specialists about their patient, with each of these encounters potentially leading to additional tests and medications (or changes in) that may be unnecessary

Care managers and social workers, who once provided longitudinal care oversight across settings, now are predominantly assigned to specific care settings

Older patients with multiple problems may be assigned to more than one care manage

Patient/Caregiver

- Patients and caregivers presume that their health care professionals will take care of their needs across the continuum of care
    - and often assume incorrectly that the providers involved in their care are sharing adequate information.
- Older patients and their caregivers are often not adequately informed about their disease process and the next steps in their care so that they are able to optimize the care the patient receives in the next setting
- Patients and caregivers may not feel empowered to express their preferences or provide input to the patient's care plan
- The level of information provided to patients has not escalated proportionately with the complexity of the current medical model
- Differing cultural orientations, expectations, and barriers such as cognitive impairment, limited English fluency, and low literacy may prevent patients and care providers from communicating clearly

ACO – REACH Program

- The Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) program is a pilot program by CMS that aims to improve the quality of care for Medicare patients
- The Goals are:
  - Improving health equity: ACO REACH requires participating ACOs to have a plan for addressing health disparities in underserved communities
  - Reducing costs: ACO REACH aims to improve health equity while reducing costs.
  - Realigning financial incentives: ACO REACH realigns financial incentives with patient outcomes, rather than volume
  - Empowering primary care physicians: ACO REACH gives primary care physicians more autonomy to deliver care

CMS Value Based Care Program

- The 3 Components of Value Based Care
- Quality care:
  - Means that instead of focusing on treating you after you are already ill, healthcare providers focus on preventing disease and detecting conditions in their earliest stages when they are easier and less expensive to treat. (Chronic Care Management)
- Provider performance: our contribution to population health and savings
  - Treating in the nursing facility costs way less than in a hospital. For example, per day, a course of treatment involving peripheral IV fluids, IV antibiotics, oxygen, and nebulizers in the hospital will cost Medicare $10,000 in the hospital and approximately (state dependent) $600/day in the nursing facility
- Patient experience: Better health outcomes, through positive interaction with healthcare system
  - Think about it, will your residents have a better experience going through the triage system at the hospital, staying for hours on a gurney unattended, at a cold clinical environment, or getting the same care in an environment of those who know and care for them in a place they know

The CMS Incentives

- These incentives give us an opportunity to treat in place, reduce unnecessary transitions and support quality transitions of care

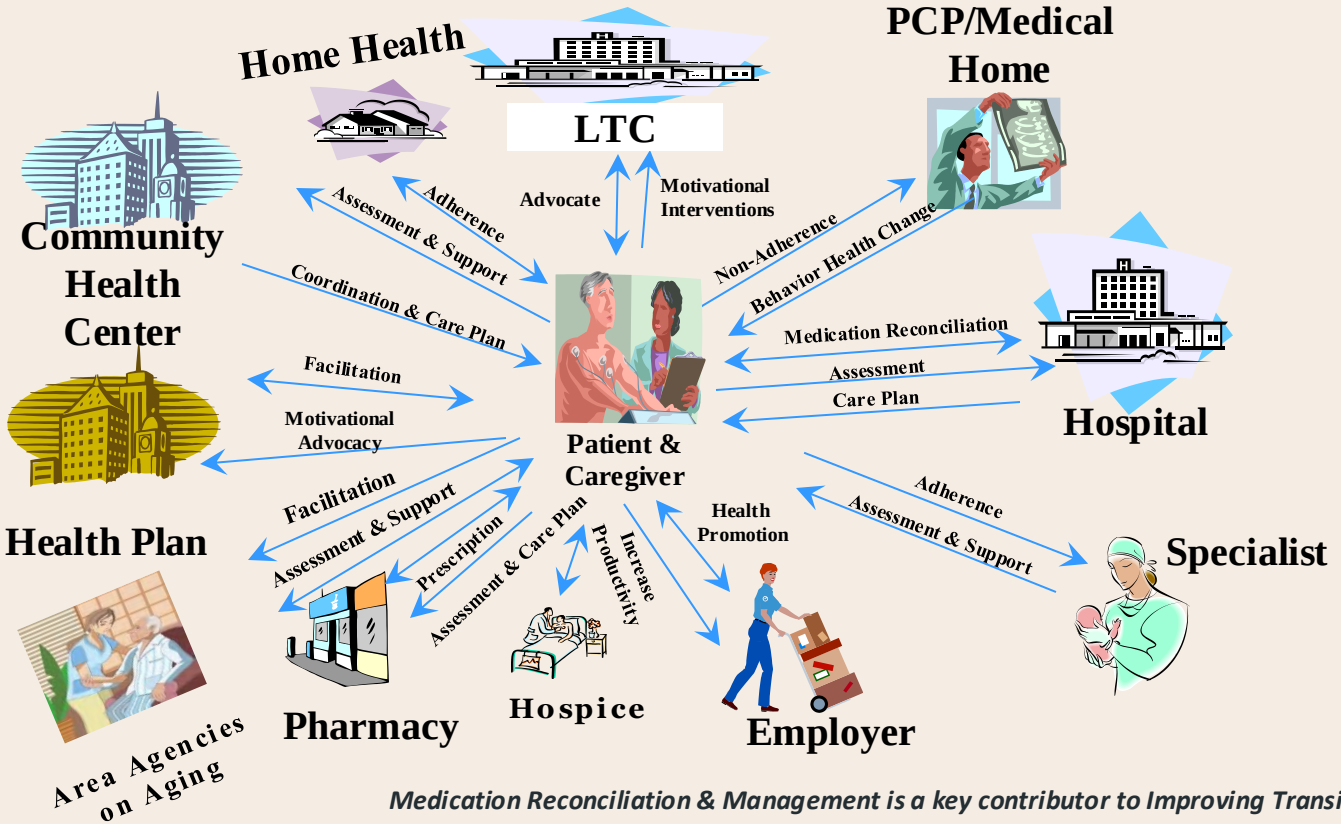
The Interprofessional Health Care Team

- Patient & Family Caregiver
- Primary Care & Specialist
- APN, PA
- Wellness or Health Coaches
- Lab and Radiology Professionals
- Rehab – PT, OT
- Administrative Staff
- Case Managers
- Community Health Workers

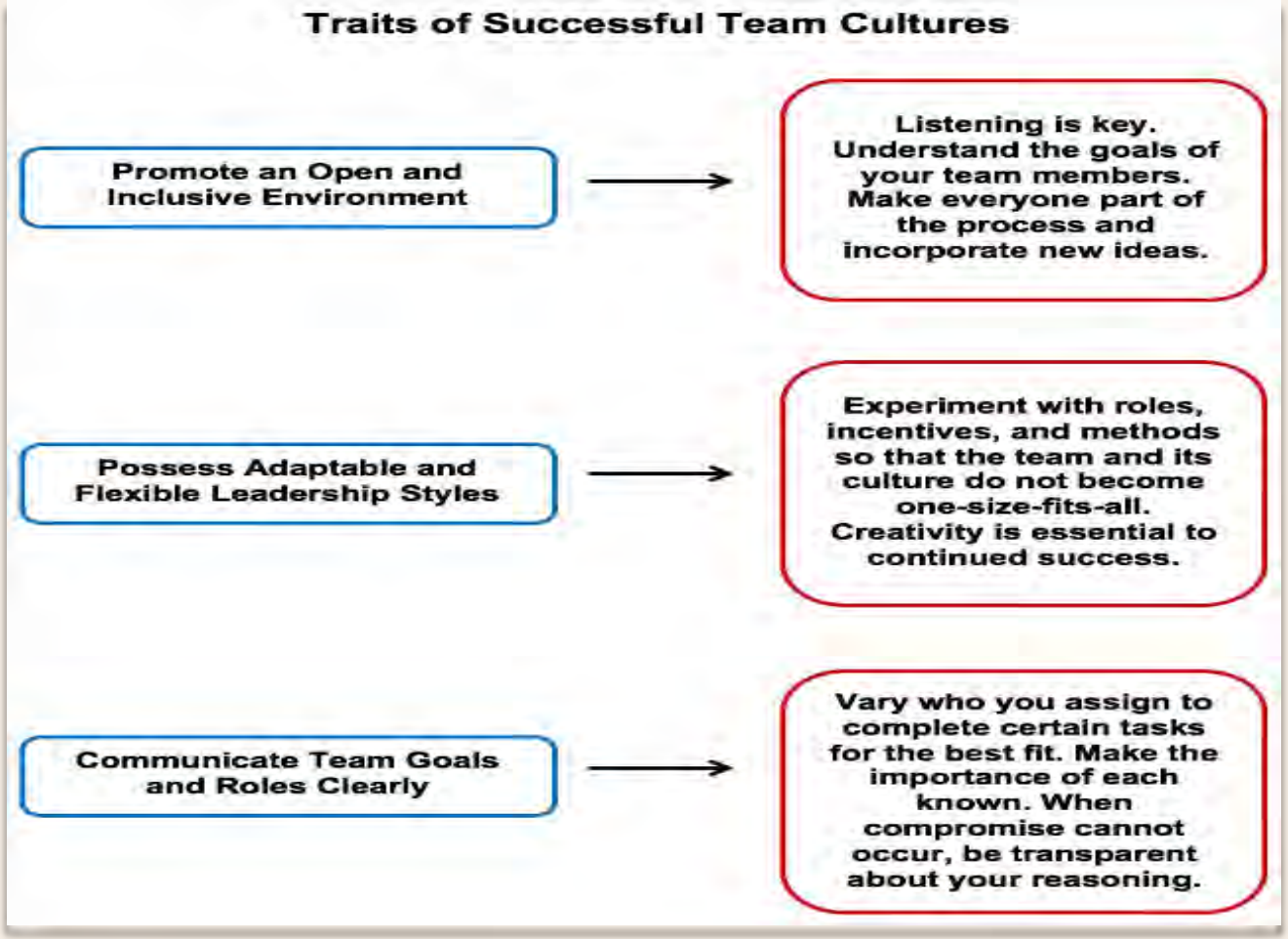
- Dietician
- Pharmacist
- Allied Health
- Hospitalist
- Nurses
- Mental Health
- Social Workers
- Patient Advocates
- Care Coordinator
- EMS Staff

Image by pch.vector on Freepik

The Playing Field for Care Coordination & Transitions of Care is Complex & Complicated



Medication Reconciliation & Management is a key contributor to Improving Transitions of Care



Sources: Harvard Business Review (1993), Jim Taylor, Ph.D. (2016)

https://www.theazaragroup.com/building-a-winning-team-culture-lessons-in-sports-corporate-america/

How Does Healthcare Define Team Culture?

NIH- Work culture is an organizational management concept that deals with the attitudes, beliefs, and perceptions of employees relative to the institution's principles and practices. In the healthcare setting, work culture determines how medical, nursing, ancillary staff, and other professionals work together to achieve organizational goals, whether they work in clinics, hospitals, health centers, or other health institutions.[1]

AMA - Think of your culture as a set of underlying rules and beliefs that determine how your team interacts with patients and each other. Culture is the way an organization “does business.” New team members may gradually absorb the practice’s culture without being taught or even noticing, but that process is not ideal. Having defined expectations and ways to achieve them can make all those in the medical practice feel part of the team.[2]

1) https://www.ncbi.nlm.nih.gov/books/NBK542168/
2) https://edhub.ama-assn.org/steps-forward/module/2702515

Collaboration is About Building a Team Culture

Collaboration among physicians, pharmacist, nurses, case managers, social workers, allied health supporting staff and community is critical to achieving the goals of the team, the organization and changing the way we deliver healthcare today

http://www.crystalgraphics.com/

Building the Team for Improving Transitions

Create and develop the team that comes together to really discuss how the roles fit together to ensure a safe and positive transitions

Do not assume any aspect of the process is someone else's responsibility – talk out the process and if needed develop a pathway

Communication is the most important aspect of using a team for delivering a positive outcome

When something isn't working bring it to the team and find the solution together – if unanswered it can lead to a negative current underlying the situation and the team

Don't be afraid to confront each other when there are differences of opinions – the strength of a team is resolving the issue together.

Having a strong care team means everyone steps up to ownership, responsibility and accountability – for a job well done and when things are not going right.

Seven Essential Intervention Categories For Designing Transitions Strategies for Patients & Caregivers Across the Continuum

7 Patient & Identified Family Caregiver Engagement /Education

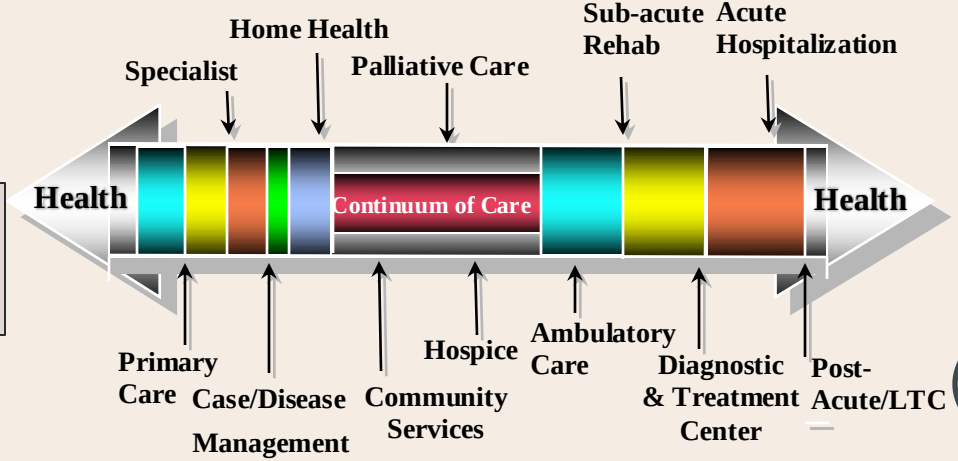
Nursing or social work case manager needs to conduct an assessment including SDOH and develops educational plan which is shared with care team and transferred to the next care setting

1 Medication Management Services & Coordination

Conduct & complete a comprehensive patient and caregiver medication intake and needs assessment, develop a medication plan which is shared with the collaborative care team – include a pharmacists

6 Physical Health, Mental Health/SUD, Social Determinants of Health Triune

Providers need to assess the whole individual. Ensure complete assessment of all areas to avoid missing crucial factors that may significantly affect others; they are not separate domains but integrated.



2 Transition Planning

Collaborative care planning & implementation, use shared decision making with patient & family incorporating findings of the patient assessment including Social Determinants of Health

3 Information Transfer

Implement bi-directional communication with provider to provider at the next level of care and provide information to the patient and family caregiver

5 Healthcare Provider Engagement & Shared Accountability Across the Healthcare Continuum

Identify interdisciplinary care teams: MD, Pharmacist, APN RN, SW, CM, allied health, community health workers, and community agencies to ensure that a healthcare provider is responsible for the care of the patient at all times

4 Follow-Up Care

Ensure timely access to medications and key healthcare providers & communicate importance to patients and their identified family caregiver

Medication Management Services & Coordination

Assess patient's medication list and needs

Assess Social Determinants of Health (SDOH)

Provide the patient and their identified caregiver education and counseling about medications

Develop and implement a plan for medication management services as part of the patient's overall plan of care

The care team members who are most likely involved;
Physician (s) – hospitalist, specialists, attending physicians
Pharmacists
Nurse
Case Manager – Social Worker, Nurse
Patient
Patient identified caregiver

Perform a complete medication review – for patients with polypharmacy concerns use your pharmacists

Make sure you address access to medications, financial costs, transportation, mobility, mentation.

Just talking with the patient and/or their caregiver is not enough to ensure understanding, follow through and adherence

At the acute level and post-acute level of care when transition if to home be sure you have a medication management plan and everyone if familiar with it.

Transition Planning

Clearly identify a practitioner (or team depending on setting) to facilitate and coordinate the patients transitions plan

Manage patient and their family identified caregivers' transitions needs

Use formal transition planning tools

Complete the transitions summary send it a timely manner and secure confirmation by the receiving entity

Develop and implement a plan for the use of medical devices and remote patient monitoring

Who are the team members ensuring this is done?
Physician
Pharmacists
Nurse
Social Worker
Case Manager
Care Coordinator
PT, OT
Discharge Planner
TOC Coordinator

The team contributes to the summary plan who is responsible for review and sending it to the next level of care?

Talk with the patient and their family caregiver hear their concerns and check the SDOH assessment.

Sending home O2, medical devices, or if there is remote monitoring be sure the family can support the use and management. Don't leave this to chance. Ensure the referral for all equipment is sent and received.

Post-acute transitions be sure all the transition instructions are clear and can be implemented at the next level of care. Never assume.

Patient and Their Identified Family Caregiver Engagement and Education

Ensure the patient and caregivers are knowledgeable about their condition and plan of care

Communicate transition information in a patient centered format & health literacy

Develop patient's self-care management skills

Facilitate patient engagement with technology including virtual visits

Care Team Members Responsible for Engagement and Education;
Physician
Pharmacists
Nurses
Social Workers
Case Managers
PT,OT, Respiratory Therapists
Dietitian
Care Coordinator

Don't take for granted the patient's or their caregivers' knowledge about their condition.

When teaching self-management skills use the "teach back method".

In today's world of technology and virtual visits, assess the patient's and caregiver's technology access and literacy. Provide a guide for preparing for a virtual visit.

Information Transfer

Implement clearly defined communication models

Use of formal communication tools

Clearly identify practitioner(s) to facilitate timely transfer for essential information – at the point of discharge most appropriate but at least with in 24 hours of discharge

Care team members engaging the patient, family and next level of care providers;
Hospitalists
Attending physicians
Specialists
Pharmacists
Nurses
Social Workers
Allied health staff – PT, OT, Respiratory Therapist, Dietitian

Models for during and post discharge for better communication.

Using an EHI or other personal health record support, ensure that the patient and family can access it and know how to use it.

Use specific transfer tool, transitions record or summary – does the patient know how to access?

Ensure the patient and their caregiver have a copy of the transfer information and have discussed appropriate interaction with the next level of care provider.

Follow-Up Care

Ensure patients and their identified family caregiver has timely access to key healthcare providers after an episode of care as required by the patient's condition and needs

Communicate with patients and their caregiver and other healthcare providers post transition from an episode of care

Care team members involved:
Hospital physicians
Primary Care physicians
Case manager – social worker, nurse
Transitions of Care Coordinator
Discharge Planner
Post-Acute Providers & Staff

Set the follow up appointments and make sure the patient is available and has transportation.

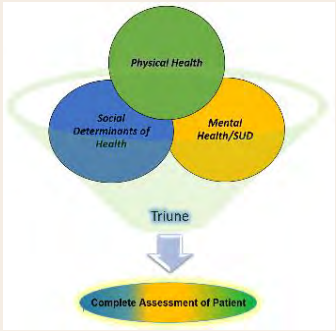
Has the primary care provider been notified and is that coordinated with any specialists' appointments.

Ensure the patient and caregiver are aware of follow up phone calls or virtual visits. Frequency of contact and who they should call with questions or concerns.

Confirm any community agency follow, or ambulatory testing needed after transition.

Physical Health, Mental Health including Substance Use Disorder, Social Determinants of Health -

Ensure complete assessment of physical health, mental health including SUD and Social Determinants of Health (SDOH) to avoid missing crucial factors that may significantly affect the others; they are not separated but integrated.



Commitment of total care team members;

Support the whole individual and their identified family caregiver.

Ask the patient and their family caregiver about the home and community goals they would like to achieve.

Assess health related quality of life; self-care, mobility, usual activities, pain/discomfort, spiritual & cultural issues, anxiety, depression.

Consider a discussion with patients and their caregiver using the 4M's Framework; "What Matters", "Medication", "Mentation", and "Mobility", within the Age-Friendly Health System.

Communicate the outcome of these discussion to the next level of care.

Complete, document and share the patient's preference about their care options including life-care planning directives.

Provide periodic reassessment of needs and goals with revision of the interventions as needed.

Healthcare Provider Engagement & Shared Accountability Across the Healthcare Continuum

Ownership, responsibility and accountability for the care of the patient and their identified caregiver at all times

Establish the processes that improve transitions and care coordination at each level of care

Establish appropriate communication and networks with all levels of care

Assume responsibility for the outcomes of the care transition process by care teams at each level of care

This is a commitment of not only the care team, but administration and payers combined;

Establish the communication processes, roles and interaction between the interdisciplinary care team and with the care teams between the various levels of care within the continuum.

Identify and mitigate any gaps in the continuum of care, especially in rural communities.

Create checklists for transitions and relevant information needed for the level of care; SNF, Rehab Hospital, home health, physical therapy, palliative or hospice.

Monitor and measure the process and outcome metrics of the care provided.

Identify barriers to successful transitions and assess hospital and post-acute readmissions to determine key issues where quality improvement interventions may be needed.

Prior to any transition, notify the patient's identified family caregiver where and when the patient is being transferred – is the transition safe?

The ***checklist*** was developed to enhance communication among health care providers, between care settings (acute care to post-acute care, home, etc.), between clinicians, their patients and identified caregivers.

The checklist is a tool that care teams can utilize to build their specific tool for reinforcing the need to communicate patient care information during a transition of care.

NASW

NTOCC
NATIONAL TRANSITIONS OF CARE COALITION

CMSA

APPENDIX C
Elements of Excellence in Transitions of Care (TOC)

TOC Checklist

*The purpose of this checklist is to enhance communication—among health care providers, between care settings, and between clinicians and clients/caregivers—of patient assessments, care plans, and other essential clinical information. The checklist can serve as an adjunct to each provider's assessment tool, reinforcing the need to communicate patient care information during transitions of care. This list may also identify areas that providers do not currently assess but may wish to incorporate in the patient's record. Every element on this checklist may not be relevant to each provider or setting.

*For purposes of brevity, the term *patient/client* is used throughout this checklist to describe the client and client system (or patient and family). The *patient/client system* (or family), as defined by each patient/client, may include biological relatives, spouses or partners, friends, neighbors, colleagues, and other members of the patient/client's informal support network. Depending on the setting in which this checklist is used, providers may wish to substitute *resident, consumer, beneficiary, individual*, or other terms for *patient/client*.

Overarching Concepts

Engagement

- Maximize patient/client involvement in all phases of intervention by promoting self-determination and informed decision-making.
- Provide educational information to support the patient/client's participation in the plan of care.
- Protect patient/client's right to privacy and safeguard confidentiality when releasing patient/client information.
- Affirm patient/client dignity and respect cultural, religious, socioeconomic, and sexual diversity.
- Assess and promote the patient/client's efforts to participate in the plan of care.

1

https://static1.squarespace.com/static/5d48b6eb75823b00016db708/t/5d49bc833b48f80001f154bc/1565113475856/TOC_Checklist.pdf

The Concepts of a TOC Checklist

- Engagement
- Collaboration
- Strengths-based Assessment
- Assessment as an on-going process

Common Elements for Assessment & Intervention

- Physiological functioning
- Psychosocial functioning
- Cultural factors
- Health literacy and linguistic factors
- Financial factors
- Spiritual and religious factors
- Physical and environmental safety
- Family and community support
- Assessment of Medical issues
- Continuity/Coordination or Care Communication

Hand-over all Assessments to the Next Level of Care Provider/Facility

	Continuity/Coordination of Care
Y N	Does the patient/resident have a primary care physician? Send assessment/DC information to the PCP - Date
Y N	Does the patient/resident have a specialty physician, e.g. cardiologists? Send assessment/DC information - Date
Y N	Does the patient/resident have a psychiatrist or other mental health provider? Send the assessment/DC information - Date
Y N	Does the patient/resident have an outpatient case manager or community health worker who should be notified? Send the assessment/DC information - Date
Y N	Ensure all transition services and care (medications, equipment, home care, SNF, Rehab, Hospice) are coordinated and documented – Date verified
Y N	Ensure patient/resident and caregiver understand all the information and have a copy of the care plan, assessment, and DC information with them – Date verified

We are working in teams in almost every level of care services – acute, post-acute, ambulatory, palliative, hospice, community – but are we successfully communicating, coordinating care and transitions across the continuum as a team.

To make this work is to see the world of healthcare from a different perspective – we are not running a game by ourselves but running a relay in which each runner knows their job/role and won't let go of the baton until the other runner has it.

A physician once told me "if we truly thought about how we would want our mother or father treated in healthcare we would do so much better".

As you build your collaborative interdisciplinary teams use some of these concepts and together, we can build a better process and provide patients and their family caregivers a safer transition experience.

Questions