The RNCM Role in Safe, Effective Care Transitions

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Lead Faculty

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- Care transition
- Discharge planning
- Hospital readmission
- Hospital Readmission Reduction Program (HRRP)
- Social Determinants of Health
- Medication Reconciliation
- Transitional Care
- Re-engineered Discharge
- BOOST
- Transitional Care Management

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About Care Transitions

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Centers for Medicare and Medicaid defines as

"The movement of patients from one health care practitioner to another or from one setting to another as persons care needs change."

Occurs at multiple levels, for example:

Within Settings
- Primary care ⇔ Specialty care
- ICU ⇔ Floor

Between Settings
- Hospital ⇔ Home
- Hospital ⇔ Sub-acute facility
- Primary or specialty clinic ⇔ Senior center

Across health states
- Curative care ⇔ Palliative care/Hospice
- Personal residence ⇔ Assisted living

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The World Health Organization defines as

> **"Transitions of care as the various points where a patient moves to, or returns from, a particular location or makes contact with a health care professional for the purposes of receiving health care"**

- Also includes transitions between home, hospital, residential care settings and consultations with different health care providers in out-patient facilities

Different from a clinical handover or handoff

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The American Geriatrics Society defines as:

> **"A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location."**

- Representative locations include but are not limited to hospitals, sub-acute and post-acute facilities, the patient's home, primary and specialty care offices and long-term care facilities

Transitional Care is essential for persons with complex care needs

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Transitions of Care are often accompanied by changes in health status:

- New diagnosis(es)
- New treatment
- Change in functional status

- All affect patient ability to manage their own conditions outside of the health care setting

- Older people with complex health issues
  - Most likely to undergo multiple transitions of care
  - Highest risk for adverse events and safety incidents

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Transitions are recognized as high risk for patient safety

- Increase in mortality
- Increase in morbidity (temporary or permanent injury or disability)
- Increase in adverse events
- Delays in receiving appropriate treatment and community support
- Additional primary care or emergency department visits
- Additional or duplicated tests or tests lost to follow up
- Preventable readmissions to hospital
- Emotional and physical pain and suffering for patients, caregivers, families
- Patient and provider dissatisfaction with care coordination

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Factors Beyond Clinical Determinants that Impact Care Transitions

Patient

- Patient cognitive status
- Patient activity level and functional status
- Suitability of the patient's home or housing stability
- Availability of support from caregivers and family
- Ability to obtain medications
- Health care and social services
- Availability of appropriate transportation.

Healthcare System

- Hospital overcrowding
- Lack of appropriate services in the community
- Economic pressures to discharge
- Continually expanding health care systems can be confusing for patients, families and system employees

RNCMs must have a clear understanding of their care delivery system as they navigate patients across a changing continuum of care

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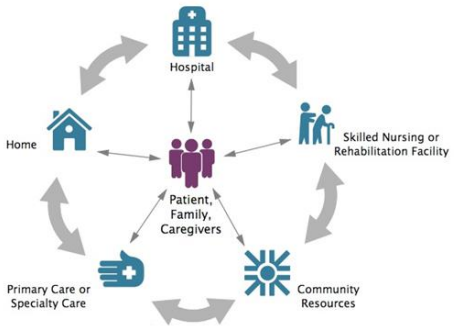
Determinants of the Appropriate Site of Care & Related Decisions about Transfer

- Patient's Medical Condition(s)
- Potential for Rehabilitation
- Decision-making capacity
- Social Support Systems



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Systematically Identifying Patients At Risk for Poor Transition of Care

- Length of stay
- Previous hospital admissions and/or ED visits
- Acuity of admission
- Comorbidities
- Number of medications

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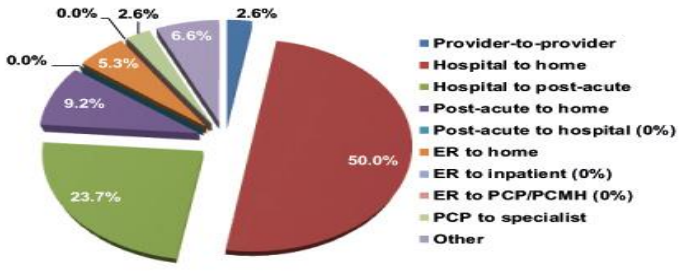
What Is the Most Critical Transition of Care?



Source: 2015 Healthcare Benchmarks: Care Transitions Management
April 2015

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$26 Billion

Spent on poor transitions of acute care Medicare patients per year

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CMS Definition of Hospital Readmission

Hospital Readmission defined for Hospitals (CMS.gov)

- Unplanned readmissions that happen within 30 days of discharge from the index (i.e., initial) admission.
- Patients who are readmitted to the same hospital, or another applicable acute care hospital for any reason.

Hospital Readmission defined for Medicare Beneficiaries (Healthcare.gov)

- A situation where you were discharged from the hospital and wind up going back in for the same or related care within 30, 60 or 90 days.

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Hospital Readmissions Reduction Program

- Medicare VBP program that encourages hospitals to improve communication and care coordination to reduce avoidable readmissions
- Conditions or procedure-specific 30-day risk-standardized unplanned readmission measures in the program include:
  - Acute myocardial infarction (AMI)
  - Chronic obstructive pulmonary disease (COPD)
  - Heart failure (HF)
  - Pneumonia
  - Coronary artery bypass graft (CABG) surgery
  - Elective primary total hip arthroplasty and/or total knee arthroplasty (THA/TKA)

- Learn more at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program

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Discharge Planning and Transitions of Care

Best Practices & Evidence-Based Interventions

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Identifying Risk Factors for Poor Transitions

- Patient's lack of physical and emotional readiness to learn
- Family member or patient caregiver not involved in the education and discharge planning efforts
- Unclear discharge instructions
- Discharge instructions that are not tailored to patient's individual learning style, social determinants or health literacy needs
- Conflicting or confusing information provided by different healthcare providers

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Risk Factors Associated with Non-Adherence After Discharge

- Lack of engagement
- Poor continuity of care
- Complex treatment regimes
- Poor understanding or confusion about needed care
- Social determinants
- Uncertainty how to schedule appointments

Assessment of patient and caregiver concerns and risk factors should be addressed throughout discharge preparation

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Medications as a Risk Factor for Poor Outcomes

- Patient Related Factors
  - Disease-state knowledge
  - Health literacy
  - Cognitive functioning
- Drug Related Factors
  - Adverse effects
  - polypharmacy
- Logistic Factors
  - Transportation
  - Medication access

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Strategies that Are Working to Reduce Unnecessary Readmissions

- Patient & Caregiver Engagement
- Provide Care Coordination and Care Setting Transition Planning
- Perform Medication Reconciliation
- Tackle the Social Determinants of Health
- Leverage Data

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Leverage Data

- Uses demographic, psychographic, geographic data, hospital and payor data to:
  - Identify higher risk patients
  - Effectively allocate resources
  - Manage social, behavioral, location-based risk factors

Applies Population Health Management Strategies

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Social Determinants of Health

"The conditions in which people are born, work, live and age *and the wider set of forces and systems shaping the conditions of daily life including economic policies and systems, development agendas, social norms, social policies and political systems."*

– The World Health Organization

"Non-medical factors influencing health related knowledge, attitudes, beliefs and behaviors" - Future of Nursing Report, 2020-30: Charting a Path to Achieve Health Equity

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Medication Reconciliation

- 16-21% of readmissions caused by medication
- 40-69% potentially preventable
  - Non-adherence (35%)
  - Prescribing errors (35%)
  - Transition errors (30%)

(Utivlugt et al. Medication-Related Hospital Readmissions Within 30 Days of Discharge: Prevalence, Preventability, Type of Medication Errors and Risk Factors. *Front Pharmocol* 2021 April 13;12-5374824.)

Medication Reconciliation Best Practice

1. Perform an assessment of patient's medications
   - At admission
   - During stay
   - At discharge
2. Assess SDoH that impact access to medications
   - Financial costs
   - Transportation
   - Mobility
   - Mentation
3. Provide the patient and their family identified caregivers' education and counseling about medications
4. Develop and implement a plan for medication management as part of the patient's overall plan of care

Resource: NTOCC Care Transition Bundle Seven Essential Categories

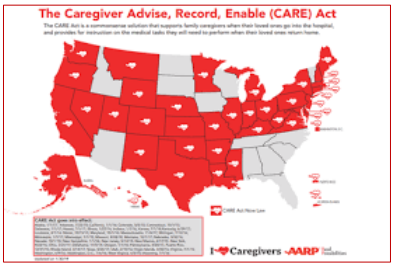
Patient and Identified Family Caregiver Engagement & Education

Engage and encourage patient and family participation in their own care and shared decision making.

- Ensure patients and their identified family caregivers are knowledgeable about their condition and plan of care
- Communicate transition information in a patient centered format
- Develop patient's self-care management skills
- Facilitate patient engagement with technology including virtual patient visits

Identifying the Family Caregiver

- The Caregiver Advise, Record, Enable (CARE) Act
- Law in > 40 States & Territories
- Additional States have initiated legislative processes



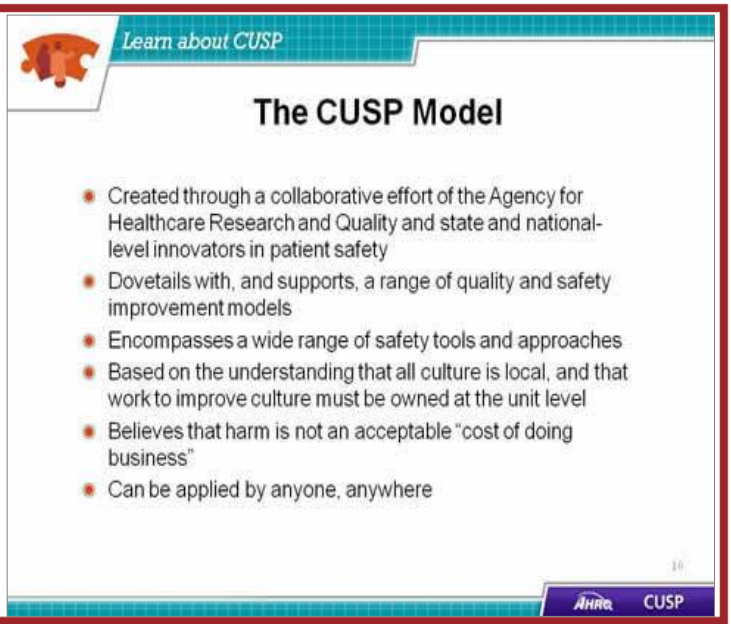
Engagement & Self-Management Tools

- Your Rights during Transitions of Care: A Guide for Patients & Caregivers
- Guidelines for a Hospital Stay for Patient, Family & Caregiver
- Taking Care of My Healthcare
- My Medicine List
- Taking Care of My COVID-19 Health Management
- Taking Care of My Pain Management

CUSP Patient & Family Engagement

- Comprehensive Unit Based Safety Program
- Team Based Patient & Family Engagement with Discharge
- Learn More/Access Toolkit at:

https://www.ahrq.gov/hai/cusp/index.html



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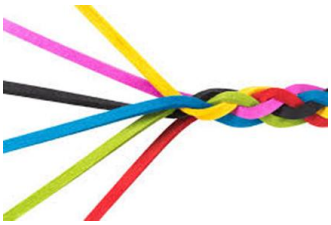
Care Coordination

Defined as

"the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services."

- Can be visualized as the common thread that runs throughout and across the healthcare system needed
  - Overcome fragmentation
  - Improve communication
  - Decrease duplication of services
  - Increase access to care



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Care Coordination & Care Transition Planning

A formal process that facilitates the safe transition of patients from one level of care to another including home or from one practitioner to another

- Clearly identify a practitioner (or team dependent on setting) to facilitate and coordinate the patient's transition plan
- Manage patients and their family identified caregivers' transition needs
- Use formal transition planning tools
- Complete a transition summary, send it in a timely manner and secure confirmation by the receiving entity
- Develop and implement a plan for the use of medical devices and remote patient monitoring

Resource: Care Transitions Bundle Seven Essential Categories (NTOCC, 2022)

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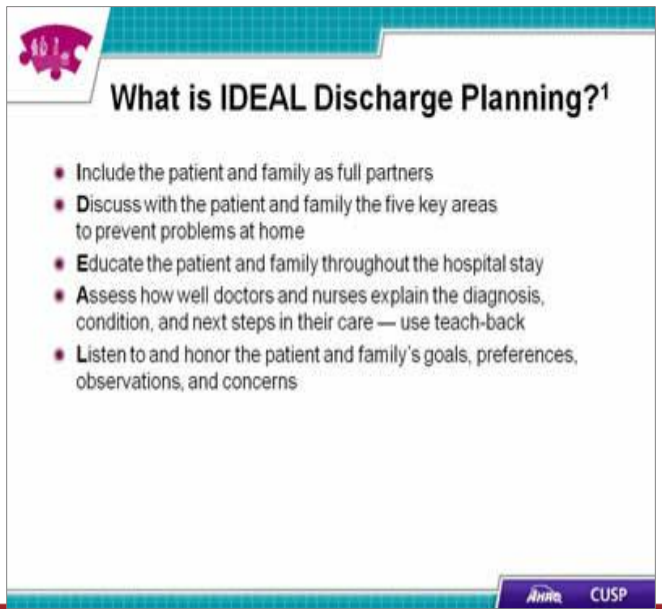
Discharge Planning Best Practice Guideline

- AHRQ CUSP Patient Safety Initiative
- **Resource:** Implementation Handbook: Care Transitions from Hospital to Home: IDEAL Discharge Planning
- Can be used with RED, Care Transitions Intervention, BOOST care transition practice models



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BOOST (Better Outcomes for Older Adults through Safe Transitions)

- 8 Ps Screening Tool to Identify Patients at Risk for Adverse Events after Discharge
- Emphasizes:
  - Medication Reconciliation
  - Teach Back
  - Discharge Patient Education Tool
- Implementation Toolkit is available
- http://tools.hospitalmedicine.org/Implementation/Workbook_for_Improvement.pdf

8 Ps:

1. Problems with Medications
2. Psychological
3. Principal Diagnosis
4. Physical Limitations
5. Poor Health Literacy
6. Patient Support
7. Prior Hospitalization
8. Palliative Care

- https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/8ps_riskassess-1.pdf

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Checklists: Transition Assurance Questions for Care Coordination Continuity

CONTINUITY and COORDINATION OF CARE:

Does the patient have a primary care physician? (if appropriate) Send assessment/plan to PCP
Date: Y N

Does the patient have a specialty physician, e.g., cardiologist? (if appropriate) Send assessment/plan
Date: Y N

Does the patient have a psychiatrist or other mental health provider? (if appropriate) Send assessment/plan
Date: Y N

Does the patient have an outpatient case manager who should be notified? Send assessment/plan
Date: Y N

All transition services and care (medications, equipment, home care, SNF, hospice) completed and documented
Date verified: Y N

Ensure patient/client and caregiver understand all information and have a copy of the care plan with them
Date verified: Y N

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Improved Discharge Planning & Transitions of Care

RED – Re-Engineered Discharge Best Practices

(AHRQ RCT – Patients receiving RED experienced 30% lower readmission rate)

1. Ascertain need for and obtain language assistance as needed.
2. Make appointment for follow-up care (e.g., medical appointments, specialists, post-discharge tests or labs).
3. Plan for the follow-up of results from tests or labs that are pending at discharge.
4. Organize post-discharge outpatient services and medical equipment.
5. Identify the correct medicines and a plan for the patient to obtain them.
6. Reconcile the discharge plan with national guidelines.
7. Teach a written discharge plan the patient can understand.
8. Educate the patient about his or her diagnosis and medicines.
9. Review with the patient what to do if a problem arises.
10. Assess the degree of the patient's understanding of the discharge plan.
11. Expedite transmission of the discharge summary to clinicians accepting care of the patient.
12. Provide telephone reinforcement of the discharge plan, 24 – 48 hours post discharge.

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Transitional Care Practice Models

Nurse-Led Intervention to Reduce Risk for Poor Outcomes

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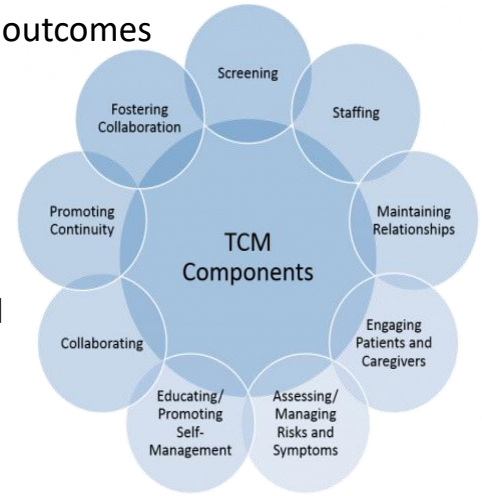
Naylor Transitional Care Model (TCM)

- Targets older adults at risk for poor outcomes
- Prepares patients & caregivers
- Nurse-led Intervention focused on transition of care risk points
- Uses EB clinical protocols that prevent decline and reduce readmission for an extended period
- TCM compliments primary care, telephonic case management, disease management programs



Coleman Transitional Care Intervention®

- 4 Week Program starting with discharge
- Focused on patients with complex needs & their caregivers
- Transition Coach is APRN or RN
- Uses hospital, home and telephonic visits

Four Pillars:

- Medication Self-Management
- The Personal Health Record
- Timely primary care/specialty care follow up
- Knowledge of red flags or worsening condition and how to respond

Transitional Care Management & Complex or Chronic Care Management

- Share high need patients with multiple chronic conditions complicated by functional limitations
- TCM concentrates on improving hospital discharge and post-acute care to prevent readmission and ED visits
- CCM focuses on stabilizing the person in the community to increase self-management of chronic conditions and reduce hospitalizations and ED visits
- Both TCM & CCM are important components of value-based care

Collaboration & communication between RNCMs practicing in each model will be important to ensure continuity and improve health outcomes

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Transitional Care Management Services (CMS)

- Goal: To improve the coordination of care for Medicare patients between the acute care settings and community setting
- CMS has created billing codes for TCM
- Provider to "oversee management and coordination of services, as needed for all medical conditions, psychosocial needs and activities of daily living support"
- Requires:
  - Initial contact with the patient within 2 business days after discharge
  - Face to face visit within a specified period of time
  - Moderate to high medical decision making during the 30-day service period

Resource: Transitional Care Management Services (CMS MLN)

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Transitions of Care Standards

RNCM Practice

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Transitions of Care Standards (ACMA)

- Intended as a common framework for all healthcare settings
- Designed to assess, quantify, identify transition gaps
- Identify opportunities to tailor staffing & TOC processes
- Align with value-based reimbursement
- Connect across healthcare & community settings
- Support longitudinal CM strategies
- Provide a framework to evaluate ROI – reduce utilization, enhance quality, improved patient experience

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Standards of Practice

- Standard 1.0 Identify patients at risk for poor transitions
- Standard 2.0 Complete a comprehensive assessment
- Standard 3.0 Perform and communicate medication reconciliation
- Standard 4.0 Establish a dynamic care management plan that addresses all settings throughout the continuum of care
- Standard 5.0 Communicate essential care transition information to key stakeholders across the continuum of care

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Using these standards can help:

- Patient engagement
- Improve patient experience
- Decrease readmission and Emergency Department utilization
- Medication safety
- Physician satisfaction
- Advance care planning improvements

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- Implementation Recommendations
- Metric Selection & Outcome Evaluation

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Next Steps

- Watch the videos that accompany this lecture
- Review the posted Resources. Download any you would like to keep.
- Complete the Practice Development Activity
- Take the Test Your Knowledge Self-Assessment Quiz
- When you're ready move on to the next topic
- Questions? Let me know:
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  - (608) 437-6035 CST

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