

TBC Basics

Care Transitions, Evaluation, and Measurement

Today's Presenters



Susan J. Vos BSN, RN, CCM

Licensed RN in the State of Michigan with expertise in practice transformation, care management, quality improvement, and understanding of models of care and payment models in respect to the healthcare industry.

Lynn Klima DNP, APRN, CNE, ANP-BC

Dr. Klima is an adult nurse practitioner and academic nursing professor with over 40 years of experience spanning clinical practice, executive leadership, and nursing education. Her work focuses on leadership development, patient-centered care, and integrating evidence-based practices to improve outcomes across diverse care settings.



AGENDA



1	TBC Basics – Historical and Current TBC Model (1.5 hours)
2	Care Management & Care Coordination (1.5 hours)
3	Care Management & Care Coordination (1.5 hours)
4	Transitions of Care / Aims / Measurement / (1.5 hours)

Presenter	Topic	Time
Canada	Status update/activities from group	10 minutes
Team	Case Study Application	20 minutes
Sue	Transitions of Care	15 minutes
Lynn	Evaluation	15 minutes
Sue and Lynn	Measurement <ul style="list-style-type: none"> • Monitoring Improvement Process 	15 minutes
Sue	Next Steps	15 minutes

Team Actions

Review the assessment tools available in the medical record today.

- Where are there opportunities for improvement or development of new assessments?
- Identify the team member who will lead this initiative.

As a team:

- Determine what conditions you will start the initial focus on. For each condition, determine if there are treat-to-target goals that can be regularly monitored (ie PHQ for depression – goal is remission, a score of less than 5, A1C for diabetes – goal below X, ...)
- Finalize a self-management action plan that captures the patients motivation for healthy behavioral changes.
 - Establish a plan for implementation and use of these documents.

Review the communication tools. Select 1 tool to start with.

- Create a PDSA to identify what data you will collect to determine what is working and what requires modifications.
- Create an SBAR for one of the conditions the team would like to focus on (COPD, HF, Depression, Diabetes).
 - Discuss with the provider and clinical team members the key information needed from the situation and background for the condition in order to make decisions.



Care Management Process - Application

Utilizing Communication Tools

Facilitating Team-based Care

Case Study Mr. B

Applying TBC Concepts



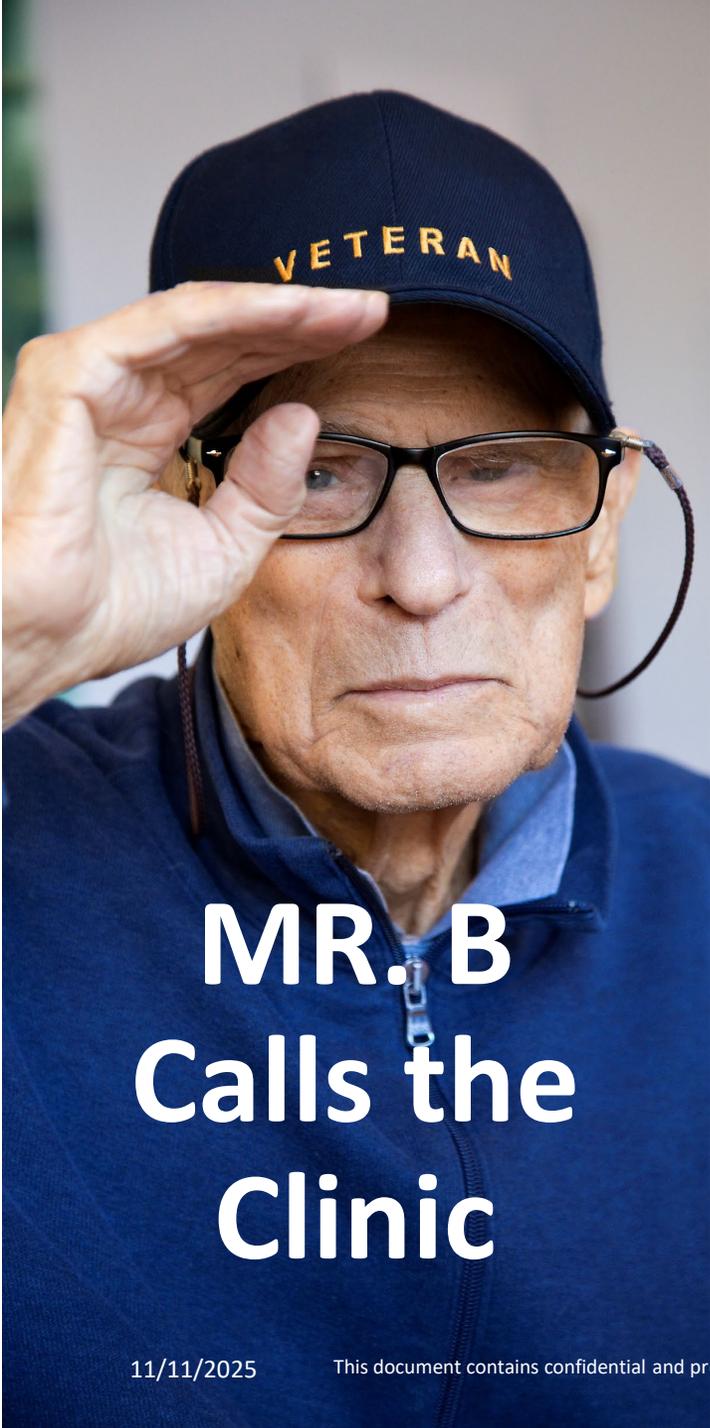
**Locate the case study in the workbook*

Current health status

- Increasing symptoms of fatigue, weakness, and shortness of breath, feeling low
- Difficulty Sleeping
- Has not been prescribed home O2
- Non-smoker

Knowledge of Current Management

- **Medications:** Unsure about his medications
 - Specifically, in the hospital, they held his hydrochlorothiazide, and on discharge, they did not give any directions about continuing to take this medication.
- **Nutrition**
 - Appetite is good. Eating a regular diet. Not restricting any fluids- doesn't recall that he should be limiting fluid intake.
- **Functional Assessment**
 - He has fallen once, no injuries other than bruises on his forehead
 - Does not use a cane or walker- "try to do it on my own"
 - He is unable to complete his own activities of daily living without some assistance ;tires easily; SOB with activity requiring help dressing
 - He can do his hygiene & feed himself
 - Daughter prepares his meals.
- **Social Determinants of Health**
 - Needs assistance with transportation to medical appointments
 - Living with daughter temporarily, wants to go back home, but his daughter is concerned about him living independently
 - Widower, retired, limited income



MR. B Calls the Clinic

Group Activity and Discussion

1. From what is retrieved in the call, what key information would be helpful for the provider to decide on actions that will resolve immediate needs/patient safety?
2. With this information, create the SBAR.

1. In addition to the SBAR, what other communication tools could be applied?
2. Based on Mr. B's situation and background, would he benefit from care management?
3. What criteria and triggers could assist the team to make this decision?
4. What will be the goal for Mr. B? What will success look like?



Mr. B Case Study

Findings: Care Manager Assessment

- Mr B. has a knowledge deficit on why he is taking his medications.
- Although he is not currently strong enough to return to independent living, it is a reasonable consideration in the future.
- He was screened for depression with a PHQ score of 12 . The diagnosis was confirmed



Mr. B Case Study

Case Plan

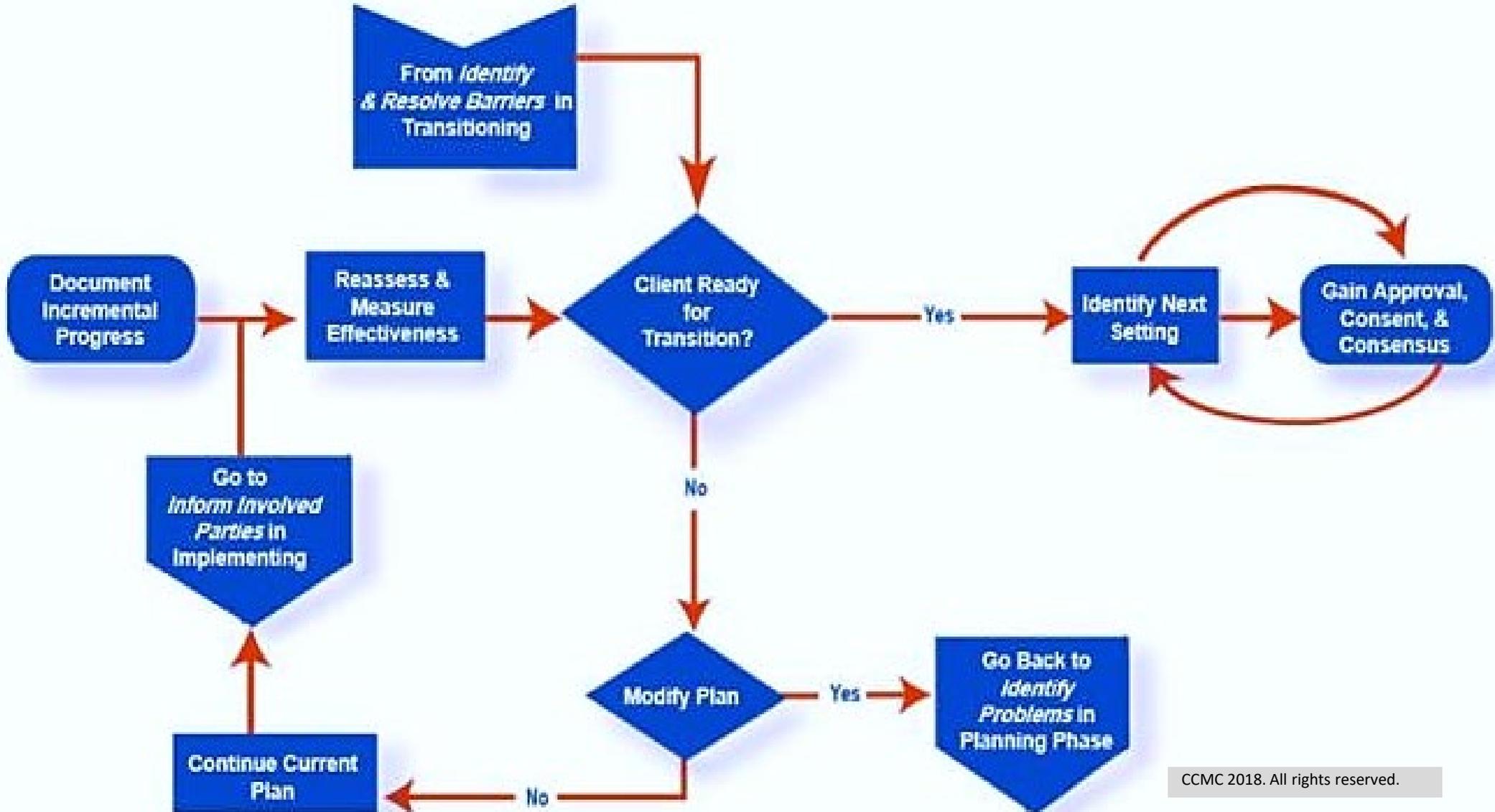
1. Based on the assessment findings, what will be the plan for Mr. B regarding his:
 - Medical needs
 - Behavioral needs
 - Social needs
2. Based on the findings, what do you think Mr. B's motivating factor is? And what care plan approach would you use to engage him?
3. What communication tools could be used during these encounters?





1. Using the care plan(s) developed, what will be regularly monitored and followed up on to determine Mr. B's progress (the treat-to-target measure)?
2. How often would you recommend the monitoring?
3. How will you determine when Mr. B is ready to be discharged from care management?
4. What will be the process to return Mr. B to having the clinic monitor Mr. B's care?
5. What communication tools could be used during these encounters?

FOLLOW UP



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TBC Basics

Care Transition



Care Transitions

Evidence-based
Cost- Effective
Models

Best Practices

Support System

Post-discharge
Assessment



TBC Basics

Care Transitions

Transitions of care refer to the various points in a healthcare setting where a patient moves to, or returns from, a physical location or makes contact with a healthcare professional to receive health care (WHO, [2016](#)).

Transition interventions comprise **activities that help ensure quality of care and patient satisfaction and safety during patient transfer and patient discharge.**

An overview of reviews report that **communication and information sharing at the discharge planning stage are areas where misses in healthcare happened** (Chaboyer et al., [2021](#)).

TBC Basics

Impactful Transitions of Care Models

Research on the different approaches of care transitions identified 4 models that had impact on quality and cost. They included:

- Care Transitions Intervention Model
 - (<https://caretransitions.health/about>)
- Transitional Care Model
 - (<https://pubmed.ncbi.nlm.nih.gov/26882510/>)
- Project Red Model
 - (<https://www.bu.edu/fammed/projectred/>)
- Project Boost
 - (<https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf>)

**See the diagram in the workbook*

TBC Basics

Common Action Themes

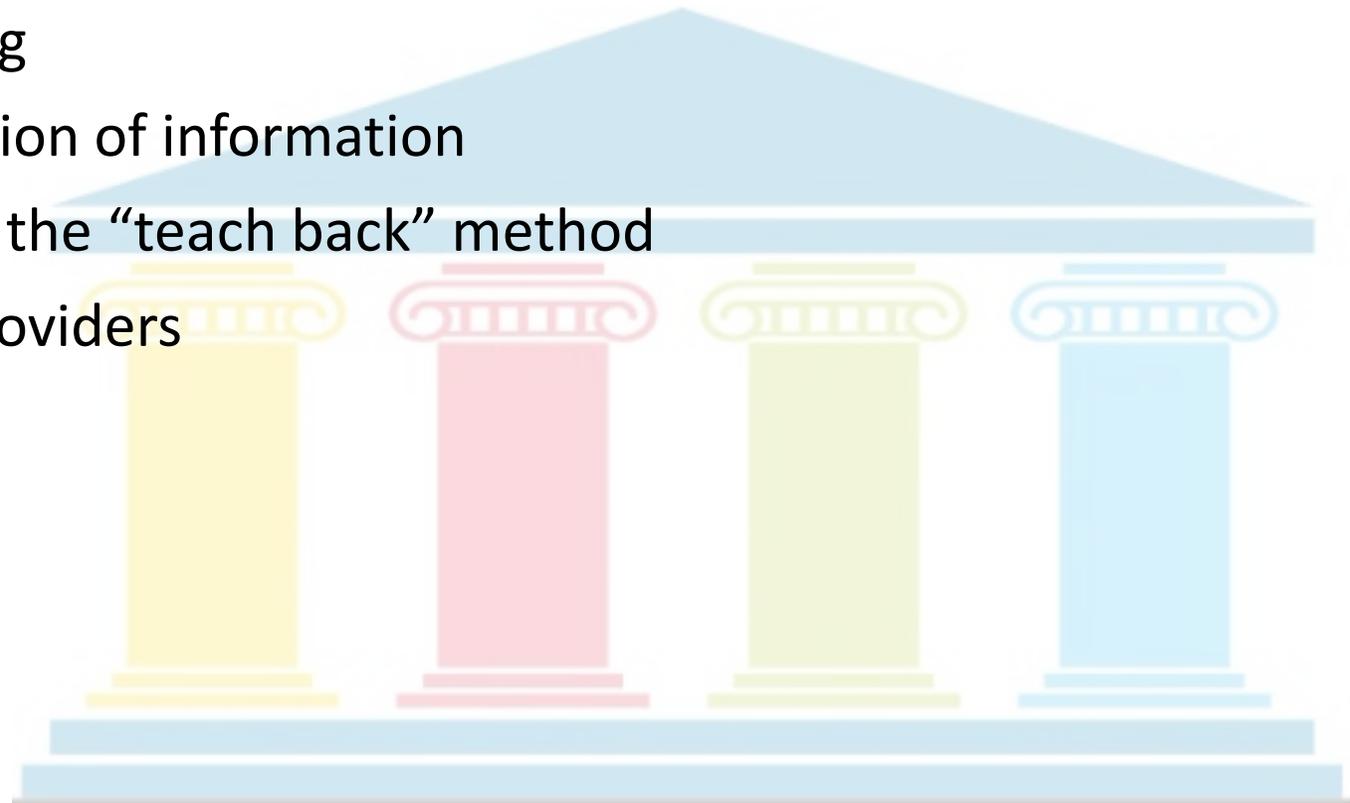
- **Review of the individual patient record (3 of 4)**
- **Dedicated staff** assigned to completing transitions of care work (3 of 4)
- **Care coordination between the inpatient and outpatient providers (3 of 4)**
- **Medication reconciliation (3 of 4)**
- **Outreach to the patient (all)**

TBC Basics

Care Transitions 4 Pillars

The “Center for Care Transitions Interventions,” identified four pillars of care transitions include:

- Comprehensive discharge planning
- Complete and timely communication of information
- Patient/caregiver education using the “teach back” method
- Open communication between providers



<https://www.chcs.org/care-transitions-intervention-coaching-patients-to-successfully-transition-from-hospital-to-home/>

Cost Effectiveness

Care Transitions Intervention	The Transitional Care Model	Project RED (Re-engineered Discharge)
Large integrated delivery system in Colorado from 2002 to 2003.	Six academic and community hospitals in Philadelphia from 1997 to 2001.	Boston Medical Center from 2003 to 2004.
Reduced readmissions within 30 days by 30 percent and readmissions within 180 days by 17 percent	Reduced the readmission rate after one year by 36 percent	Reduced the combined rate of 30-day readmissions and emergency department (ED) visits by 30 percent.
Estimated 15 percent net savings (\$390 per patient) in total hospitalization costs six months after the intervention. Program costs were factored in to the net savings estimate. ¹³	Net costs fell by 38 percent (\$4,845 per patient) in the year after discharge. Program costs were factored into the net savings estimate.	Total health care spending in the 30 days after discharge dropped by 34 percent (\$412 per patient) before deducting the cost of the intervention. The authors do not estimate net savings, but estimate the staff time required for the intervention as a half-time nursing position and a 0.15-time pharmacist position.

<https://www.ncbi.nlm.nih.gov/books/NBK55516/table/ch18.tab1/?report=objectonly>

Communication with the Patient

Key Components of the Post Discharge Call

Guidance from AHRQ states the follow up phone call consists of five components:

- Assessment of health status.
- Medicine check.
- Clarification of clinician appointments and lab tests.
- Coordination of post discharge home services.
- Review of what to do if a health or medical problem arises.



<https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool5.html>

*****See the post-discharge assessment sample in the workbook***

Operations and Implementation

Transitions of Care Across the Team

- Identify where and how the admission discharge reports are received in the clinic.
- Determine which patients will receive a post-discharge call (if data is available, identify conditions and populations with a high readmission rate).
- Determine who on the care team will complete the post-discharge call and if it is a non-licensed individual, develop a “red flag” list that will require a licensed individual to follow up on the red flag issue.
- Develop a protocol and standard work to include timelines for completion of the post-discharge call and for the post-discharge follow up.



<https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool5.html>

***See the post-discharge assessment sample in the workbook*



Questions?

TBC Basics Care Transition



TBC Basics

Evaluation



Team-based Care and Care Management Evaluation



The Evaluating phase calls for measuring the results of implementing the client’s case management plan of care (e.g., the objectives, goals, treatments and interventions, and return on investment) and their effect on a client’s condition. In this evaluation, you focus on several types of outcomes of care:

- Clinical
- Financial
- Quality of life
- Experience and satisfaction with care
- Physical functioning
- Psychosocial and emotional well-being
- Self-care management ability and health engagement
- Knowledge of health condition and plan of care, including medications management

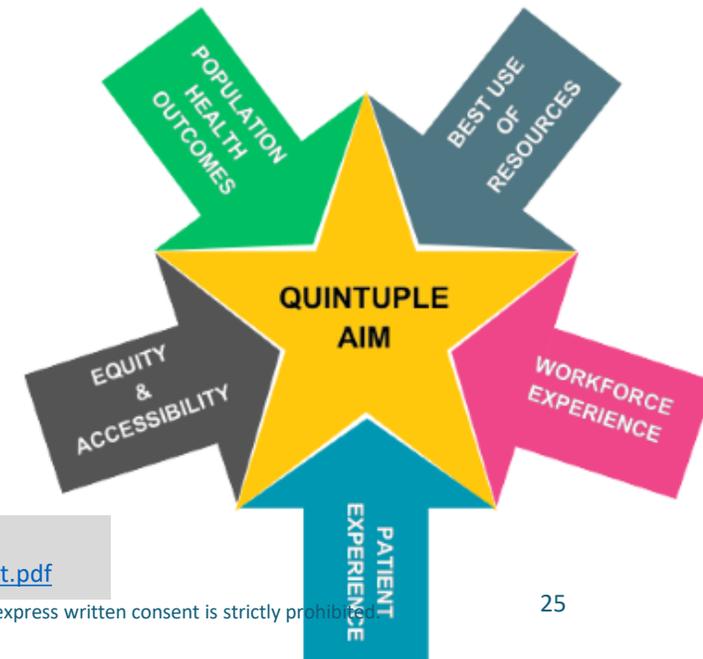
During this phase,
Generate outcomes reports
Communicate the findings or disseminate the reports to key

Outcomes Measures

Know Your WHY

Measuring and Monitoring
Clinical Outcomes

- Better outcomes is part of the “Quintuple Aim”.
- Our primary objective is to help patients.
- Improving patient outcomes is why we practice in a team-based care model.
- Outcomes measures tell us if we have truly made a difference in patient care.



<https://pmc.ncbi.nlm.nih.gov/articles/PMC8608191/>

<https://www.infantheating.org/stategrants/docs2023/Quintuple%20Aim%20for%20Healthcare%20Improvement.pdf>

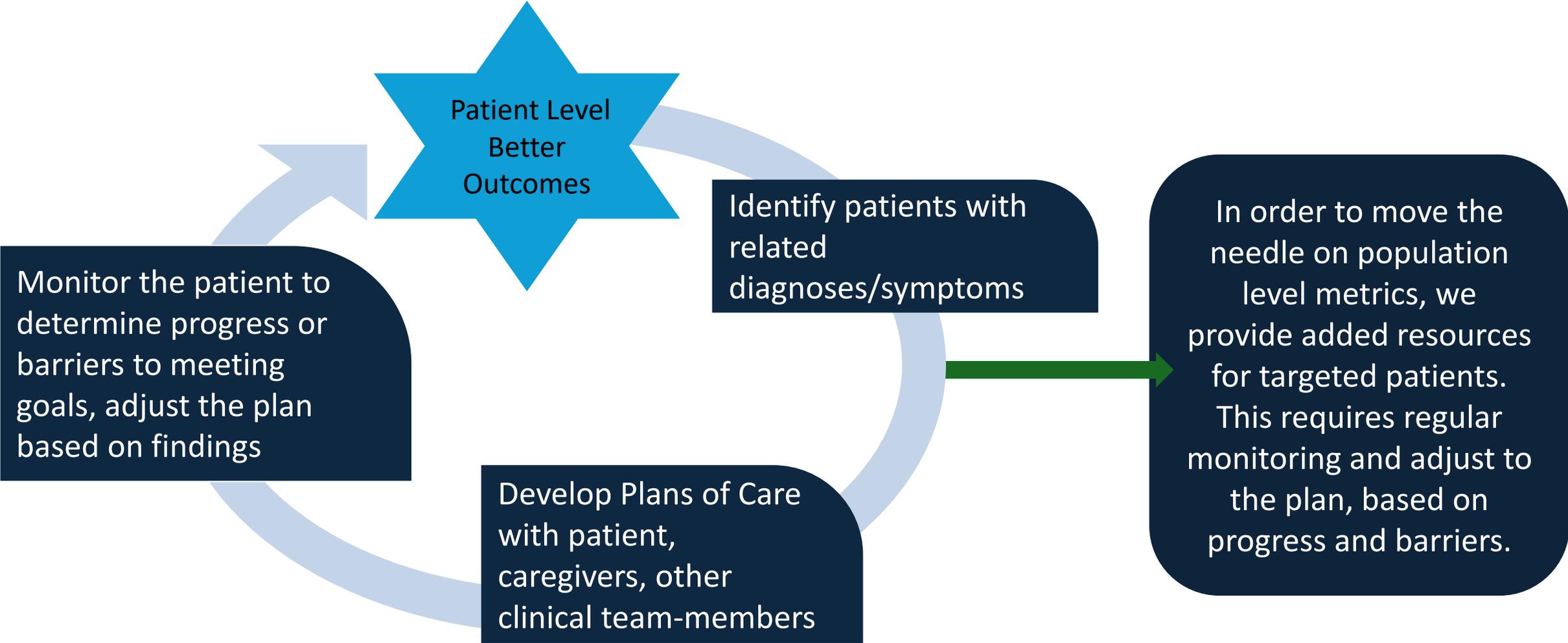
Know Your WHY

Impact of Unmet
Outcomes

Input:

What is the impact of outcome measures being “out of control”?

Impacting Outcomes: It Takes Quality & Quantity



TBC Basics

Tracking Quality to Evaluate Success



Metrics resources:

Working with your teams and leadership, identify available reports and resources to gather data

Examples:

- Admission discharge lists
- Patients on chronic disease medications
- Patients with moderate or high risk (based on the practice/leadership definitions)

Population Health

Population health is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups.

In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health.

Goals of a Population Health Approach

- ◆ To maintain and improve the health status of the entire population
- ◆ To reduce inequities in health status between population groups

Diabetes Tracking Worksheet

NOTE: DO NOT COPY AND PASTE DATA FROM CELL TO CELL AS THIS MAY UNDO IMPORTANT FORMATTING.

KEY: A1c = hemoglobin A1c; DFE = dilated fundoscopic exam; BMP = basic metabolic panel; BP = blood pressure

Patient name	Sex	Date of birth	ID number	Provider	A1c	Date of last A1c	Date of last DFE	Date of last foot exam	Date of last BMP	LDL	Date of last lipids test	Systolic BP	Diastolic BP	Date of last BP	Co-morbidities
Adams, Jane	F	03/14/56	111-11-1111	Ortiz	6.5	1-Mar-06	1-Apr-05	1-Mar-06	1-Mar-06	75	23-Nov-05	140	90	23-Nov-05	HTN, obesity
Baker, John	M	10/05/70	222-22-2222	Ortiz	5.7	24-Feb-06	12-Dec-05	24-Feb-06	24-Feb-06	90	24-Feb-06	110	75	12-Dec-05	
Brown, Jane	F	02/22/63	333-33-3333	Ortiz	6.3	23-Jan-06	24-Jul-05	23-Jan-06	23-Jan-06	103	23-Jan-06	105	85	23-Jan-06	HTN, Retinopat
Carter, John	M	07/05/73	444-44-4444	Ortiz	7.8	16-Feb-06	20-Mar-05	16-Feb-06	12-Nov-05	98	12-Nov-05	131	75	16-Feb-06	
Doe, Jane	F	08/06/66	555-55-5555	Ortiz	6.8	24-Oct-05	21-Jul-05	24-Oct-05	24-Oct-05	88	24-Oct-05	120	80	24-Oct-05	
Douglas, John	M	07/01/49	666-66-6666	Ortiz	7.5	6-Aug-05	2-Feb-05	9-Jan-06	9-Jan-06	87	9-Jan-06	130	80	9-Jan-06	HTN
Jones, Jane	F	10/01/42	777-77-7777	Ortiz	6.2	19-Dec-05	16-May-05	19-Dec-05	19-Dec-05	99	19-Dec-05	128	77	19-Dec-05	
Lane, John	M	01/01/64	888-88-8888	Ortiz	6.4	31-Jan-06	31-Jan-06	31-Jan-06	31-Jan-06	67	31-Jan-06	115	80	31-Jan-06	
Smith, Jane	F	07/31/38	999-99-9999	Ortiz	6	17-Dec-05	17-Dec-05	17-Dec-05	17-Dec-05	100	17-Dec-05	130	80	17-Dec-05	



TBC Basics

Evidence-based Care Resources

Evidence-based information on how to treat certain clinical conditions can be found in assortment of ways.

Examples:

- Professional societies: [American Heart Association](#), [American Cancer Society](#), [American Diabetes Association](#), etc.
- [Hypertension Canada](#)
- [Diabetes Canada](#)
- [Canadian Thoracic Society](#)
- [Canadian Medical Association](#)
- Institutes within the National Institute of Health
- Up-To-Date



Steps to Success

Aligning Outreach with Outcomes



Align Outreach with Outcomes

Southlake leadership share which conditions and measurements will be initiated for monitoring impact

Work with your practice team and providers to identify patients who need support to improve the key outcomes measures.

Evidence-based Guidelines

Top Adult Outcome Measures

- Lower ED Utilization
- Lower Inpatient Utilization
- A1c in Control
- BP in Control
- PHQ Improvement

Top Pediatric Outcome Measures

- Lower ED Utilization
- Lower Inpatient Utilization
- ED Visit Follow-Up for Mental Illness
- Weight Management
- ADHD Medication Management
- Asthma Medication Management



Integrated Care (Behavioral – Medical – Social)

Evidence-based
Cost- Effective
Models

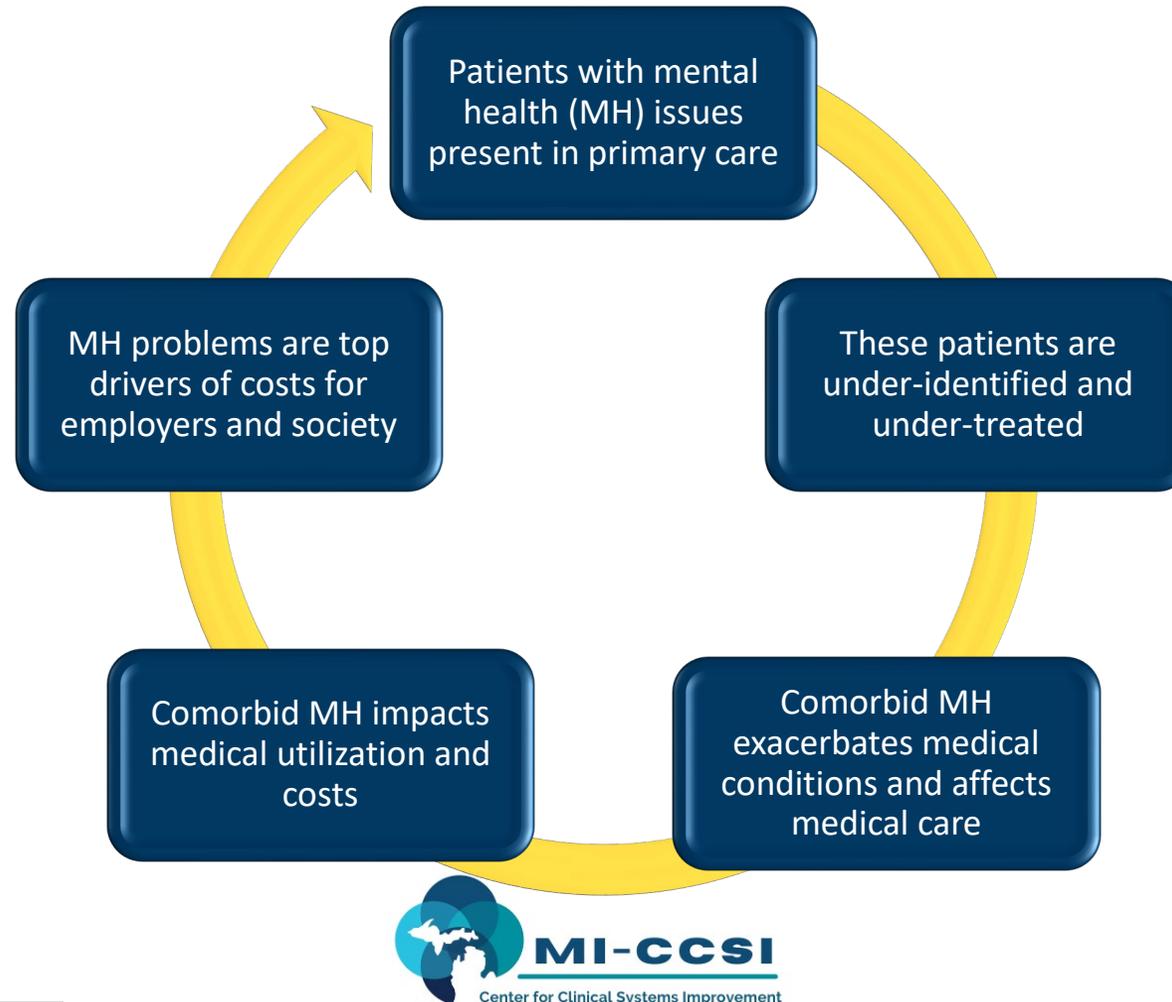
Best Practices

Support System

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Impacts to Primary Care and Beyond Integration of Mental and Physical Health



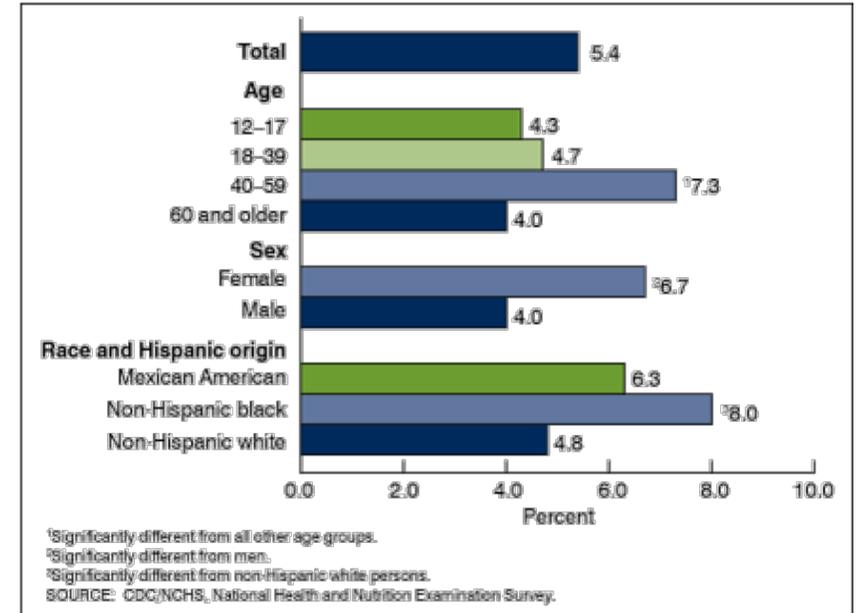
Source: Mt. Auburn Cambridge Practice Association

Depression

Over one-third of Canadians present symptoms of depression and anxiety, with more than 38% reporting depressive symptoms and one-third reporting anxiety symptoms.

At any given time, **8%** of American adults suffer from depression.

This costs **\$84 billion per year** in health care and lost productivity.



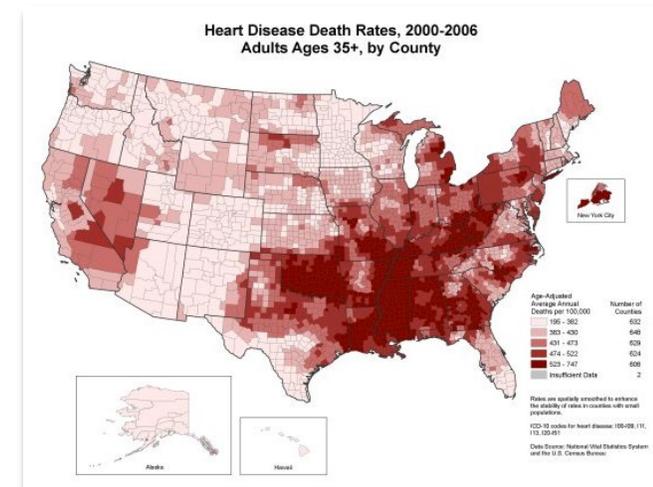
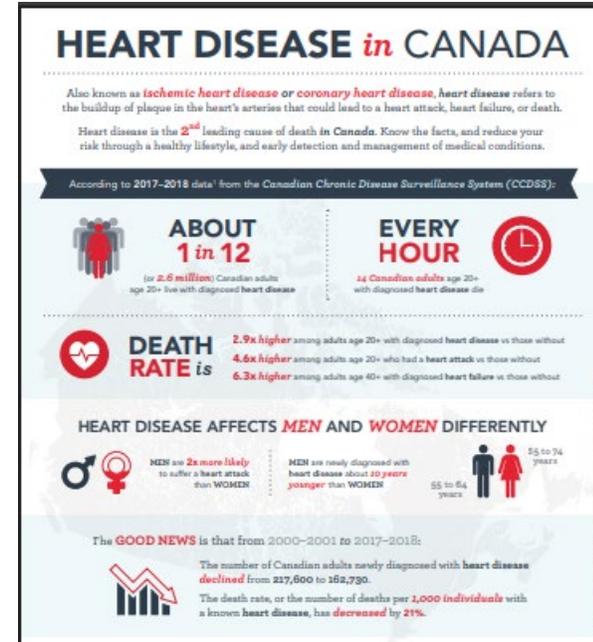
Source: CDC accessed November 2014

About **1 in 12** (or 2.6 million) Canadian adults age 20 and over live with diagnosed heart disease

Heart Disease

33% of US adults are living with some form of cardiovascular disease.

By 2040, this will have risen to **40%** with a cost of **\$818 billion per year.**

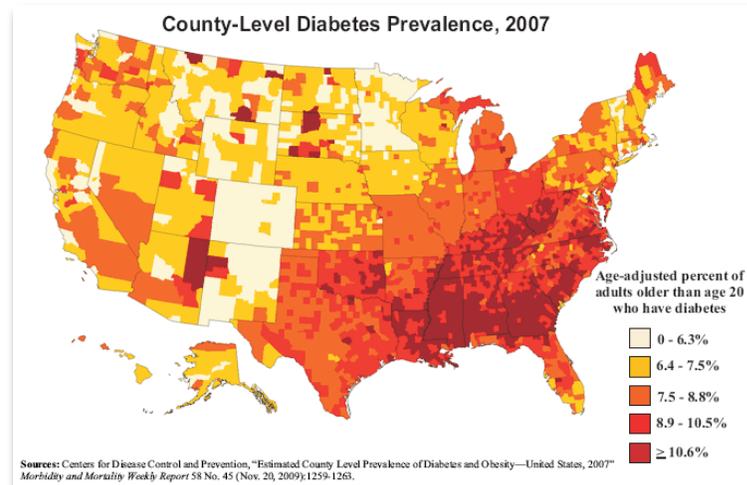


Source: CDC accessed November 2014

Almost 1 in 10 Canadians aged 20 years and older has been diagnosed with diabetes
27% of US residents over 65 have DM. Expected increase to **85%** by 2034.

Diabetes

Cost will increase to **\$334 billion** per year.



Source: CDC accessed November 2014

SNAPSHOT OF DIABETES IN CANADA, 2023

DIABETES is a chronic condition that occurs when the body does not produce enough insulin or when it cannot use it effectively, resulting in high blood glucose levels. There are different types of diabetes.¹

TYPE 1 5-10% OF CASES ²	Non-preventable auto-immune condition that requires insulin therapy for life.
TYPE 2 90-95% OF CASES ²	Potentially preventable (or at least delayable), type 2 diabetes is treated with health behaviour modifications and/or medications (oral or injectable such as insulin).
GESTATIONAL DIABETES 10% OF WOMEN WHO GIVE BIRTH ³	Temporary condition that develops during pregnancy and that resolves after delivery. It is associated with an increased risk of developing type 2 diabetes later in life.
OTHER UNCOMMON TYPES	Diabetes resulting from genetic mutations (such as neonatal diabetes mellitus or maturity-onset diabetes of the young), other diseases (such as cystic fibrosis) or medications use (such as steroids).

Goals Of an Integrated Approach

Health

Experience

Affordability

Improve

- depression outcomes
- diabetes control
- hypertension control

Increase

- clinician satisfaction
- patient satisfaction

Decrease

- costs
- unnecessary hospital & ED use

Expand

- workforce roles

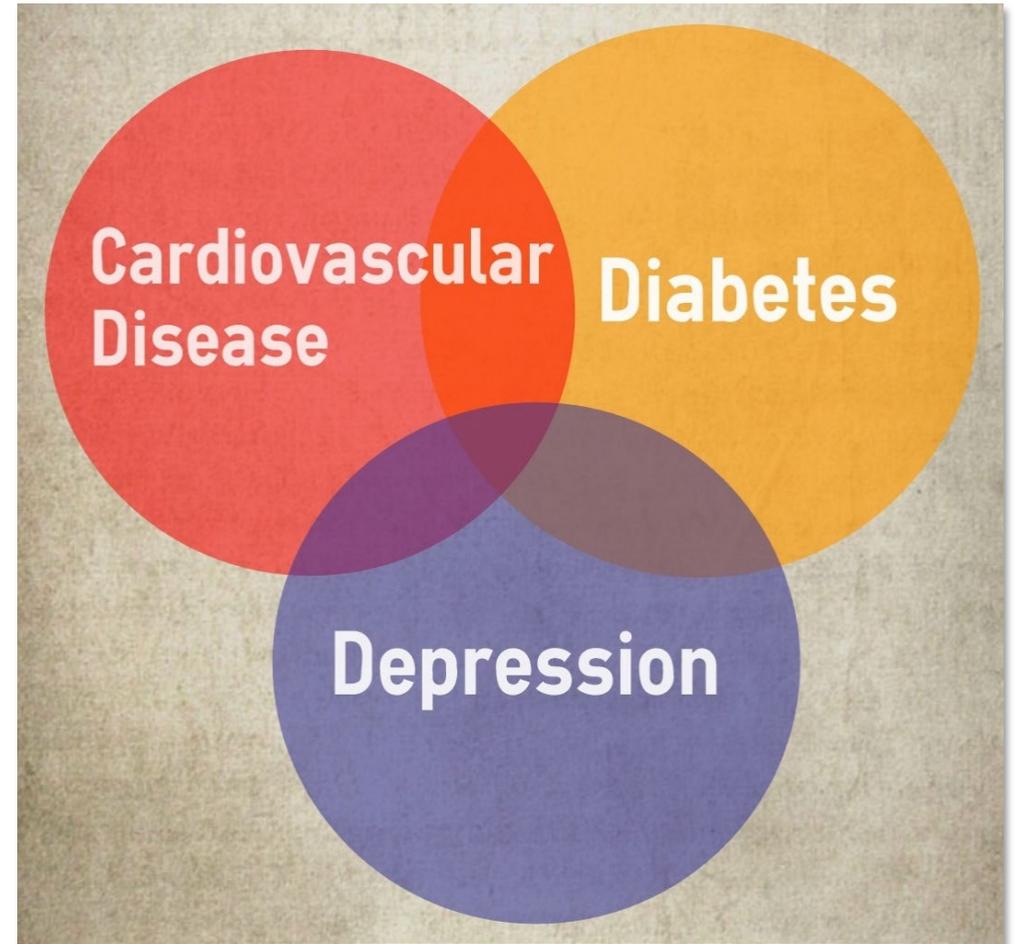


Complex Comorbidities

15% of patients with diabetes or heart disease have depression.

When depression is present with chronic disease:

- ✓ costs are higher
- ✓ complications higher
- ✓ premature death



Develop a Process to Monitor and Measure Impact

Medical Condition	Population definition (potential population)	Data Source(s)	Outcome measurement definition (goal)	Number of patients in defined population	Percentage of patients (population) at outcome measure (current state)	Number of patients screened per practice protocol	Percentage of patients that screened positive (not meeting outcome measure)	Of the percent of patients screened, the percentage that received interventions (or referrals) per protocol	For patients with interventions (or referrals), the percentage that received regularly monitoring per protocol	Percentage of patients that treatment intensification considered for patients not at target during monitoring	Percent of post intervention (or referral) patients at target	Percent of patients at outcome measure 1 year later
Diabetes Example	Individuals with diagnosis of diabetes (type 1,2 or other specific types)	Electronic medical record, coding system, lab results	Glycemic goal (A1C ≤ 5.0)	500 patients	30% (150 patients at target)	n/a	n/a	n/a	Of the 70% not at goal (350 patients) 35% received intervention or referral (122 patients)	Of the 35% (122) that received an intervention or referral 80% were monitored and considered for treatment intensification (98 patients)	Of the patients monitored (98 patients) 50% are at target (49 patients)	35% patients at or below target
Diabetes												



**See Table titled, "Population Measures for Condition Specific Management."*

Tracking population with:

1. Diagnosis of (condition(s) of focus
2. Number of screenings completed with those diagnosed
3. Number of screenings completed upon initiation of treatment
4. Number patients with a positive diagnosis and meeting defined risk level for care management enrolled and monitored by care management.
5. Number of screenings for the condition completed subsequent to initiation of treatment (treat-to-target)
6. Number of individuals with positive diagnosis that have:
 1. Reached remission and or goal
 2. Have an improvement of X or more on the number
 3. Have a 50% improvement

Measuring Impact Example



Questions?

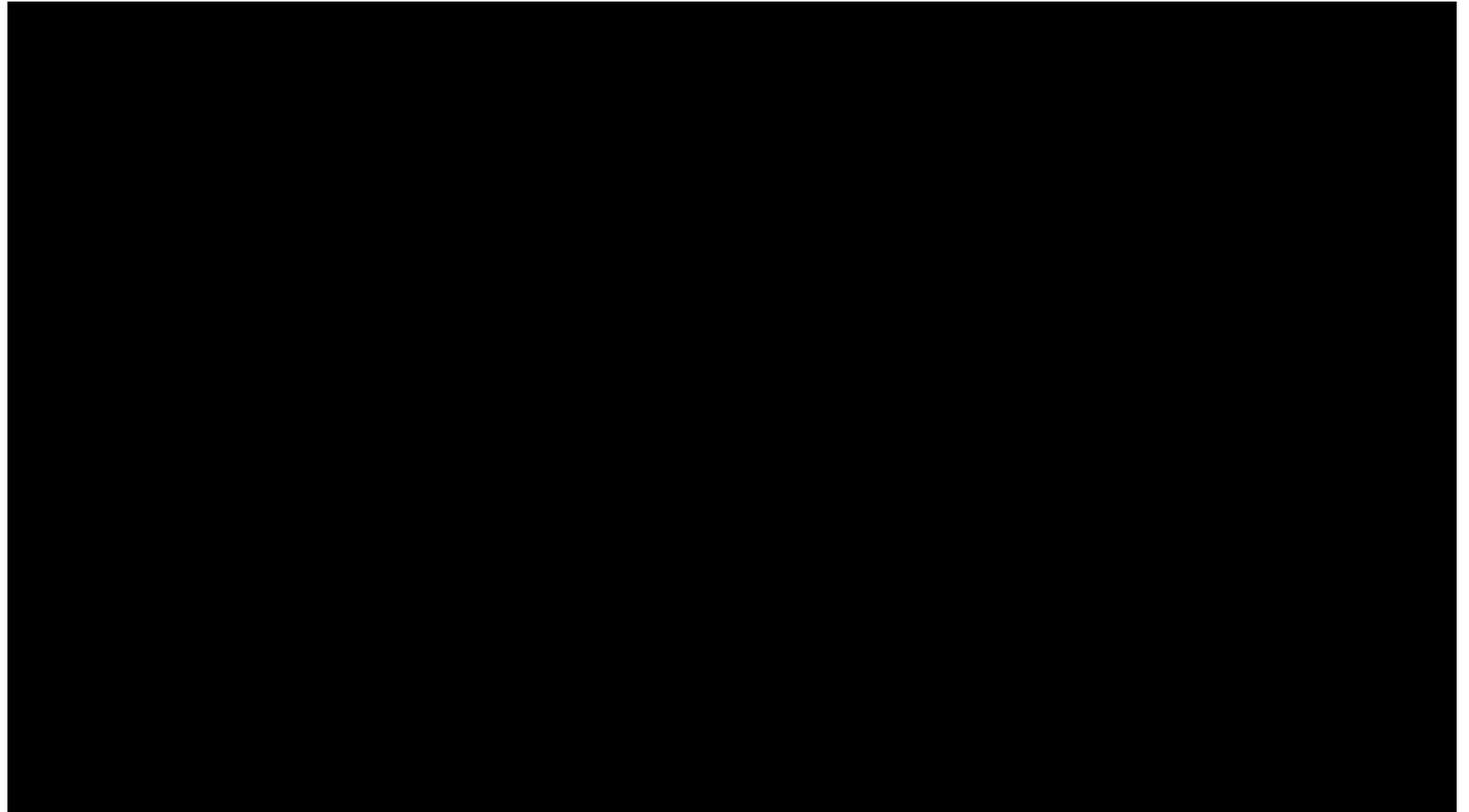
TBC Basics Evaluation



TBC Basics

Managing Advanced Stages – Serious Illness

Serious Illness Overview



Serious Illness

What Is a Serious
Illness
Conversation and
Why It Matters

Recognizing Red
Flags and Tools to
Help Identify
Patients

Team Roles and
Steps to
Implement



Why It Matters

- Millions of patients in primary care have serious illnesses.
- Early identification improves outcomes and prevents crises.
- Primary care is uniquely positioned to detect decline early.

What Is a Serious Illness?

Serious illness” is a health condition that carries a ***high risk of mortality*** AND either ***negatively impacts a person's daily function or quality of life OR excessively strains their caregivers.*** (Kelley and Bollens-Lund, 2018)

- Involves **uncertainty** about prognosis and outcomes.
- Focus: *Understanding patient goals, values, and tradeoffs.*

Care Management and Risk Levels

Tier	Risk Profile	Care Management Focus
Tier 1 — Low Risk	Stable chronic disease (Coronary Artery Disease, Diabetes, Arthritis, etc.)	Ongoing monitoring of disease control
Tier 2 — Rising Risk	Multiple chronic conditions, increasing utilization, SDOH issues	Goal setting, proactive outreach
Tier 3 — High Risk	Frequent ED/hospital use, serious illness, poor control, polypharmacy, high cost	Intensive case management, care team meetings, home visits, specialty referrals
Tier 4 — Advanced / Serious Illness	Life-limiting or progressive conditions, functional decline	Palliative focus, goals-of-care, SIC conversations, caregiver support



Examples Of Serious Illness

- Chronic obstructive pulmonary disease or interstitial lung disease, only if using home oxygen or hospitalized for the condition
- End stage renal failure (stage 4 or 5)
- Congestive heart failure, only if hospitalized for the condition
- Advanced liver disease or cirrhosis
- Advanced neurological disease (i.e. Parkinson, ALS)
- Diabetes with severe complications (ischemic heart disease, peripheral vascular disease and renal disease)

Recognizing Red Flags

- Worsening symptoms (pain, fatigue, breathlessness)
- Frequent ER or hospital visits
- Weight loss or functional decline
- Dependence in daily activities
- Caregiver strain
- 'Surprise Question': Would you be surprised if this patient died within a year?

Everyone Plays a Role

- Nurses & MAs: Notice and document changes
- Providers: Initiate conversations
- Social Workers / Care Managers: Connect to resources

Next Steps After Identification



1. Document and notify provider



2. Schedule Serious Illness or Goals-of-Care discussion



3. Coordinate with care management or palliative care



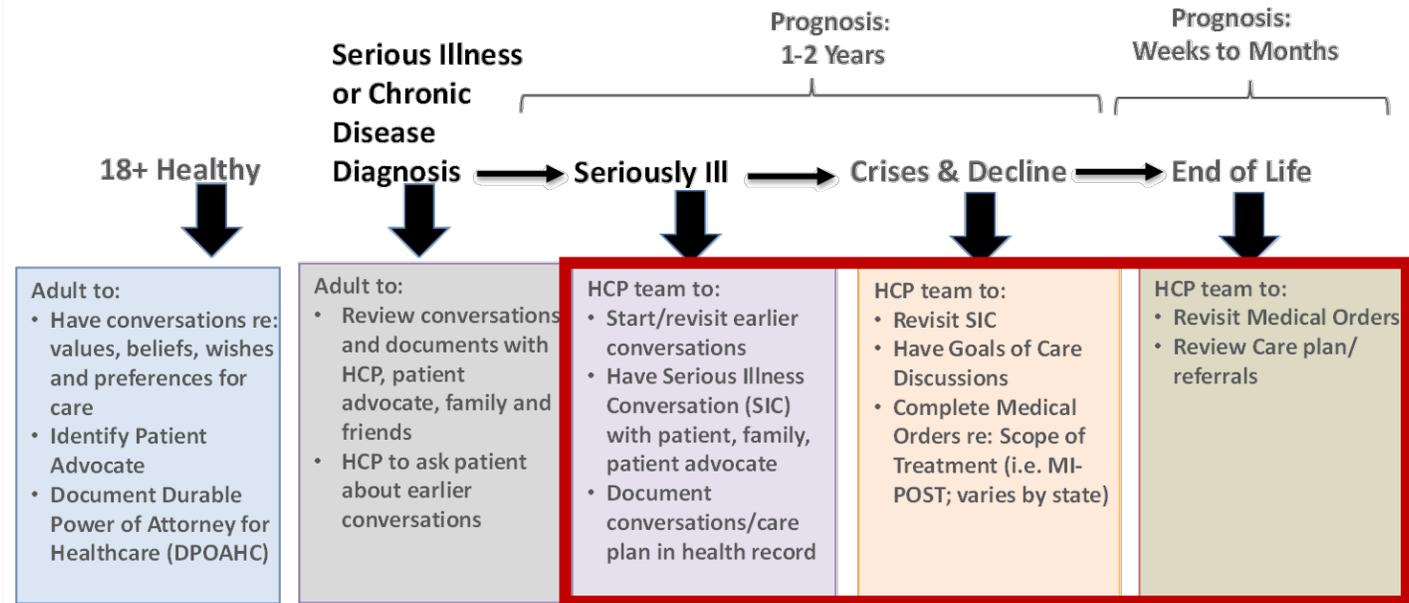
4. Provide education materials



Advance Care Planning Continuum

Advance Care planning is “a process and supports adults at any age or stage of health in understanding and sharing their *personal values, life goals, and preferences regarding future medical care.*”

Sudore et al., 2017



Advance Care Planning - Planning in Advance of Serious Illness

Serious Illness Care Conversation - Planning in the context of progression of serious illness

Goals of Care Discussion- Decision making in context of clinical progression/crisis/poor prognosis

BC Centre for Palliative Care Draft, 2017, Adapted from Ariande Labs



The Impact

Improved symptom control

Fewer hospitalizations

Reduced family distress

Care aligned with patient goals

Serious Illness Key Takeaways



- PRIMARY CARE IS THE FRONTLINE FOR SERIOUS ILLNESS RECOGNITION.



- SMALL OBSERVATIONS MAKE BIG DIFFERENCES.



- EARLY, TEAM-BASED ACTION IMPROVES OUTCOMES.



“THE EARLIER WE TALK, THE BETTER WE CARE.”





Questions?

TBC Basics

Managing Advanced Stages – Serious Illness

TBC Basics

Serious Illness References

Kelley, A. S., & Bollens-Lund, E. (2018). Identifying the Population with Serious Illness: The "Denominator" Challenge. *Journal of palliative medicine*, 21(S2), S7–S16.

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<https://doi.org/10.1016/j.jpainsymman.2016.12.331>

Next Steps

- Implementation Planning
- Chronic Conditions Review and Case Management Planning
 - Asthma and COPD
 - Cardiovascular Conditions
 - Heart Failure
 - Hypertension
 - Diabetes
 - Depression