Seamless Transitions: Achieving patient safety through communication and collaboration

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WHAT STARTS HERE CHANGES THE WORLD
Healthcare Reality

• At least 25% Preventable hospitalizations among Medicare patients with chronic diseases

• Fragmentation of healthcare delivery system
System Re-design

• To facilitate coordination of care across the continuum

• Four levels
  – Patient
  – Healthcare Team
  – Healthcare organization
  – Environment (political & social)
    • CMS Readmission Penalty
Case for Transitional Care

• “A broad range of time-limited services designed to
  – Ensure healthcare continuity
  – Avoid preventable poor outcomes among at-risk populations, and
  – Promote the safe and timely transfer of patients from 1 level of care or setting to another”

• Significant ↓ in hospitalization from 19 to 70%
Integrated Care Delivery models

• Complete Vertical Integration
  – Buy or Build

• Joint Venture
  – Partnership agreements between separate but established entities providing the desired complement of services
Implementation Challenges

• Achieving collaboration among providers across disciplines and/or facilities
• Fit within the workflows of the clinicians at all transition points
• Foster relationships with all stakeholders
• Match goals and patient targets
• Be aligned with organizational mission and values

WHAT STARTS HERE CHANGES THE WORLD
TRansitions Across Care Settings (TRACS) - An Austin Case Study
Partners

• St. David’s Healthcare System
  • Acute care hospital system (6 hospitals) in the central Texas region

• Harden Healthcare
  • 6 facilities (4 Skilled Nursing Facility, 1 Home health Agency, 1 Hospice) in the central Texas region
  • The Harden Integrated Care Division - “Setting" & “Service" agnostic
TRACS Roadmap for Patients

Roadmap to Recovery

My Care Coach
Phone

WHAT STARTS HERE CHANGES THE WORLD
Planning Stage

- Steering committee
- Goals establishment
- Identification of best practice model - CTI
- Adaptation of best practice model to local context
- Leveraging strengths & identifying areas for improvement
Steering Committee

• Criteria for selection
• Director of Case Management (SDH)
• Director of Home Health Quality (HH)
• President of Integrated Care (HH) and
• Senior VP of Clinical Innovation (SDH)
Goals

• Strengthen SDH’s discharge and care transition programs by partnering with HH to build a patient-centered communication network

• Successful hand-off and follow up across settings

• ↓ Avoidable readmissions by promoting patient self-management and informed decision making
Identification of Strengths

• Key strengths include
  – Decade-long relationship between SDH and post-acute service facilities of HH
  – Well-established case management referral process
  – Physician buy-in at SDH acute-care facilities
  – Strong commitment to supporting a culture of patient safety by leaders in both institutions
Areas needing improvement

• Post-referral care coordination and feedback

• Specific role or setting responsible for coordination across the entire care continuum

• Integrate providers from physician practice offices in post-acute care transitions
Coleman’s Care Transitions Intervention (CTI)

• Transition Coaches

• 4-week intervention composed of
  – a pre-discharge hospital visit,
  – a post-discharge home visit,
  – and 3 follow-up telephone calls
TRACS Transition Coach

• Liaison between SDH and HH
• Hand off patient-centered care plans
• Follow and Track patients through the care continuum
  – Home visit & follow-up phone calls
  – Patient / family education & environment assessment
  – 4 Pillars
4 Pillars

• Medication reconciliation

• Patient-centered personal health record (PHR)

• Follow-up with other healthcare providers

• Identification & response to red flags
Medication Reconciliation

• Upon admission an accurate list of patient’s medications are compared at every transition of care

• Discrepancies and/or any clinical significant findings are identified and reconciled with physician
Patient-centered PHR

• 9X12 Envelope
  – Most current Medication Profile
  – Copies of lab work/x-rays
  – Any recent discharge summaries from hospital or ER visit
  – Any documentation pertinent to patient health status
TRACS Envelope

Important Medical Papers

To Take With You To:
- All physician appointments and medical visits
- Hospital and/or emergency room
- Any other

Recommended Items to Keep in Your Envelope:
- Discharge papers from the most recent hospital visit
- Complete medication list
- List of all physicians you are currently seeing
- List of all allergies
- Questions you have for your physician
- Instructions from your physician
- Any information you deem pertinent to your health care

St. David’s HealthCare

TRACS
Transitions Across Care Settings
(512) 788-0169

THE UNIVERSITY OF TEXAS AT AUSTIN
Follow Up

• Appointments
  – Scheduling
  – Reminders
  – Removing barriers in keeping appointments
  • Transportation
Communication Loop

• Discharge planner/case manager
  – Transition to another care setting
  – Potential ER admission

• Physicians / Home health / SNF
  – Any new/changed information/status
  – Phone calls or documentation in TRACS database
Physician Communication Form

TRACS
TRansitions Across Care Settings
Physician Communication Form

Date of Visit: __/__/____
Physician Name: ____________________________________________

☐ Primary Physician   ☐ Consulting MD (specify specialty) ____________________________

☐ First Visit       ☐ Regular check-up       ☐ Post Hospital Discharge       ☐ PRN Visit

Changes in Medications: ☐ No       ☐ Yes _______________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Labs order: ☐ No       ☐ Yes _______________________
__________________________________________________________________________
__________________________________________________________________________

Specific Instructions for Patient:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Comments/Additional Information:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Future appointments: __________________________________________
__________________________________________________________________________

Physician Signature: ________________________________________________
Stoplight Zones Tools

- Evidenced based tools / education material
- Informed decision making by patients based on symptoms they may be experiencing or how they feeling
- Green Zone
- Yellow Zone:
- Red Zone
Culture of patient safety

• Prompt follow-up by the transition coach
• Identification of patient safety concerns
  – Education on medications and disease management
  – Support resources on disease management such as transportation to physician appointments, medication affordability and access and affordability of healthy food
  – Assessment of patients’ home environment for any unsafe living conditions
TRACS Program Implementation

• Initial target population
  – PNA, CHF, AMI

• Compliance with federal regulations
  – HIPAA, CoP, BAAs

• Human resources and staff competencies
  – 2 FTE: i) RN with case manager & home health experience, ii) LVN
  – Reported to Harden Integrated Care Division
TRACS Program Implementation

• Material & educational resources
  – Clinical pathways – AMDA
  – Patient education guides
  – Care protocols
  – Scripts for weekly calls
• Internal training – Meetings & in-service
• Physician Education
  – “What Physicians need to know”
TRACS Program Implementation

- Technology capability
  - Referral System - Curaspan
  - TRACS Database - Excel

- Post-TRACS: Metrics & Outcome evaluation
Early Results

- Pilot – North Austin Medical Center & HH
- Sample size: 104 patients
- Overall readmission rate at 4.8%
- Readmission rate for
  - AMI was 0%
  - CHF was 7.1% and
  - PNA was 4.4%
Case Study: COPD Intervention

Patient 1 is a bed bound patient referred to Harden Transitions program by SDH Case Management. Home Health was ordered. During first week, wife called Transitions Coach due to patient having shortness of breath.

- Coach visited home for assessment and contacted Home Health Case Manager
- PCP contacted to order x-ray
- Mobile x-ray was done, pneumonia confirmed
- Patient placed on antibiotics and no hospital admission ever occurred. (All services completed within 6 hours, from first complaint through medication administration.)
- Patient remains home with caregiver, and continues to respond well to additional training / guidance
Case Study: Care Continuum

Patient 2 was an ER frequent flyer with pain issues, CHF and AMI.

- After educational presentation on Transitions program, ER Physician asked if Transitions could enroll patient into program directly from ER.
- During next episode where patient came to ER, Transitions Coach was called to visit with patient. Assessment was performed and patient was a weekend admit to local SNF with hospital admission averted.
- Patient discharged from SNF after acute condition stabilized and continued on Transitions program with Home Health.
- Home Health followed patient and reported to Transitions Coach decline in condition with Hospice recommendation.
- Transitions Coach coordinated with patient, family and physician to transition to Hospice program, patient was able to “age in place” with the appropriate level of care across the continuum.
Lessons Learned

• Team communication

• Employee turnover

• Cumbersome technology
Conclusion

• Key ingredients for establishing collaborations between hospitals and PAC settings:
  – Leadership commitment at the highest level
  – Regular communication among all stakeholders

• Next iteration of a transitional care model
  – > 1000 patients enrolled
Questions??