TRANSITIONAL CARE

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TRANSITIONAL CARE

Learning objectives:
• Understand the rising importance of transitional care
• Define transitional care and recognize several models of transitional care
• Explain the key components of transitional care
• Describe aspects of transitional care assessments and interventions
• Identify primary causes of readmissions and correlating interventions
• Learn to guide a chronic disease patient through patient engagement
• Apply learning through a case study
WHY TRANSITIONAL CARE NOW?

The Transition from Volume to Value

• In fee-for-service, the more we do, the more we get paid
• In Value based arrangements we get a fixed amount for each person
• Currently 35% of St. Luke’s reimbursement is under an “at-risk” arrangement
• 5% of patients are responsible for about 50% of health care costs
• Major diagnosis that account for that 5% are: CHF, COPD, DM, CKD, Cancer
• Most of the long term success or failure for those patient depend on lifestyle factors: diet, activity, avoidance of toxins (tobacco/ETOH)
TRANSITIONAL CARE

Defined: Transitions of care are a set of actions designed to ensure coordination and continuity. They should be based on a comprehensive care plan and the availability of well-trained practitioners who have current information about the patient’s treatment goals, preferences, and health or clinical status. They include logistical arrangements and education of patient and family, as well as coordination among the health professionals involved in the transition.

Care transitions occur when a patient leaves one care setting (i.e. hospital, nursing home, assisted living facility, SNF, primary care physician, home health, or specialist) and moves to another. For example:

1. Within settings; e.g., primary care to specialty care, or intensive care unit (ICU) to ward.
2. Between settings; e.g., hospital to sub-acute care, or ambulatory clinic to senior center.
3. Across health states; e.g., curative care to palliative care or hospice, or personal residence to assisted living.
4. Between providers; e.g., generalist to a specialist practitioner, or acute care provider to a palliative care specialist.
SOME MODELS OF TRANSITIONAL CARE

• Transitional Care Model – Naylor model
  • http://www.transitionalcare.info/

• Care Transitions Intervention Model– Coleman model
  • http://caretransitions.org/about-the-care-transitions-intervention/

• Better Outcomes for Older Adults through Safe Transitions - BOOST model
  • http://www.hospitalmedicine.org/BOOST/

• The Bridge Model
  • http://www.transitionalcare.org/the-bridge-model/

• Re-Engineered Discharge Program – Project RED
  • https://www.bu.edu/fammed/projectred/

• Guided Care
  • http://www.guidedcare.org/
KEY COMPONENTS OF TRANSITIONAL NURSING CARE

• Screening – target patients at high risk for poor outcomes
• Relationship building – foster relationships between patients, caregivers and providers
• Engaging patients and caregivers – develop collaborative care plans that honor patient’s preferences, values and goals
• Assessing and managing symptoms and risk factors – identify and address patient’s priority risk factors and symptoms
• Promoting self management of chronic conditions – educate to prepare patients to recognize yellow and red zone danger signals and take appropriate actions; encourage patients to embrace lifestyle changes; promote medication management
• Promoting continuity – foster communication between health care settings
• Coordinating care – promote follow up care and connections to needed health care and community resources
SCREENING CRITERIA AND RISK ASSESSMENT

Are the following statements true for the patient?

- Documented primary or secondary diagnosis of Congestive Heart Failure (CHF), Acute Myocardial Infarction (AMI), or/and Chronic Obstructive Pulmonary Disease (COPD)
- Lives within 30 miles of the discharging facility
- Not referred to Hospice
- Does not pose a risk to in home care provider

If yes to all on previous slide, must have one asterisked or two or more of the following risk factors:

- * PRIMARY DIAGNOSIS OF HEART FAILURE or COPD
- * HOSPITALIZATIONS WITHIN THE LAST 30-DAYS
- * ISSUES WITH MEDICATION OR TREATMENT ADHERENCE
- Poly pharmacy (6 or more medications)
- Two or more hospitalizations in the last 6 months
- Inadequate support system
- Age 80 or older
- Moderate to severe functional deficits (subjective assessment)
- Three or more comorbidities
OUTLINE OF A TRANSITIONAL CARE INTERVENTION

• Meet the patient at the bedside to introduce the program
• Communicate with inpatient team and participate in discharge plan
• Visit/assess patient in home within 3 days of discharge
• Coordinate needed care
• Attend medical office visits and participate in plan of care
• See patient in person or talk with patient by phone once weekly over a course of 30-60 days
• Graduate patient from program
COMPREHENSIVE IN HOME VISIT

• Physical
  Symptom assessment pertinent to reason for hospitalization and chronic conditions
  Vital signs  Focused Nursing/system assessment  Education

• Psychosocial
  Support system  Barriers to care  Depression/anxiety  Advanced directives

• Medications
  Reconciliation  Management/organization  Adherence  Education

• Discharge instructions/follow up care
  Appointments  Diagnostics  Instructions/self-care  Education

• Nutrition/diet habits
  24 hour recall  Knowledge of therapeutic diet(s)  Education

• Functional status
  • Home safety  ADLs/IADLs  Assistive devices  Education

• Goals and action plans
PRIMARY CAUSES OF READMISSION

- Gaps in care – premature discharge or timing of discharge, continuity of care
- Health condition/Change in status – high risk diagnoses/co-morbidities, pt lack of awareness/whom to contact
- Medications – barriers to adherence, errors
- Health care coverage – Medicare highest risk factor, self pay, Medicaid
- Plan of care - lack of goals of care discussions, pt unable to keep appointments
- Demographics and psychographics – race, gender, age, income
- Patient engagement – readiness to discharge, understanding of self care, understanding of follow up plan, connection/relationship with outpatient providers
Transitions of Care often boils down to Maslow’s Hierarchy!

Patients need a place to live, food, safety and security before you can address other barriers.

If a patient has to choose between food and medication refills...

If a patient is “non-compliant” with their prescribed low sodium diet but they only get meals-on-wheels...

If a patient is the primary caregiver for a disabled spouse...

If a patient lives at the shelter...

If a patient has untreated depression...

If a patient is being taken advantage of by one of their children...
3 primary causes of medication non-adherence:

1. Knowledge deficits related to the purpose and importance
   • Assess knowledge
   • Address knowledge deficits
2. Concern about side effects
   • Educate about purpose and SEs
   • Weigh benefit vs risk
   • Encourage discussion with provider
3. Financial burden - Utilize resources to identify lower cost options
   • Insurance company formularies
   • Low cost clinics
   • Pharmaceutical programs - http://www.needymeds.org/
   • Other - https://www.pparx.org/prescription_assistance_programs
PATIENT ENGAGEMENT/SELF MANAGEMENT

Heart Failure Self-Management Plan
- Green Flags — Doing Well
  - Your symptoms are under control
  - No symptoms of shortness of breath
  - No weight gain of more than 3 pounds in a day or 5 pounds in a week
  - Able to engage in your usual activities

- Yellow Flags — Getting Worse
  - Your symptoms are getting worse
  - Noticeable shortness of breath
  - Noticeable weight gain

- Red Flags — Medical Emergency
  - Unusual or severe shortness of breath
  - Unable to sleep
  - Inability to ambulate

Heart Disease Self-Management Plan
- Green Flags — Doing Well
  - No symptoms of shortness of breath
  - No weight gain or chest tightness

- Yellow Flags — Getting Worse
  - Noticeable shortness of breath
  - Noticeable weight gain

- Red Flags — Medical Emergency
  - Unusual or severe shortness of breath
  - Unable to sleep

COPD Self-Management Plan
- Green Flags — Doing Well
  - No chest tightness or shortness of breath
  - No weight gain

- Yellow Flags — Getting Worse
  - Noticeable shortness of breath
  - Noticeable weight gain

- Red Flags — Medical Emergency
  - Unusual or severe shortness of breath
  - Unable to sleep
What is Motivational Interviewing? “...a collaborative, person-centered form of guiding to elicit and strengthen motivation for change.” Braastad, J.

- The spirit of MI can be translated into five central principles summarized by the acronym DEARS:
  - Develop discrepancy
  - Express empathy
  - Amplify ambivalence
  - Roll with resistance
  - Support self-efficacy
OPEN ENDED QUESTIONS – MASTER IT!

Examples to use with chronic disease patients:

• What is most important to you right now concerning your health?
• What are you currently doing to care for your ____________?
• What does having ____________ mean to you?
• What are the most important components in caring for your ____________?
• Which behavior is particularly challenging?
• Which behavior would you like to work on?
• Which behavior would you be most successful changing?
SMART GOALS/ACTION PLANS

• Specific
• Measurable
• Attainable
• Relevant
• Time bound

In writing your action plan, be sure it includes:
1. What are you going to do?
2. How much are you going to do?
3. When are you going to do it?
4. How many days a week are you going to do it?

Example: This week I will walk (what) around the block 3 times (how much) before lunch (when)3 times this week (how many)
How confident are you? (0 = not at all confident; 10 = totally confident) ________
PUTTING IT INTO PRACTICE!

A glimpse at a patient’s journey:
53 y/o male referred to the Care Transition Program during hospital admission - dx acute decompensated systolic heart failure, ejection fraction 25%

Delving in – Face sheet, chart review, discharge summary, review of diagnostics, outpatient care review
DRIVERS OF READMISSIONS

1. Medication reconciliation
2. Identification of High Risk patients
3. Standardization of the discharge process
4. Communication/coordination with Post-Acute settings
5. Communication/coord with outpatient providers/services
6. Post-DC Care Coordination

PCP, specialty services
Community resources (e.g., volunteer groups)
Home Care
Home/Family/Caregiver
ALF
Facilities (SNF, rehab, LTAC)
The Face of Heart Failure

- 58 Year old male
- Coronary Artery Disease
- Diastolic dysfunction, Heart Failure Preserved Ejection Fraction with RV dysfunction
- Obstructive Sleep Apnea
- COPD (chronic obstructive pulmonary disease)
- Diabetes Mellitus
- Obstructive Nephropathy
- Chronic Kidney Disease, stage III
- Morbid Obesity
- Chest Pain
- Unspecified Depressive Disorder
- Unspecified Anxiety Disorder
- 34 prescribed medications on his medical record
Care Coordination Works….. But it takes a LOT of work!

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Over the two year period this patient saw 54 different providers (MD, APP, RN, LCSW, LMSW, RT, PT, DPM, OT)

“Never ever depend on governments and institutions to solve any major problems. All social change comes from the passion of individuals.” Margaret Mead
REFERENCES

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