Transitional Care Across the Continuum

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A JOURNEY OF A THOUSAND MILES MUST BEGIN WITH A SINGLE STEP.
Objectives

• Define transitional care.

• Understand the dangers of disconnected care across the continuum.

• Identify creative methods to improve care transitions to positively impact quality of life and reduce readmissions in the high risk patient.

• Identify how Respiratory Therapists can make a difference in transitional care.
What is Transitional Care?

Transitional care: a set of actions designed to ensure the coordination and continuity of care received by patients as they transfer between different locations or levels of care.


Transitional care: encompasses a broad range of services and environments designed to promote the safe and timely transfer of patients from levels of care or across settings, has emerged to bridge the gap between and among a diverse range of providers, services and settings (Coleman & Bout 2003; Naylor, 2003).

Transitional Gaps

- Operational Shortfalls
  - Poor Communication (inpatient to outpatient)
  - Patient did not receive or understand discharge instructions
  - Medication reconciliation incorrect
  - No follow-up appointment

- Psychosocial/Socioeconomic Issues
  - Inability to pay for meds or doctor visits
  - Inability to get to appointments
  - Low health care literacy
  - Behavioral health needs
Consequences

• Suboptimal chronic disease management

• Decline in health and functional status

• Preventable hospital re-admission

• Increase in cost to the patient/organization
Readmission Focus

- Restrictions on Reimbursement for Readmissions

- Penalties for conditions with highest risk of readmission
  - Acute MI
  - Pneumonia
  - Heart Failure
  - COPD
  - Hip/Knee
Identify Root Cause

- Kaiser Health studies showed that system issues were cause of 75% of readmissions
- Patient compliance was attributed to only 25% of readmissions
Making an Impact – New Models of Care

- **Community Care Program**
  - House calls for advanced COPD/HF patients
  - Care Plans/Action Plans/E-Kit
  - Decrease Exacerbation & Increase QOL
  - APRN, RN, SW, RT and other resources
  - Patient has PCP and Specialists

- **Transitional Care Clinic**
  - Post-discharge care of unassigned patients
  - 30-45 Day Transition
  - Barriers to Care
Community Cares Program
Patient Summary (Start thru June 2016) n=194

- 12 Months Prior: ED Visits (700), Inpatient Admissions (500), Observation Patients (100)
- 30 Days Prior: ED Visits (200), Inpatient Admissions (100), Observation Patients (50)
- 30 Days After: ED Visits (50), Inpatient Admissions (20), Observation Patients (10)
- Total Since Joining: ED Visits (350), Inpatient Admissions (320), Observation Patients (120)
Transitions Clinic

Patient Summary (Start thru June 2016) n=1,399

12 Months Prior: ED Visits
30 Days Prior: ED Visits
30 Days After: Inpatient Admissions
30 Days Post-TC: Observation Patients
Right Level of Care

Transitional Care Clinic - ED Referrals
Patient Summary (Start thru April 2016) n=204

- ED Visits
- Inpatient Admissions
- Observation Patients
Simple Cost Avoidance

<table>
<thead>
<tr>
<th>Transitions Clinic</th>
<th>12 Months Prior</th>
<th>30 Days Prior</th>
<th>30 Days After</th>
<th>30 Days Post -TC</th>
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<td>ED Visits</td>
<td>2,909</td>
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<td>Observation Patients</td>
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<td>n=1,399 patients</td>
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2696 (30 days prior to TCC) – 209 (30 days post transition) = 2487 encounters

2487 x $2,000 (conservative est. cost per encounter) = 4,974,000 x 82% (% unfunded)

= $4,078,680 (cost avoidance)
What Part Does RT Play?

- Protocols & Assessment with Interaction
  - Identify risk factors
- Individualized care plans for DC & beyond
  - Follow Up Phone Calls
- Medication reconciliation
- Education
- Equipment
- Home care
- Skilled care
Patients Living with COPD

- Increase Prevalence
  - 3rd Leading Cause of Death (CDC, 2011)
  - >80 million baby boomers
  - 24 million dx with COPD
Change in Mindset

- Exacerbation
  - Acute Event
  - Worsening Symptoms
  - Accelerates the decline in lung function.
- Major burden for the patient, family and healthcare organizations
#1 Goal of Disease Management is to reduce the rate of progression

- Sustain symptom control
- Reduce risk factors
- Improve patient function
- Improve quality of life
Success in Transition Care

• Everyone Can Make a Difference!
• Be Creative
• Partner with Community Resources
  • Home Health
  • Paramedics
• Discharge phone calls
• Identify barriers
• Be an advocate!
“Every day do something that will inch you closer to a better tomorrow.”
References


Preventing Unnecessary Readmissions: Transcending the Hospital’s Four Walls to Achieve Collaborative Care Coordination. Clinical Advisory Board: The Advisory Board Company (2010).