Strategies for Managing Transitions of Care

Office Hours

Topics for discussion

Why managing care transitions is so important — especially from the ED to skilled nursing facilities

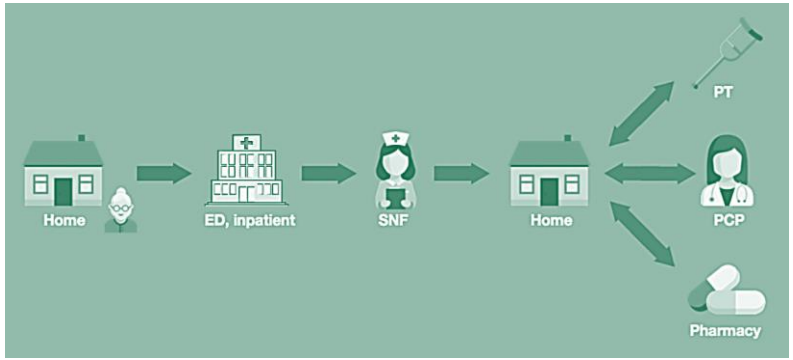
Best practices for managing transitions of care

Potential barriers to care transitions and how to overcome them

Why managing care transitions is so important

What are transitions of care?

Transitions of care involve efforts to ensure coordination and continuity while moving individuals from one setting of healthcare services to another. (Naylor and Keating, 2008)



Poorly coordinated care transitions

- Can lead to miscommunication among providers
- Cause confusion regarding treatment plans, duplicative testing, discrepancies in medications and missed physician follow-up
- Ultimately lead to fragmented care and patient dissatisfaction
- Hospital readmissions result from poor coordination, incomplete discharge planning or inadequate access to care

("Exploring Transitional Care: Evidence-Based Strategies for Improving Provider Communication and Reducing Readmissions" 2015)

Cost of avoidable hospital use

- The estimated annual cost of readmissions for Medicare is $26 billion annually and $17 billion is considered avoidable.
(Center for Health Information & Analysis)

- An estimated 13% to 27% of ED visits in the United States could be managed in physician offices, clinics and urgent care centers, saving $4.4 billion annually.
(Weinick, et al., 2010)

Challenges transitioning older adults

- Clinical complexity
- Multiple chronic conditions
- Higher acuity
- Multiple medications
- Poor comprehension of discharge instructions
- Dementia-related behavioral disturbances
- Under-utilized or unprepared caregivers

("Understanding transitional care provided to older adults with and without dementia: A mixed methods study" 2020)

Transitions to post-acute care

More than 40% of Medicare beneficiaries receive post-acute care after a hospital discharge.

(“Patient Outcomes After Hospital Discharge to Home With Home Health Care vs to a Skilled Nursing Facility” 2019)

Benefits of improved transitions

- Patient satisfaction
- Provider satisfaction and quality of collaboration among partners
- Reduced healthcare utilization and costs (e.g., readmissions)
- Health outcomes consistent with the patient's wishes

Best practices for managing care transitions

Collaboration

- Identify an interdisciplinary team from the hospital and SNF to design a care transition process, care plan, outcome metrics.
- Work to hardwire handoffs between the ED and SNFs.
- Establish points of accountability for sending and receiving (for emergency physicians and “SNFists”).
- Create ongoing dialogue with SNFs to standardize communication and care protocols.
- Discharge patients only to facilities that coordinate care and meet the hospital’s quality standards.

Collaboration (continued)

- Facilitate clinician-to-clinician communication when the transitions occur.
- Ensure SNF staff are ready and capable to care for the resident.
- Offer education or onsite support to SNFs so patients are less likely to be readmitted.
- Strategize to minimize movement of patients with the focus of treating patients in their originating setting when feasible.
- Educate ED staff about SNF capabilities.

Care management

- Discharge planning should start when patients are still in the ED whenever possible.
- Assess patient (psychosocial, cultural, health literacy and linguistic, financial, spiritual/religious, physical and environmental safety, family and community supports).
- Work with vulnerable populations, such as patients unable to verbalize their medical histories and needs.

Care management (continued)

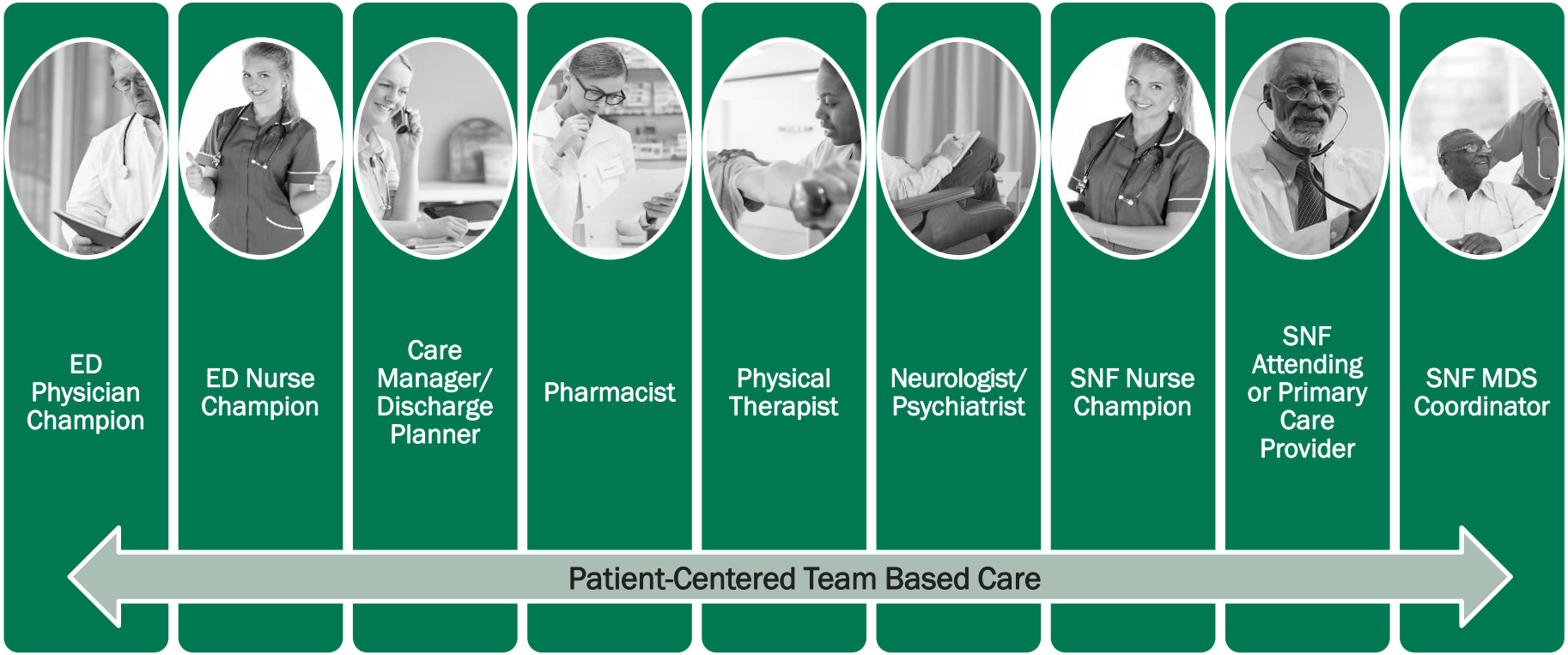
- Outreach to SNF and patient prior to transfer/admission to provide guidance and set expectations.
- Coordinate follow-up visit with PCP or “SNFist” w/in 7 days of discharge from ED.
- Patient/caregiver education using the "teach back" method.
- Reconcile the treatment plan and proactively plan for condition changes for high-risk patients.

Multidisciplinary team

Work with patients to address “whole person” care needs.

ADLs	Advance directives/end of life choices	Behavioral health	Ensure access to key providers (respiratory, PT, psych)	Follow-up appointment tracking	Medical follow-ups
Medication reconciliation	Mobility	Nutrition	Patient compliance	Primary care/ “medical home"	Referral tracking
Safety assessments	Self management support	Shared decision making	Telehealth for expanded access	Test tracking	Transportation

Multidisciplinary team (continued)



Shared care plan

- Proactive care plan that takes into account patient/family's preferences and is shared with all providers involved in the patient's care.

- Include: chief complaint/discharge diagnosis, procedures and tests performed and any results pending, medication changes, ED physician note, consultation notes (if applicable) and follow-up plan.

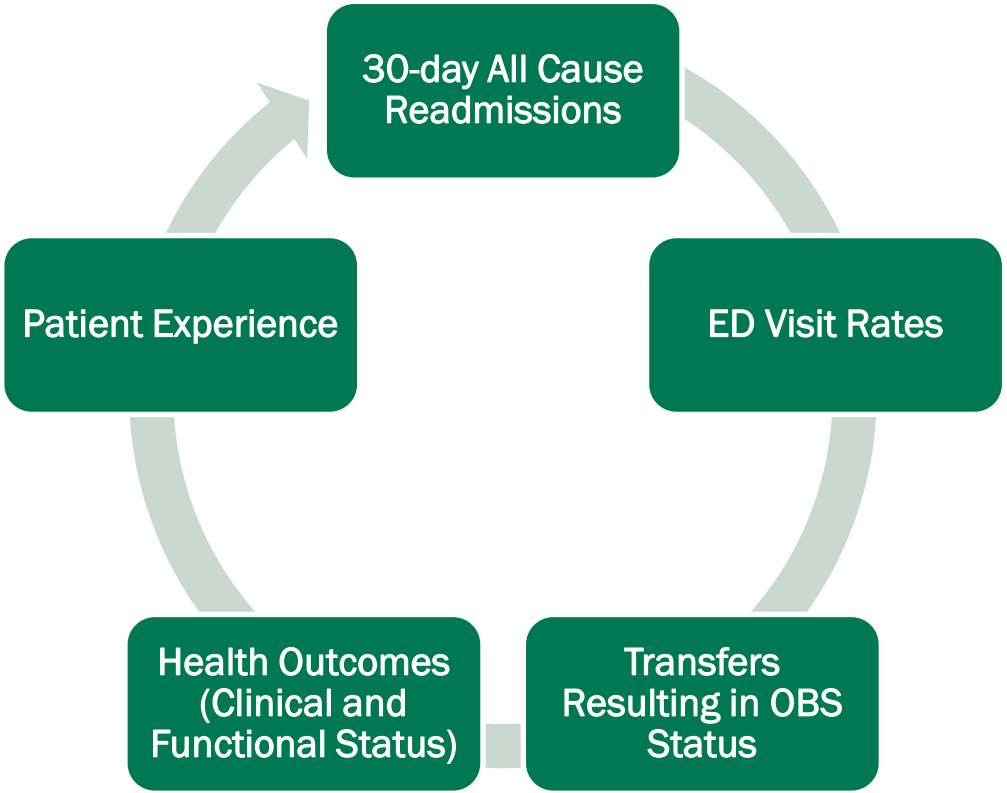
Patient engagement

- Prepare patient for transfer, educate for self-management, gain agreement w/transition and appropriate communication (language preference and health literacy).
- Ensure HIPAA-compliant discharge instructions are provided to family/care providers and/or SNF.
- Take care that the discharge summary is presented in a format suitable for older adults (large font, in lay terms).
- Engage the resident and family/caregiver in a partnership to create an overall plan of care.

Health information

- Implement an EHR system that includes standardized medication reconciliation elements.
- Ensure the EHR system is interoperable and information is available to both patients and providers outside your health system.
- Consider health information exchange for sharing care plans across the continuum using disparate EHRs.
- Work with EMR vendors common to EDs to produce transition support tools.

Measuring improvement



- Consider working with SNF partners to develop a CQI process.
- Agree on measures and set goals for improvement.

Potential barriers to care transitions and how to overcome them

Barriers

Strategies to overcome barriers

Measure Improvement and Quantify “Value” of Collaboration

Collaborate despite competing business motives	Process map an ideal transfer (from perspective of ED and SNF)	Enter into collaborative care agreement	Develop standardized transfer process and criteria
Accurate and timely information is necessary	Make best practice the standard of care	Physician engagement	Optimize team-based care

Commit to Continuous Quality Improvement

Additional resources

IHI's "How-to Guide: Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations"

ACEP's "Transitions of Care Task Force Report"

Journal of Emergency Medicine's "Sentinel Paper Review: Exploring Care Transitions FromPatient, Caregiver, and Health-Care Provider Perspectives" September 2021

GEDC's Optimizing Transitions between Nursing Homes and EDs in the Age of COVID-19 on-demand webinar

Discussion

Thank you.

The Statewide Voice for New York's Hospitals and Health Systems