Navigating the Post Stroke Continuum: A Closer Look at Transitions of Care

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Disclosures:

Jean Luciano – Genentech Speakers’ Bureau

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Objectives

• Describe potential gabs in care during stroke patient transitions throughout the continuum of care

• Review strategies for potentiating seamless transitions

• Discuss a needs assessment for stroke survivors and their caregivers

Synonyms for Transition

• changeover
• conversion
• evolution
• passage
• progression
• shift
• transformation
• upheaval
• alteration
• flux
• metamorphosis
• passing
• transit
• transmutation
• realignment
• turning point
Transitions of Care Definition

- **Transitions of Care** refer 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.

- Specifically, they can occur:

Multidisciplinary Care
Care Coordination Definition

- **Care coordination** is a function that helps ensure the patient’s needs and preferences for health services and information sharing across people, functions, and sites are met over time.

- Coordination maximizes the value of services delivered to patients by facilitating beneficial, efficient, safe, and high-quality patient experiences and improved healthcare outcomes.

Principles

1. Care coordination is important for everyone

2. Some populations are particularly vulnerable

3. Care coordination measures may be appropriate at the clinician-level; others may be appropriate at the group, practice or organizational-level

4. Patient/family surveys are essential to measure care coordination; performed within close proximity to the healthcare event
Elements of Transitions of Care

- Education
  - Medication Reconciliation
  - Changes in Plan of Care

- Communication
  - Involvement of team during IP, DC and Follow Up
  - Transfer of all information when site of care changes

- Follow Up
  - Diagnostic Tests
  - Treatments

Geriatric Evaluation for Transition
Includes risk assessment using 8Ps

- Problematic Medications
- Psych
- Principle Diagnosis
- Polypharmacy
- Poor Health Literacy
- Patient Support
- Prior Hospitalization
- Palliative care

[http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/PDFs/TARGET.pdf]
Transitions in Care

New Roles
Stroke Nurse Navigator, Family Advocate
Transitional Care Coordinator
- Family training, scheduling follow up visits prior to discharge, coordinating follow up referrals
- Respite care information
- Community resources
- Support Groups
- Follow up phone calls

Documentation Tools
Interdisciplinary Rounds
- Integration of patient and family in planning goals and discharge
- Main family contact for coordination with record of contact
- Community integration referrals and follow up

Inpatient Rounding
Include patient and family
- Daily rounds
- Family planning and readiness for discharge
- Identify vulnerable patient population going home with documented cognitive or physical impairment

Care Transitions Models Improve Processes, Information Flows, and Capacity

Evidence-based models include:
- Care Transitions Intervention
- Transitional Care Model
- Guided Care
- GRACE
- Others

TJC DSC: Primary Stroke Centers Certification Seminar, 2014
The Care Transitions Intervention (CTI)

• “The Coleman Model”
• Qualifications: CTI Coach can be layperson
• Length of intervention: 30 days
• Average cost: $196 per patient
• Steps:
  • Four pillars--Medication management; Patient-centered record; Follow-up; Red flags
  • Five encounters--Hospital/SNF Visit; Home Visit; 3 Follow-Up Calls

Transitional Care Model
“The NAYLOR Model”

• Dr Mary Naylor PHD, RN
  • Pts. assigned a TCN upon admission
  • Comprehensive assessment of patient and family caregiver needs
  • Discharge plan with the family and hospital provider team
  • Implements the plan in the patient’s home
  • Assists the patient with management of their care needs
  • Facilitates communication and the transition to community providers and services
• Length of intervention: 1 to 3 months
• Average cost: $982 per patient
Home Follow-Up

- The Transitional Care Nurse is available to the patient seven-days per week through home visits and telephone access for one to three months of home follow-up (two months on average)

- Targets cognitively intact older adults
  - 2 or more risk factors
  - including poor self-health ratings
  - multiple chronic conditions
  - history of recent hospitalizations

Key Components

- Each nurse manages an active caseload of 15 to 20 patients, with an average of 18 patients
  - In-hospital visit for assessment and goal setting
  - In-home visits by phone or in person
  - Nurse visit with physician at initial follow-up and one more visit if needed
    - Facilitate, advocate, educate
Guided Care

- Developed at Johns Hopkins University since 2001
- Qualifications: Guided Care Nurse must be an RN
- Length of intervention: For life
- Average cost: $1743 per patient per year
- Steps:
  - Conduct comprehensive home assessment, create care guide and action plan for patient, provide monthly monitoring and self-management coaching, coordinate care, facilitate access to community services, engage/educate informal caregivers

GRACE: Geriatric Resources for Assessment and Care of Elders

- “The Counsell Model”
- Qualifications: Nurse practitioner and social worker
- Length of intervention: Long term/indefinite
- Average cost: $1432 per patient per year
- Steps:
  - In-home assessment, home visit after any hospitalization, one phone or in-person follow-up per month, collaborate with PCP, hospital discharge planner and others in a team-based approach
The Most Dangerous Transition for a Patient

DISCHARGE!!

ON AVERAGE,
1 IN 5
MEDICARE BENEFICIARIES
DISCHARGED FROM THE
HOSPITAL IS READMITTED
WITHIN 30 DAYS

Many QI opportunities to reduce hospitalization . . .

Prevention of 2nd Admission
Self Management
Coordination of Transitions in Episodes of Care
HOME
1st Hospitalization
Discharged Patient
2nd Hospitalization

Population Management

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Transitions Quality Projects

• “Time Out” for Discharge
• My Penn Pharmacy
• My AH Portal
• My INR Clinic
Unanticipated VS Unassessed Issues

• Depression!
• Caregiver Stressors
• Transportation
• COMMUNICATION
• Follow up

How Technologies May Support Care Processes

- Telemedicine
- Smart Sensors
- Wireless Broadband Networks
- Video-Based Education
- Remote Patient Monitoring
- Home Medication Management
- Patient Health Records
Case Studies

Also Known As.....

- Falling through the cracks
- Swiss cheese
- Lessons from the other side of the bed!
References

Coleman EA, Mahoney E, Parry C. Assessing the Quality of Preparation for Post-Hospital Care from the Patient's Perspective: The Care Transitions Measure. Medical Care. 2005;43(3):246-255.


Guided Care by Johns Hopkins Medicine (Nurse-based chronic care management) www.johnsHopkinsSolutions.com