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Care Transitions

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Disclosure

No relevant financial conflict

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Description

- Care transitions occur when a patient/client shifts from one practice setting to another (such as from hospital to home) which may be a vulnerable and confusing time for patients/clients and health care providers alike as necessary information may be missing or inaccurate leading to possible adverse events.
- This course will provide health care providers with strategies and tools to improve the flow of necessary information so that proper care is provided throughout the care continuum.

Objectives

Upon completion of this course, participants will be able to:

1) Define care transitions, health information supply chain in relation to therapy practice and as part of an interdisciplinary team.

2) Describe how to effectively receive a handoff and provide a handoff within the practice setting and between practice settings.

3) Describe how to include the patient as a central partner in the care transition process and the driver of the care plan along the care continuum.

4) List at least three tools available to improve information flow via electronic and traditional means.

Background

- Institute of Medicine (IOM)
  - To Err is Human (1999)
    - 44,000-98,000 die each year in hospitals related to medical errors
  - Preventing Medication Errors (2007)
    - A hospital patient is subject to at least one medication error per day
- Affordable Care Act
  - Innovations Center – new care models

Targeted Conditions

- Congestive heart failure
- Pneumonia
- Acute myocardial infarction
- Chronic obstructive pulmonary disease (exacerbation)
- Total knee or hip arthroplasty

Hospital Readmission

- Risk Factors (during transitions from hospital to home.
  - Medical complexity
  - Age
  - Comorbidities
  - Access to care
  - Hospital length of stay
  - Social support
  - Impaired physical function

Care Transition Models

- Model objectives
  - Improve provider-to-provider communications
  - Improving coordination of care
  - Educating patients on how to self-monitor and manage their medical conditions

Health Information Supply Chain (HISC)

- Supply Chain
  - "A supply chain can be defined as the physical and informational resources required to deliver a good or service to the final consumer."

    – **Reha Uzsoy**
- Health care "supply chain" consists of multiple independent agents, such as insurance companies, hospitals, doctors, employers, and regulatory agencies.

Health Information Supply Chain

- Matches resources with demands
  - Resources include
    - human capital (e.g., nurses, therapists),
    - physical capital (e.g., intensive care beds, ambulances, sponges), and
    - intellectual capital (e.g., a patient medical record or an evidence-based medicine protocol).

HISC and Therapy Practice

- HISC – Transfer of information between therapists is key.
  - Information between upstream and downstream providers must be available, accurate, and timely
  - Information between therapists and the other interdisciplinary team members in the same practice setting must be available, accurate, and timely

Case Scenario

- 75 year old female referred for therapy from acute care hospital.
  - Admitting Dx: S/P ORIF R hip secondary to traumatic fall.
  - What orthopedic orders does the downstream therapist need to have with the referral?
    - Weight-bearing status
    - Orders for knee brace
    - Activity restrictions

System Approach to Care Transitions

- Discharge Planning
  - DC location/services necessary
  - Collaboration with community providers about dc, follow up plan, follow up visits
  - Hospital Physician <-> Community Physician
  - Acute Care PT <-> Home Care PT
  - Patient/Caregiver involved in dc planning process

System Approach to Care Transitions

- Transfer of Information
  - Include functional information
  - Often lacking in hospitalist hospital discharge summaries
    - unresolved biomarkers
  - Therapists information should be included in the discharge or transfer information sent down stream

System Approach to Care Transitions

- Availability of information
- Timeliness of information
- Clarity of information
- Organization of information
- Medication Safety
- Educating patients to promote self-management
- Enlisting help of home and community supports
- Advance care planning
- Coordinating care among team members
- Monitoring and managing symptoms after discharge
- Outpatient follow-up

Falvey JR, Burke RE, Malone D, Ridgeway KJ, McManus BM, Stevens-Lapsley JE. The Role of Physical Therapists in Reducing Hospital Readmissions: Optimizing Outcomes for Older Adults During Care Transitions From Hospital to Community. *Phys Ther*. 2016;96(8):1125-1134.

Role of Therapists

"None of these innovative care transition models formally include physical therapist analysis of, or intervention on, known independent functional predictors of hospital readmission, such as gait speed, strength or activities of daily living (ADL) ability."

Falvey JR, Burke RE, Malone D, Ridgeway KJ, McManus BM, Stevens-Lapsley JE. The Role of Physical Therapists in Reducing Hospital Readmissions: Optimizing Outcomes for Older Adults During Care Transitions From Hospital to Community. *Phys Ther*. 2016;96(8):1125-1134.

Care Transitions

- "Handoffs"
- Vulnerable Exchange Points
  - Medication Discrepancy
  - Adverse clinical events
  - Potentially avoidable hospitalizations
    - 20% of Medicare Beneficiaries readmitted within 30 days.
    - 34% readmitted within 90 days.
    - 15 billion annually spent

Transitional Care

"…defined as a broad range of time-limited services designed to ensure health care continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another."

Naylor et al.

Positive Effects on Transitional Care on Re-admissions

- Coaching
- Disease/case management
- Discharge management plus follow-up
- Telehealth

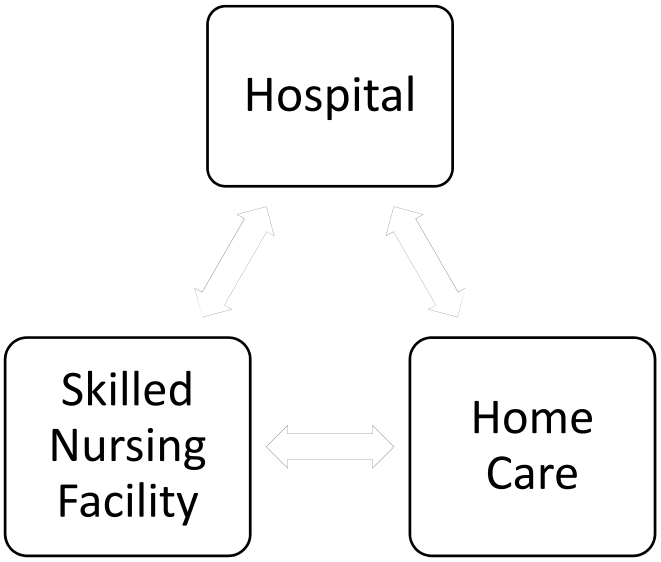
Naylor MD, Aiken LH, Kurtzman ET, Olds DM, Hirschman KB. The care span: The importance of transitional care in achieving health reform. *Health Aff*. 2011;30(4):746-754.

Reducing All Cause Re-hospitalization

- Patient Self-Management
- Interventions to connect acute care providers with primary care physicians
- Interventions to connect acute care providers with other health care providers

Naylor MD, Aiken LH, Kurtzman ET, Olds DM, Hirschman KB. The care span: The importance of transitional care in achieving health reform. *Health Aff*. 2011;30(4):746-754.

Upstream <-> Downstream



Communication vs. Collaboration

Communication: communication, in the sense of cross-fertilization of ideas, involving two or more academic disciplines
(National Institutes of Health 2013)

Collaboration: an interpersonal process in which members of different disciplines contribute to a common product or goal
(Bronstein 2003)

Methods of Communication

- Non-Verbal
  - Written
  - Facial expressions/Body Language
- Verbal

TeamSTEPPS

- TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) is an evidence-based framework to optimize team performance across the healthcare delivery system.
- Describes leadership and communication tools to improve patient safety.

Communication is

- **Complete**
  - Communicate all relevant information
- **Clear**
  - Convey information that is plainly understood
- **Brief**
  - Communicate the information in a concise manner
- **Timely**
  - Offer and request information in an appropriate timeframe
  - Verify authenticity
  - Validate or acknowledge information

From TeamSTEPPS 2.0

Tools to Improve Team Communication (TeamSTEPPS)

- Brief: This is a short session for planning prior to start to discuss team formation; assign essential roles; establish expectations and climate; and anticipate outcomes and likely contingencies
- Huddle: When problem solving is needed, this ad hoc planning is used to reestablish situation awareness; reinforce plans already in place; and assess the need to adjust the plan.
- Debrief: This informal information exchange session is designed to improve team performance and effectiveness. Feedback from the team drives future process improvement.

Communication Challenges

- Language barrier
- Distractions
- Physical proximity
- Personalities
- Workload
- Varying communication styles
- Conflict
- Lack of information verification
- Shift change

TeamSTEPPS 2.0

Communication Tools

- Situation, Background, Assessment, Recommendations, Questions (SBARQ)
  - SBARQ is a technique for communicating critical information that requires immediate attention and action concerning a patient's condition and is especially important during handoff.
- Call Outs: used to communicate important information to all team members simultaneously
- Check Backs: closed-loop communication to ensure that information conveyed by the sender is understood by the receiver as intended (i.e. restate what was said)
- Handoffs

SBARQ

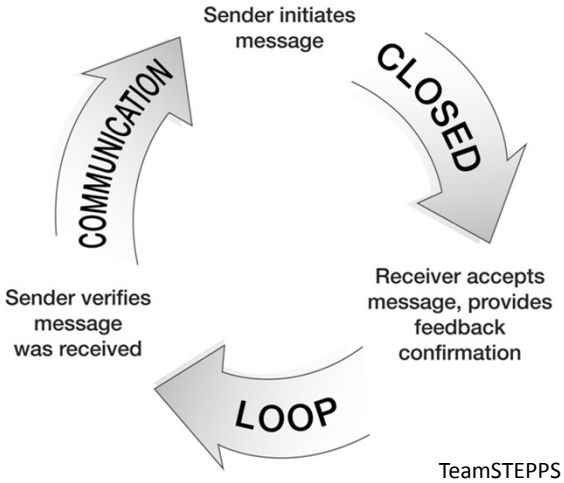
- Situation —What is going on with the patient?
- Background —What is the clinical background or context?
- Assessment —What do I think the problem is?
- Recommendation and Request —What would I do to correct it?
- Questions— An opportunity to ask or answer any questions.

Call Out

A strategy used to communicate important or critical information

- It informs all team members simultaneously during emergency situations
- It helps team members anticipate next steps

Check-Back is…



TeamSTEPPS 2.0

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Game of "Telephone"

- Fill in the gap
- Guessing what was said…
- All orders should be read back and confirmed.
- Should clinicians take orders off of voice mail?

Handoff

- The transfer of information during transitions in care across the continuum
  - Includes an opportunity to ask questions, clarify, and confirm
- Transfer of responsibility and accountability
- Clarity of information
- Verbal communication of information
- Acknowledgment by receiver
- Opportunity to review

Intra-organizational Communication

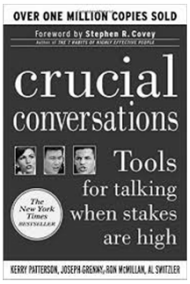
- Interdisciplinary Conferences
- Team Meetings
- Written messages
  - Email
  - Memos
  - Bulletin Boards
- Handoff

Inter-organizational Communication

- Written communications
  - Discharge Summaries
- Electronic Access
  - Notifications
  - Portal Access
- Conference Calls
- Navigators

Improving Communication

- Crucial Conversations
  - The power of dialogue
  - Stay focused on what you really want
  - Make it safe to talk
  - Staying in dialog
  - How to listen



Organizational Design

- Care Delivery Models
  - Patient Centered Medical Home (PCMH)
    - Comprehensive Care
    - Patient-Centered Care
    - Coordinated Care
    - Accessible Services (telephone care)
    - Quality and Safety
- Accountable Care Organizations (ACO)
  - Improved coordination of care

https://pcmh.ahrq.gov/page/defining-pcmh
https://innovation.cms.gov/initiatives/aco/

Patient-Centered Care Planning

- Reducing Adverse Events
  - An informed patient/caregiver can advocate for appropriate care
  - Improve coordinated care

Patient-Centered Care

- Actively engage patients and their families and caregivers in the management or improvement of their health in four ways:
  - Communicate with patients
    - the role of patients and providers, and what each can expect of the other
  - Support patients in self-care.
    - Reduce risk factors, helping patients with chronic illnesses develop and update self-care goals and care plans
  - Partner with patients in shared decision-making
  - Improve patient safety by giving patients access to their medical records so they can detect and prevent errors, and by including patients in areas such as: safe medication use, infection control initiatives, and reporting complications or errors

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Improving the Patient Experience

"Research suggests that **good interdisciplinary communication** leads to improved patient and family outcomes (i.e. high levels of patient and family satisfaction, symptom control, reductions in length of stay and hospital costs) " (Kuziemsky et al 2009)

Case Scenarios

- Transitions from one practice setting to another
- Handoff from clinician to clinician between organizations and within an organization

Improving Information Flow

- Tools
  - Portals
  - "Tiger Text" and other communication smart phone applications
  - Electronic Medical Record
    - Notifications/Alerts
  - Email/Traditional Text

Thank You

Questions and Answers

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