Transitions of Care

Training and Education

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Transitions of Care Objectives

- Identify conditions and acuity appropriate for a post discharge call
- Review care team interventions to minimize complications and re-admissions
- Review the 7 essential intervention categories identified by the National Transitions of Care Coalition
- Case study application

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Transitions of Care

Transitions of care is defined as "the movement of patients between healthcare settings as their conditions change". Joint Commission

For the purpose of this pilot we will be focusing on the transition from the hospital to the primary care office.

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Transitions of Care Goals

Your input:

Key goals of completing the post-discharge call and follow up visit call subsequent to an ER visit and or hospital admission/discharge

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7 Essential Intervention Categories See hand-out

NOTCC identified the seven key interventions:

- Medication management
- Transition planning
- Patient/family engagement/education
- Information transfer
- Follow-up care
- Healthcare provider engagement
- Shared accountability across provider organizations

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Current Event Activity

1. Review the 7 Essential Intervention Categories developed by NOTCC
2. Read the Washington Post article

In your group identify:

1. How the use and awareness of the 7 essential categories could have prevented the outcome of this case?
2. For each of the essential categories where or how you see your role being involved?

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Source for patient identification or notification of admission discharge transfer (ADT)

- How will you be notified of ADT?
- How will you determine who will call patients?
- What will be your criteria and how will that assessment differ?
- When a non-licensed person completes the post-discharge call, will there be triggers indicating a licensed individual should follow-up?

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Post Discharge Phone Call PCP Office

- Ensures that patients are contacted by someone they know and with whom they have a relationship
- Follows the PCMH principles of the practice for patient care coordination
- Ensures continuity in the patient education process and provides an opportunity to assess the patients understanding of the post-discharge care and follow-up

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- Identify patients at risk for readmission
  - Admission due to a medical condition or an unplanned admission
  - Admission due to complications of a chronic condition
- Exclusions may include
  - Elective admissions – use clinical judgment if the patient has a chronic condition or is frail
  - Post delivery or maternity

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Transitions of Care Call Process:

- Call Preparation
  - Review patient discharge summary
  - Review and reconcile demographic information such as phone number/contact information, address, etc.
  - Medication reconciliation (discrepancies from hospital records and the EMR/medical record)
  - Review scheduled or outstanding testing and follow-up
  - Review scheduled or outstanding specialist care
  - Review the discharge date and complete the call within 24-48 hours
- Elicit patient concerns and questions
- Completing the Call
  - Assess care giver support
  - Assess patient's medical status
- CCM
  within 24-48 hours
  weekly x 4 weeks, or more frequently if indicated

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Completing the Call

- Completing the Call – callers other than the RN or CM
  - Schedule an appointment
  - Elicit patient concerns and questions
  - If questions/concerns become apparent follow the triage protocol
- Care Manager or RN
  - Assess care giver support
  - Assess patient's medical status using the assessment tool
  - Elicit patient concerns and questions
  - Assess risk and safety

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Patient and Family Engagement/Education

- Confirm the patients questions and needs have been met prior to ending the call
- Using teach back, confirm the patient understands the next steps, who to call with questions, and what is emergent/urgent
- Confirm the patient completed the post-discharge follow-up visit

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In Summary

- A good transition will result in:
  - Improved patient experience
  - Increased safety in the delivery of care
  - Better clinical outcomes
  - Reduction in re-admissions