Introduction to Transitions of Care

Margie McLaughlin

Director of Education Development
What’s a LAN?

• **Learning Action Network**
  – Community of people connected through education, dissemination and sharing ideas and best practices
    • Dynamic!
    • Community of “sharers”
    • Share shamelessly!

• **Rhythm**
  – Prepare > Deploy > Pollinate > Review
What’s Pollination Education?

- **Method for spreading information**
  - Small learning modules with corresponding activities and engagement
    - How far and wide can you pollinate?
  - Pollination happens all throughout your organization
    - Collaborative-interdisciplinary (all the other teams!)
    - Everyone becomes involved and aware of the work that is being done
    - Families, residents too!
How do we Pollinate?

• Creatively!!
  – Table tents in the break room
  – Posters, bulletin boards
  – Resident/Family Council meetings
  – Progress boards
    • How many staff have filled out the survey, watched the video, attempted the homework assignment

• Create awareness, transparency energy

• Make it fun and worthwhile
What will the Series 1 topics include?

- Introduction to Transitions
- Integrating QAPI into Transitions
- Preventing Adverse Events
- Interact Training
- Reducing Healthcare Acquired Conditions
- Advanced Directives
- End of Life Care
- Discharge to Community
- Improving areas of clinical risk
- Getting a Seat at the Referral Table
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These topics contain evidence-based practices that, when applied in SNFs, can have the most effective and dramatic results.

- Example: Jewish Home
Intended Outcome

• Save Lives and Improve Care by ensuring that our staff:
  – have a vast working knowledge of transitions and all of its many related facets
  – know what to do and
  – have a sense of confidence that they’re doing the right thing

• As a community we become adept at transitions
Preparing for Series 1 (03/26-04/26)

1. Review the instructions that accompany this webinar
   a) Who is the Champion
      • And alternative
      • Who is the team
   b) Check your computer equipment
   c) Make a plan
      • For rolling out the education program
      • Getting staff/families engaged
   d) Complete the QAPI Assessment (also in survey monkey)
   e) When you are all done submit your responses in the survey monkey
      • This is the means by which you will receive your link to the modules
Introduction to Transitions of Care: Foundations

Margie McLaughlin
Director of Education Development
From a system perspective, a safe transition from a hospital to the community or a nursing home requires care that centers on the patient and transcends organizational boundaries.

Learning Objectives

• Participants will:
  – Review key definitions
  – Identify settings that constitute the LTC Continuum
  – Examine the issues

*Use the Introduction to Transition of Care Foundations Worksheet*
Transitions of Care

- **Transition of care** refers to the movement of patients between health care locations, providers, or different levels of care within the same location as their conditions and care needs change.
A transition of care can occur . . .

- **Within settings:**
  - e.g., primary care to specialty care, intensive care unit to ward;

- **Between settings:**
  - e.g., hospital to subacute care, ambulatory clinic to senior day-care center;

*And also . . .*
A transition of care can occur . . .

• Across health states:
  – e.g., curative care to palliative care or hospice, personal residence to assisted living; or

• Between providers:
  – e.g., generalist to specialist practitioner, acute-care provider to palliative care specialist, hospitalist to primary care practitioner (PCP).
Transitional Care is

- Transitional Care a set of actions designed to ensure coordination and continuity of care
Transitional Care

• Transitional Care should be based on:
  – a comprehensive care plan
  – the availability of well-trained practitioners who:
    • have current information about the patient’s treatment goals
    • preferences
    • health
    • clinical status
Transitional Care

- It includes:
  - logistical arrangements
  - education of patient and family
  - coordination among the health professionals involved in the transition
Examples

It is common for residents in the long-term care continuum (LTCC) to be transferred from one care setting, level of care, or caregiver team to another.

For example:

1. A resident of a center within the LTCC who experiences an acute change of condition may be transferred to the emergency department (ED), admitted to the hospital, and ultimately discharged from the hospital back to the original care setting.

2. A resident of a senior apartment complex may be hospitalized for a surgical procedure, transferred to a skilled nursing facility (SNF) for rehabilitation, and subsequently transferred either back to his or her senior apartment or, if unable to resume living independently, to an assisted living community (ALC).
Care Coordination

• Care coordination is the deliberate organization of patient care activities among two or more participants (including the patient and/or family) involved in a patient’s care to facilitate the appropriate delivery of health care services.
Care Coordination

• Organizing care involves the marshalling of personnel and other resources to carry out all required patient care activities.
• This is often managed by the exchange of information among participants responsible for different aspects of the care.
Long-term Care Continuum (LTCC)

- The long-term care continuum (LTCC) is a comprehensive, longitudinal, patient-centered system of formal and informal health and support services intended to improve, maximize, or stabilize, when possible, the function of patients with chronic disease across various settings over an extended period of time and to provide compassionate care at the end of life.
The Long Term Care Continuum (LTCC)

• Encompasses a broad range of sites of care
• Look at all of these!
<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Nursing Home/Skilled Nursing Facility (SNF)</td>
<td>An SNF (also known as a nursing home) is a place of care for people who require 24-h nursing and rehabilitation for chronic medical conditions or impaired mental capacity and who have significant deficiencies in activities of daily living. The goal of care is to assist the individual in achieving his or her highest level of function and well-being. Both SNFs and NFs care for frail elderly patients and younger adults with physical disabilities (although pediatric and other specialized SNFs also exist). Many SNFs and NFs offer special care units (e.g., dialysis, ventilator units).</td>
</tr>
<tr>
<td>Subacute (“Step-Down”) Care Facility</td>
<td>Subacute or “step-down” care can be the bridge between an acute hospital stay and a return to a community home. It combines aspects of both the hospital and the SNF to reduce the cost of services while maintaining quality of care. This type of care requires frequent patient reassessment and review of the clinical course and treatment plan for a limited time period, until the patient’s condition has stabilized or a predetermined treatment course is completed.</td>
</tr>
<tr>
<td>Long-Term Acute-Care Hospital (LTACH)</td>
<td>Patients who require long-term (usually longer than 25 days), clinically complex acute medical care qualify for admission to an LTACH, which is typically a free-standing unit, although it may be located within an acute-care hospital (i.e., hospital within hospital). LTACHs often specialize in respiratory/ventilator care and accept patients from intensive care units. They may also provide other specialized services such as post-stroke rehabilitation, with the goal of preparing the patient to return to his or her community home.</td>
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<td>Type</td>
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<td>Intermediate-Care Facility for the Mentally Retarded (ICF/MR)</td>
<td>An ICF/MR provides care for individuals with mental retardation or developmental disabilities. Services provided are based on client needs, which vary according to age and level of disability. Individuals may reside in the facility from youth until old age; thus, the facility becomes a permanent home and its staff a second family. Common goals of ICF/MRs are to assess each individual’s level of functioning and help each person achieve his or her potential through education and training.</td>
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<td>Assisted Living Community (ALC)</td>
<td>An ALC provides care for individuals who need some help with activities of daily living (ADLs) yet wish to remain as independent as possible. A middle ground between independent living and nursing homes, ALCs aim to foster as much autonomy as the resident is capable of. Most facilities offer 24-h supervision, most often by nonlicensed staff, and an array of support services that may include medication management and dementia care services.</td>
</tr>
<tr>
<td>Continuing Care Retirement Community (CCRC) or Life Care Facility</td>
<td>CCRCs offer accommodations at many levels, including independent and assisted living, as well as medical and nursing services up to and including SNF care. Some CCRCs also offer special-care units (e.g., for patients with Alzheimer’s disease). Residents are cared for as they age and their health status changes.</td>
</tr>
</tbody>
</table>
| Senior housing                                                      | Under the Fair Housing Act, “housing for older persons” is housing that:  
  ♦ is specifically designed for occupation by elderly persons under a Federal, State, or local government program;  
  ♦ is occupied solely by persons who are 62 or older; or  
  ♦ houses at least one person who is 55 or older in at least 80% of the occupied units, and adheres to a policy that demonstrates intent to house persons who are 55 or older.  

The Housing for Older Persons Act of 1995 (HOPA), eliminated the initial requirements for “significant services and facilities” within designated senior housing units or areas. Benefits to senior housing may include location near shopping or medical facilities, security features, safety-equipped (handrails, pull cords) units, and community activities or transportation. Housing options may include luxury retirement living, moderate apartment-style living, or rent-assisted/low-income housing. |
| Adult Day Care                                                      | Families who are unable to provide supervision for a family member during the day due to job responsibilities or other obligations may use adult day care. Adult day-care centers can offer supervision, social and recreational activities, lunch, and possibly health-related oversight during the day for adults who may need care outside of the home or residential care facility. Adult day care also offers respite for those who might normally care for a family member at home. |
| Hospice | Hospice is a concept of care designed to provide comfort and support to patients and their families when a life-limiting illness is no longer appropriate for cure-oriented treatment. The focus of care is on relieving symptoms and supporting patients as they approach the last stages of life. Hospice care involves a team-oriented approach that incorporates expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient’s needs and wishes. Although many hospice patients are diagnosed with cancer, hospice services are also available to patients with AIDS, Alzheimer’s disease, heart disease, neurological disorders, pulmonary disease, and other terminal illnesses. Hospice care can be provided in any care setting. |
| Palliative Care | Palliative care is best understood as a system of care based on a patient-centered, quality-of-life model that values patient autonomy and focuses on anticipating, preventing, and treating the suffering of patients and families regardless of diagnosis or stage of illness. Although the palliative paradigm differs from the more traditional illness-centered, curative model, palliative care can be integrated into curative and restorative treatment plans. Thus, no specific therapy should be excluded from consideration as a palliative treatment if it can enhance comfort or improve the patient’s quality of life. Palliative care is usually delivered by an interdisciplinary team. Multiple disciplines are needed to address medical, nursing, and other therapeutic aspects of care and to meet the patient’s or family’s needs for social, emotional, and spiritual support. (Reference: American Medical Directors Association. Palliative Care in the Long-Term Care Setting. AMDA: Columbia, MD 2007) |
What’s the issue?

• It is also all too common for adverse events and avoidable complications to occur as a result of poor communication and coordination among caregivers, health care professionals, and the patient during such transitions.
Poorly Executed Care Transitions

• Increase hospital readmissions, duplicate services, and waste resources.
• They are the leading cause of medication errors, which frequently result from lack of coordination between prescribers across settings.
• It is often unclear which practitioner is responsible for the patient in the interval between discharge from one setting and admission to another.
High Risk

• Some older adults are at particular risk for transition problems following a hospitalization.
• Those with multiple medical problems, cognitive deficits, or depression or other mental health problems; isolated seniors; non-English speakers, immigrants, and refugees; and those with few financial assets are especially vulnerable.
How big?

• Jencks et al recently estimated that close to one fifth of all Medicare beneficiaries discharged from the hospital are readmitted within 30 days, that 90% of these readmissions are unplanned, and that the cost to Medicare of unplanned rehospitalizations amounted to $17.4 billion in 2004.
How big?

- Patients with heart failure accounted for 26.9% of all readmissions within 30 days; patients with pneumonia, 20.9%.
From where are the problems coming?

• Studies have shown that medication changes upon hospital admission or discharge are a frequent reason for adverse events. A prospective study of 151 patients admitted to general internal medicine units at a teaching hospital found that a regularly used medication was discontinued in 46.4% of cases; 38.6% of these omissions were considered to have the potential to cause moderate or severe discomfort or clinical deterioration.

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Benefits of Continuity of Care

• Evidence is mounting that efforts to ensure continuity of care for older patients during care transitions can improve patient outcomes.
• By improving core discharge planning and transition processes out of the hospital; improving transitions and care coordination at the interfaces between care settings; and enhancing coaching, education, and support for patient self-management; the rate of avoidable rehospitalizations can be reduced.
Will You Help?

• Creating safe transitions for our older patients is key to their well-being.

• Leading your team into a process of developing systems to ensure the safety and well-being requires a national commitment.
If everyone is moving forward together, then success takes care of itself.
— Henry Ford
References

AMDA:

- *Transitions of Care in the Long Term Care Continuum*
Introduction to Transitions of Care: Solutions

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Safe Transitions

Institutional Care

Fragmentation

Reimbursement Based on Volume

Individualized Care

Reimbursement Based on Outcomes and Value
Factors Associated with Low Rehospitalizations

- 47 Nursing homes in NY (N=26,746 patients)
- Measured Clinical and non-clinical factors associated with rehospitalization rates
- Three strongest predictors:
  1. Training provided to nursing staff on how to communicate effectively with physicians about a resident’s condition
  2. Physicians who practice in this nursing home treat residents within the nursing home whenever possible, saving hospitalization as a last resort
  3. Provided better information and support to nurses and aides surrounding end-of-life care

DANGER!!

- 1st 48 hours after hospital transfer/admission
- Transfers on Friday afternoons
- Critical thinking by staff
- Lack of close communication among CNA’s nursing and other NH staff and between nursing home staff and physicians/APRN’s
Strategies for Reducing Transitions

• Start with Staffing:
  – Follow the 20-50 Rule
  – What does Friday look like
  – Do staff know the plan
Strategies to Reduce Hospitalizations

INTERACT III
Is a comprehensive program that uses these strategies

• Track your rehospitalizations
• Improve Communication
  – Externally (e.g. with hospital/ER)
  – Internally (e.g. between nursing & physicians)
• Identify small changes in a resident’s status early on
• Change Staffing
  – Consistent Assignment
  – Reduce staff turnover
  – Utilize nurse practitioners
• Advance Care Planning
INTERACT II Program Tools

- Comprehensive approach to reduce hospitalizations
  - Acute care transfer log to track/measure rehospitalizations
  - QI Improvement review tool
    - Evaluation to assess each hospitalization (Root cause analysis)
  - Standard Transfer Form
  - Communication Tool with Physicians (SBAR)
  - Resident assessment tool & algorithms
    - Stop & Watch and Care Paths
  - Advance care planning resources

http://www.interact2.net