Care Transitions

Objectives

- Target potential gaps in your discharge process
- Identify education opportunities to share with staff for a safe and effective patient discharge to a lesser level of care
- Create a plan for your organization to develop a discharge process to help improve your re-hospitalization and improve patient outcomes

Hospital Challenges

- Reduce 30-day readmission rates (nearly 20% of hospitalized Medicare patients will be readmitted within 30 days of hospital dc, the national average HF 30 day readmission rate is 21.9)

- Prevent adverse events(during this same time frame approx 1 in 5 patients experience adverse events-adverse drug events and hospital related complications- both diagnostic & therapeutic errors)

- Centers for Medicare & Medicaid publicly report hospital risk adjusted 30 day readmissions for patients hospitalized with pneumonia, MI & heart failure

- Ensuring safe transition from hospital to home or other care facility for patients

Patient Factors that impact re-hospitalization

- Severity of Illness
- Poor social support
- Health literacy
- Medication Adherence
- Adherence to discharge plan of care
- Capacity for self management
- Cognitive, Visual, Hearing Impairment
- Poverty
- Discharge location
- Transportation Difficulties
- No PCP

- Nearly 20% of 30 day readmissions are preventable

What is Transitions of Care

Bridging the care gap as patients move across different health care settings and providers, TOC is designed to promote the safe and timely passage of patients between the many levels of health care.

Goals of a Transitions of Care Program

- Engage patients in their discharge process
- Improve patient's continuity of care
- Improve patient's quality of life
- Improve patient handoffs to and from acute care setting
- Improve your hospitals Re-hospitalization rates

Effective Transitions of Care

- Improves communication between medical staff and patient/caregiver
- Minimize patient/caregiver confusion
- Involves the patient/caregiver in the decision process
- Discharge patient to the appropriate level of care
- Stop the revolving door with patients who are not prepared to manage their own care; and ultimately help decrease hospital readmissions

The 4 Pillars of Care

- Medication self Management- Does the patient understand about their meds and have a dispensing system in place
- Patient centered records- Is the patient able to manage his or her own care
- Follow up care- Can patients schedule & keep their Dr. appointments
- Red Flags- Does the patient understand about his or her disease and are they able to recognize signs/symptoms that their condition is worsening

If the answer to any of these questions is NO…
think about this ! Are You discharging the
patient to the RIGHT Level of Care

What needs will the patient have at discharge

- Does he/she have support at home?
- Are they going home with New treatment therapy?
    - New Medication
    - New Oxygen
    - Infusion Therapy
    - Wound Care

Discharge Options

- Home alone
- Home with family, friend
- Home with Outpatient services PT/OT
- Home with Cardiac Rehab
- Skilled Nursing Facility/Rehab Unit
- Home with home health Nursing, PT/OT, MSW, HHA

Discharge checklist

- Discussion: Patient knows where they are going when leaving the hospital and why if somewhere other than home.
- Medication education-patient has an accurate discharge medication list with new prescriptions in hand or what pharmacy they were called into
- Arrangement for follow-up appointments and tests have been made or scheduled.. Specialists, heart failure clinic, PCP
- Referrals to a home care agency and/or appropriate support organization in the community have been made.
- Determine whether caregiver training or other support is needed for a safe transition to home

Discharge without a plan!

Discharge with a plan…

Bibliography

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CMS.gov Centers for Medicare & Medicaid Services

Question slide

An Effective discharge plan should provide all except?

a. Decrease a patients risk of return to the hospital within 30 days
b. A guarantee of a healthy recovery
c An accurate medication list
d. Patient understanding of risk factors & signs/symptoms to look for