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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.

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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.

Parry, C., Mahoney, E., Chalmers, S.A. and Coleman, E.A. 2008. Assessing the quality of transitional care further applications of the care transitions measure. Medical Care. 2008(3):317-322.

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).

Naylor, M. Transitional Care: A Critical Dimension of the Home Healthcare Quality Agenda. Journal for Healthcare Quality 2006;8(1):48-55

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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

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Readmission Focus

- Restrictions on Reimbursement for Readmissions

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

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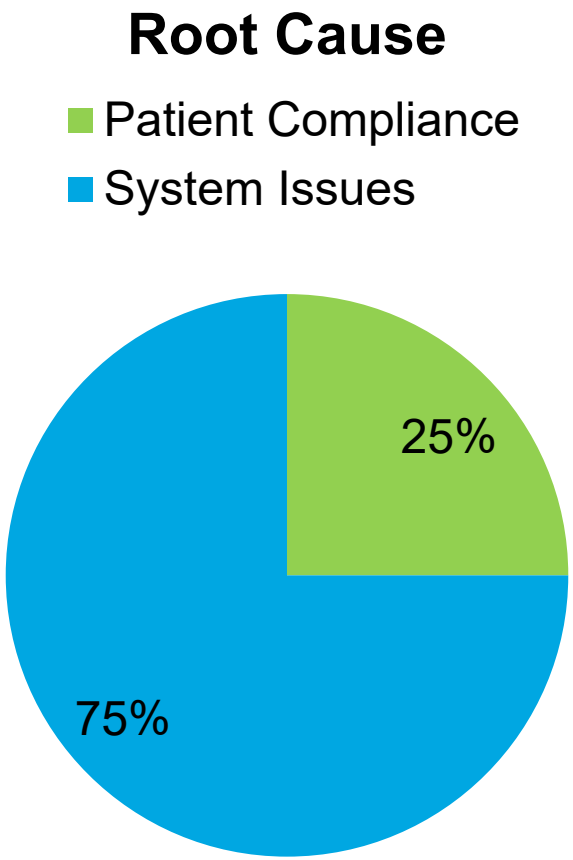
Identify Root Cause



- Kaiser Health studies showed that system issues were cause of 75% of readmissions
- Patient compliance was attributed to only 25% of readmissions

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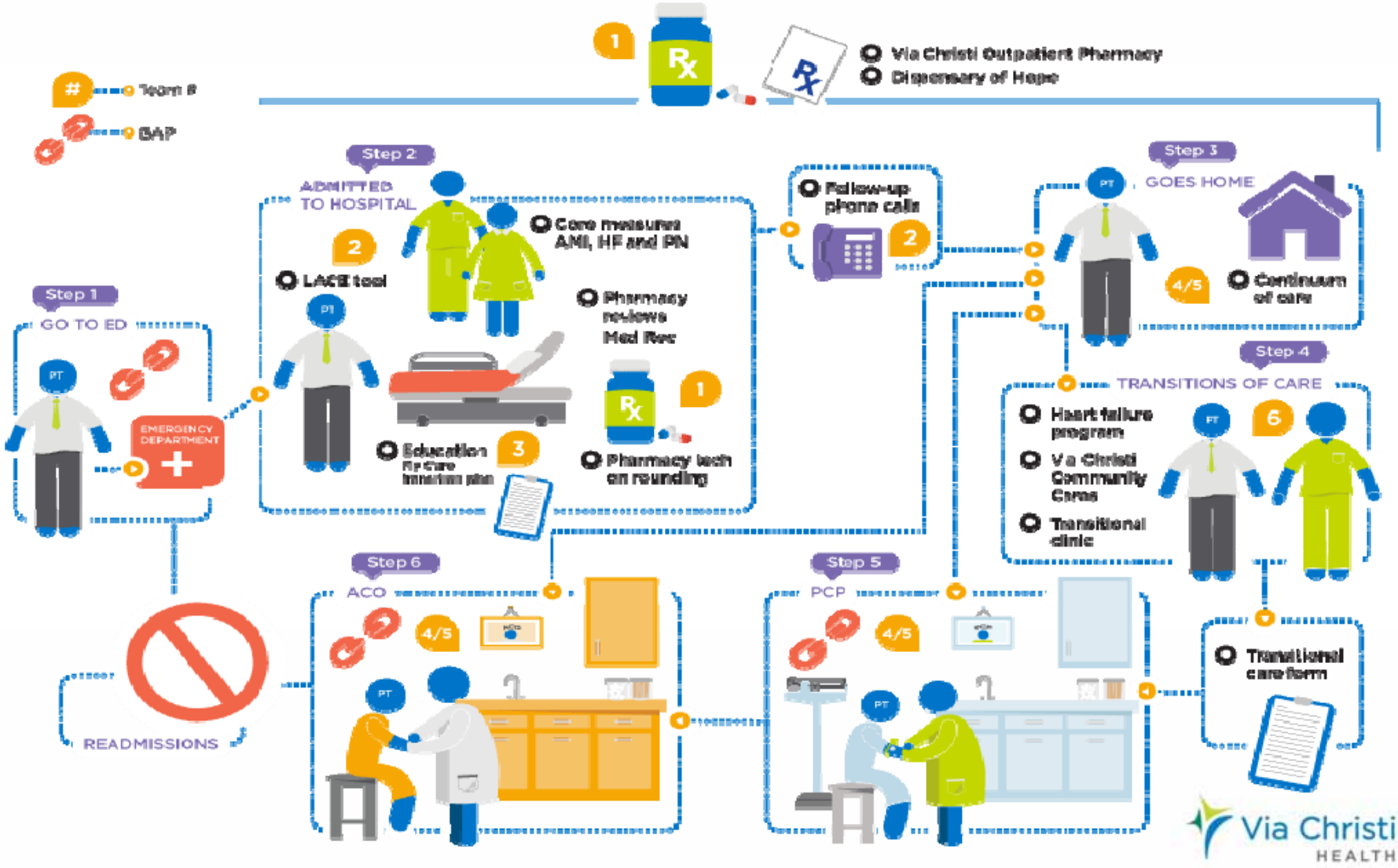
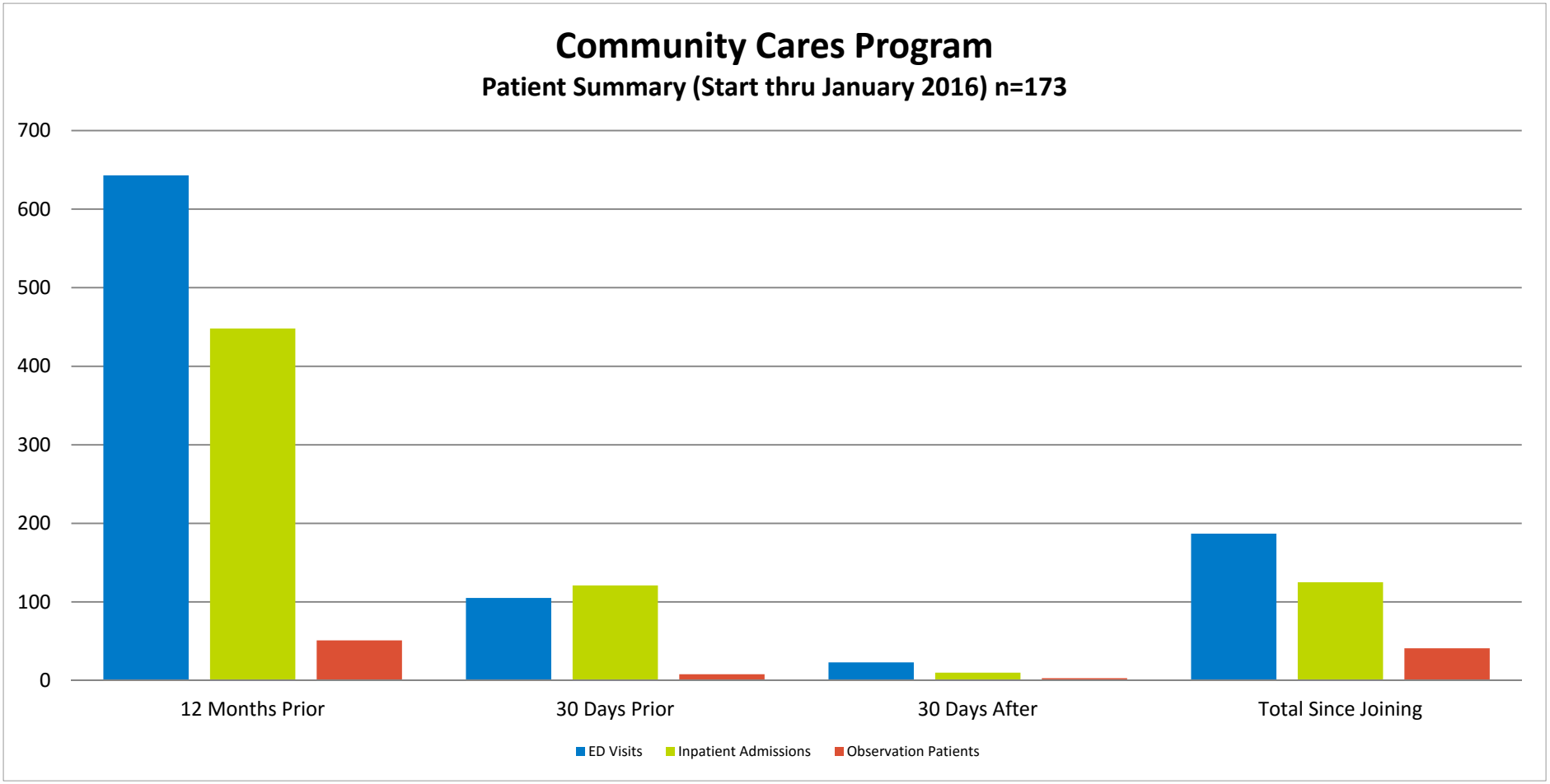
Point of Impact



Making an Impact

- Cardiopulmonary Rehab
  - Improved quality of life, physical & emotional tools for symptom management
- Heart Failure Program
  - Education, medication management, acute crisis management
- Community Care Program
  - House calls for advanced COPD/HF patients
- Transitional Care Clinic
  - Post-discharge care of unassigned patients

Community Cares



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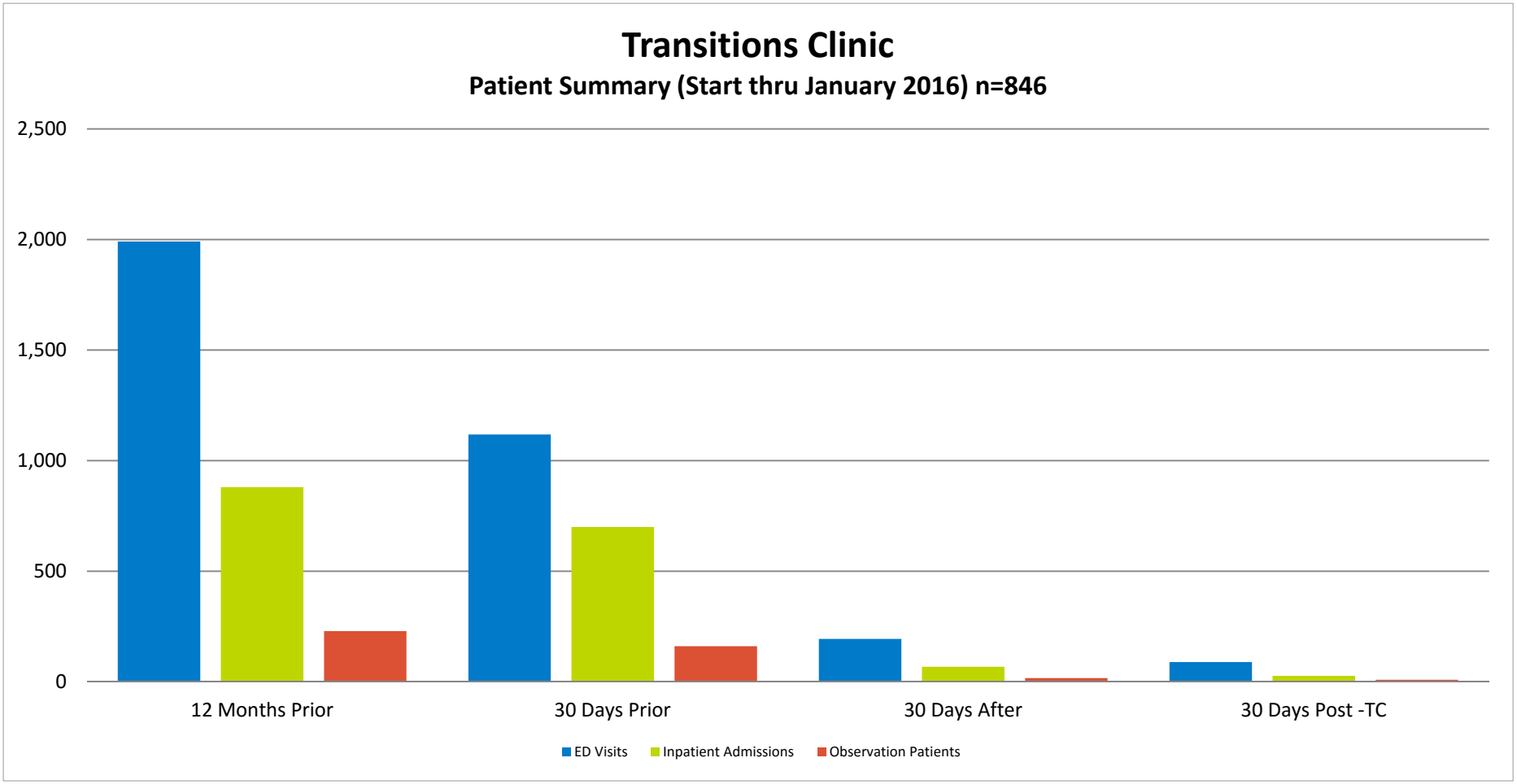
Transitions Clinic



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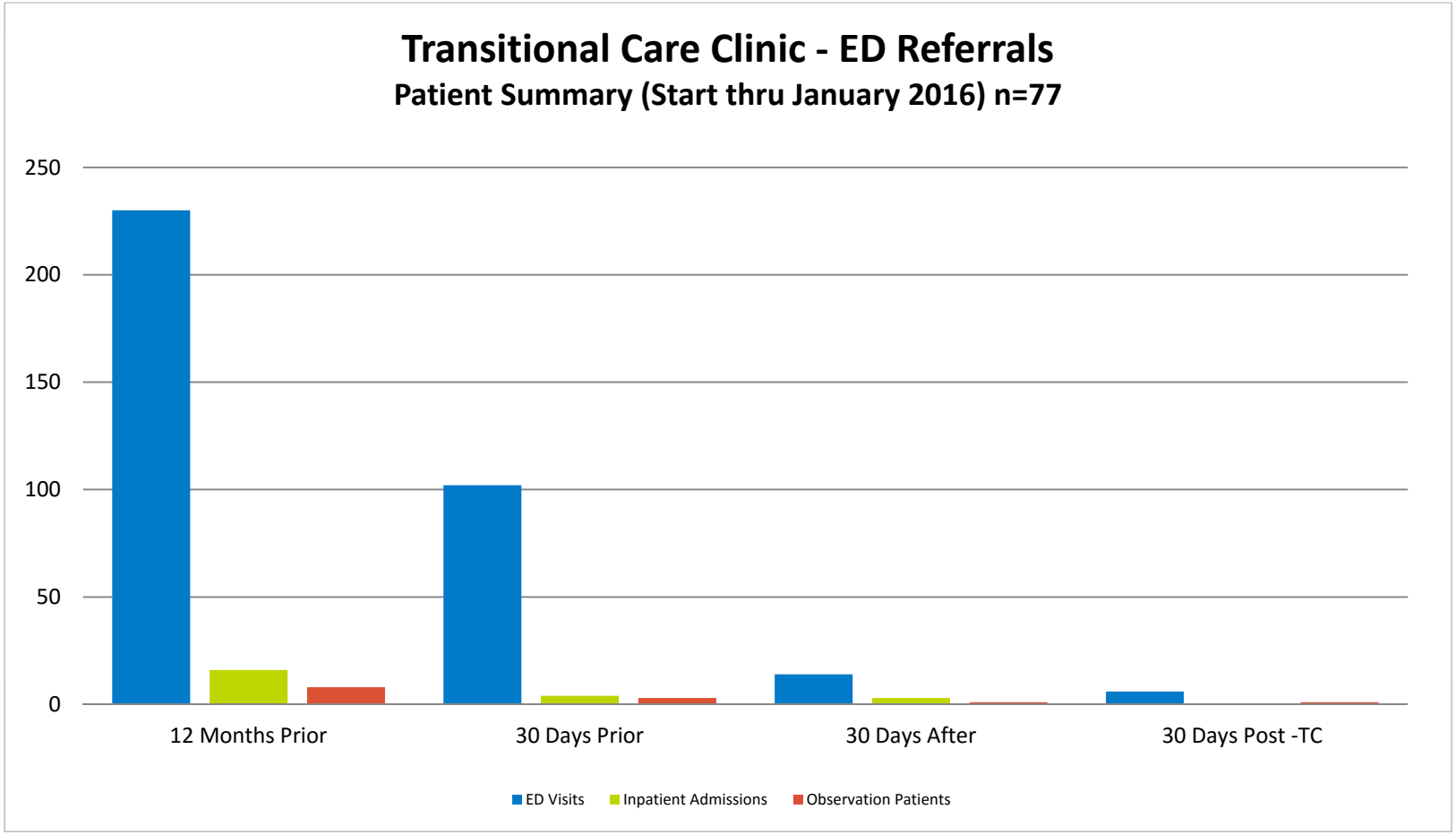
Right Level of Care



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What Part Does RT Play?

- Protocols & Pt assessment with each tx
  - Identify risk factors
- Individualized care plans for DC & beyond
- Medication reconciliation
- Education
- Equipment
- Home care
- Skilled care

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Patients Living with COPD

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

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Change in Mindset

- Exacerbation
  - Acute Event
  - Worsening Symptoms
  - Accelerates the decline in lung function.
  - Major burden for the patient, family and healthcare organizations

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Chronic Disease Management

#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

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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!

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“Every day
do something
that will inch you
closer
to a better tomorrow.”

References

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