

Best Practice Transitional Care: Updates for Case Managers



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Agenda

- Welcome and Introductions:
 - Nancy Freeborne, DrPH, MPH, PA-C
 Senior Advisor for Educational Programming
 Health2 Resources
 - Teresa M. Treiger, RN, MA, CCM, FABQAURP Chair
 - Commission for Case Manager Certification
- Presentation:
 - Dr. Toni Cesta, Ph.D, RN, FAAN
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Learning Outcomes

After this presentation, the successful participant will be able to:

- 1. Understand the differences between discharge planning and transitions of care.
- 2. Describe risks and poor outcomes associated with transitions of care.
- 3. Discuss strategies for effective handoffs across the continuum.
- 4. Develop transitional care plans utilizing best practices of transitional care.

Exam Prep Resources







Practice Exam



Glossary App



Certification 360 Virtual Workshops



Printable Glossary



Exam Prep References



8-Week Prep Circuit



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http://bit.ly/3V1xQEW

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Best Practice Transitional Care: Updates for Case Managers



Teresa M. Treiger, RN, MA, CCM, FABQAURP Chair Commission for Case Manager Certification Communicating with the client, support system, and the clinical team

Case Managers facilitate smooth transitional care by...

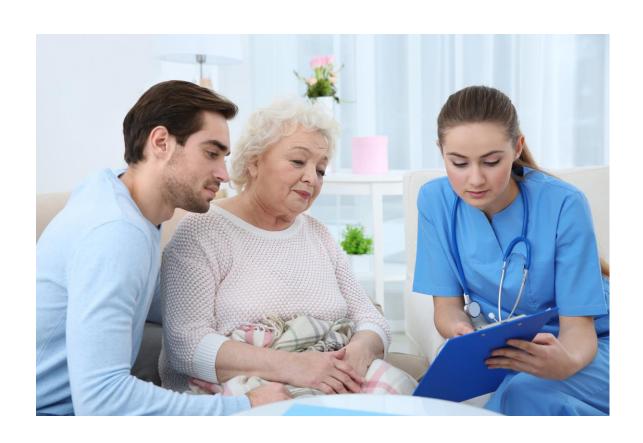
Setting goals for acute care episodes and transition of care

Determining best post-acute care options

Assessing environment, client needs, support system capacity to help, and finances prior to transfer

Proprietary to CCMC®

How Case Managers Improve Transitional Care Outcomes



Among other responsibilities:

- Listening, coaching, and communicating with stakeholders
- Helping facilitate comprehensive hand-offs to next level of care
- Client risk assessment
- Medication reconciliation
- Providing a point of contact

Proprietary to CCMC®



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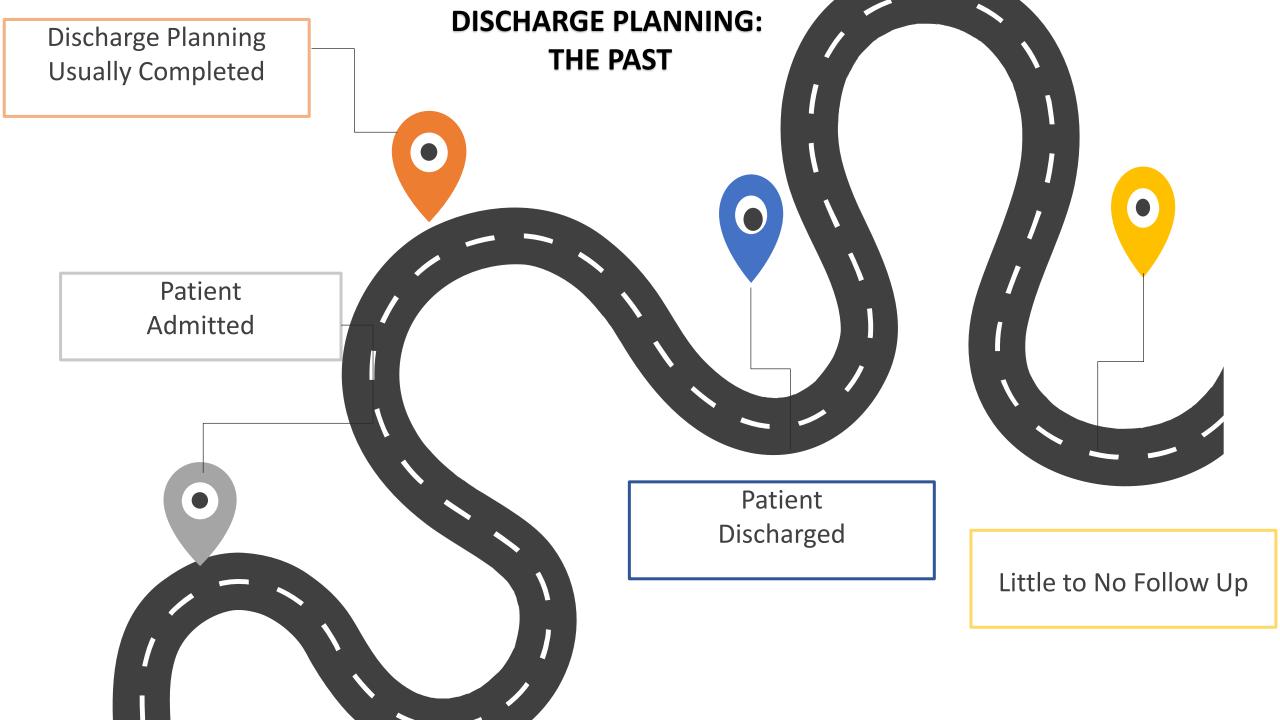
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OBJECTIVES

- 1. Understand the differences between discharge planning and transitions of care.
- 2. Describe risks and poor outcomes associated with transitions of care.
- 3. Discuss strategies for effective handoffs across the continuum.

4. Develop transitional care plans utilizing best practices of transitional care.

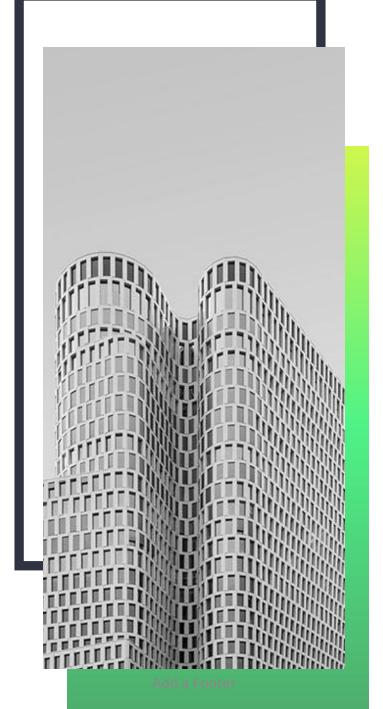


OUR GOAL: TIMELY, APPROPRIATE, COMPLETE AND COMPLIANT DISCHARGE **PLANNING AND TRANSITIONS**

Prompt handoffs in hospital: nursing, ancillary services, physicians, case management Information regarding postacute care providers provided to patient, family and/or caregiver Timely post-acute care planning initiated, including assessment of appropriate care providers (as needed) Prompt and complete handoffs to appropriate post-acute care providers

Patient admitted with timely and appropriate referral to social work

FROM DISCHARGE TO TRANSITIONS



TRANSITIONS OF CARE

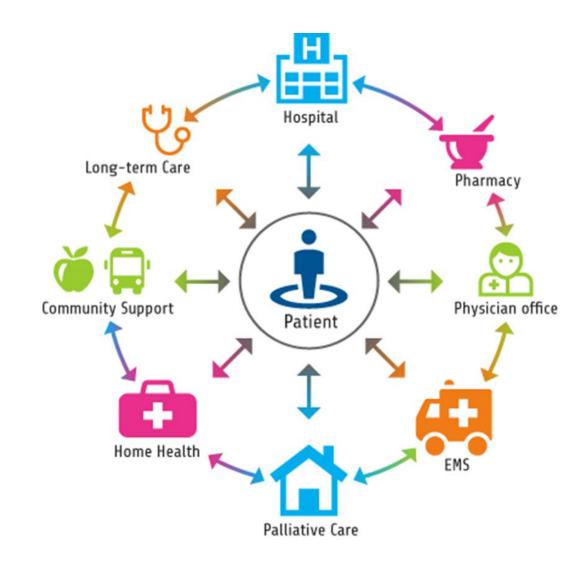
"Refers to the movement of patients between health care practitioners, settings, and home as their condition and care needs change"

Example

Patient might receive care from primary care physician or specialist in an outpatient setting, then transition to hospital physician and nursing team during an inpatient admission, then move on to yet another care team at a SNF. Finally, might return home, where care is received from visiting nurse or support from family member or friend.

Joint Commission Transitions of Care

GEOGRAPHY OF TRANSITIONS OF CARE



Source: Healthy Transitions Colorado, 2015

DEFINITIONS – THE CONTINUUM OF CARE

In medicine, describes the delivery of health care over a period of time. In patients with a disease, this covers all phases of illness from diagnosis to the end of life.

A concept involving an integrated system of care that guides and tracks patients over time through a comprehensive array of health services spanning all levels of intensity of care.



- Is the glue that holds the continuum of care together
- Integrated care cannot happen without it
- Case managers must be at all transition points
- Case managers must link across all healthcare settings and providers

AMERICAN CASE MANAGEMENT ASSOCIATION TRANSITIONS OF CARE STANDARDS

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



EXPECTATIONS OF EFFECTIVE TRANSITIONS OF CARE

- Post-acute care alignment, tracking and feedback
- Effective and timely identification of plan and communication with patients, families and stakeholders
- Integrated electronic medical records among care providers: acute and post-acute
- Appropriate staffing to maintain effective transition plan
- Appropriate roles across continuum
- Clear and effective policies
- Ensuring appropriate transitions through leadership mentoring and auditing—regardless of setting



TRANSITIONAL PLANNING PROCESS

Assessment of the patient's condition, risks and needs

Development of the discharge plan, including the goals of treatment and disposition

Implementation of the plan

Evaluation, on-going monitoring, and modification of the plan as warranted

Confirmation of, and final preparation for, the patient's transition

Transition of the patient to another level of care or to home

Follow-up with patient post-transition





- Multiple providers
- Patient, family and/or caregiver decision making for next level of care
- Payer reimbursement variation
 - Fee for service, bundled payment, alternative payment models
 - Inadequate funding for next level of care needs: unfunded, underfunded, lack of supplemental coverage
- Avoidable days/delays
- Readmitted patients
- Physician practice patterns
- Communication across continuum
- Inadequate coordination of care
- Inadequate planning and goal setting
- Post-acute care providers
 - Compromised care: readmissions, increase in costs and length of stay
 - Delays in accepting patients

MORE TRANSITION CHALLENGES

Ability to build expanded post-acute care relationships

Managing post-operative mortality, which is increased in the first 3 months postop: 1/3 of deaths in US from heart attacks and strokes

Smaller hospitals with high Medicare populations will have a higher percentage of patients at risk

TRANSITIONS ARE DEPENDENT ON EFFECTIVE HANDOFFS

\$26B Spent on
Poor Transitions of
Acute Care
Medicare Patients
by CMS Per Year
(ACMA)

HANDOFF

"Transfer and acceptance of patient care responsibility achieved through effective communication. It is a real-time process of passing patient-specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient's care."

Joint Commission Sentinel Event Alert

Clinical handoffs, also known as sign-outs, shift reports, or handovers, occur in many places along the healthcare value chain. It involves the 'transfer of professional responsibility and accountability for some or all aspects of care for a patient, or groups of patients, to another person or professional group on a temporary or permanent basis.

Agency for Healthcare Research and Policy

Add a Footer

COMMUNICATION DURING CARE TRANSITIONS

VERBAL

• Systemized methods for making sure that the person taking care of the patient speaks to the person to whom the patient is going to be taken care of

ELECTRONIC

- Checklists
- Time out forms
- Transitional minimum data sets
 - Give providers baseline information on the patient can help avoid unnecessary readmissions

Use a transitional minimum data set (TMDS) to improve communication



STANDARDIZED HAND OFF PROTOCOLS

The transition of care as well as the transfer of patient-specific information by one healthcare professional to another with the purpose of providing a patient with safe, continuous care

Can only be achieved by effective communication, verbal and/or written

A typical teaching hospital may perform 4,000 handoffs every day

INEFFECTIVE HANDOFFS CAN MEAN MORE ERRORS

As health care has evolved and become more specialized, with greater numbers of clinicians involved in patient care, patients are likely to encounter more handoffs than in the simpler and less complex health care delivery system of a few generations ago

Ineffective handoffs can contribute to gaps in patient care and breaches (failures) in patient safety, including medication errors, wrong-site surgery, and patient deaths

HANDOFFS CAN BE DIFFICULT

Clinical environments are dynamic and complex, presenting many challenges for effective communication among health care providers, patients, and families

Some nursing units may transfer or discharge 40 percent to 70 percent of their patients every day, thereby increasing the frequency of handoffs encountered daily and the number of possible breaches at each transition point

WHAT CONTRIBUTES TO FUMBLED HANDOFFS?

Ineffective handoffs can lead to a host of patient safety problems

A study of incidents reported by surgeons found communication breakdowns were a contributing factor in 43 percent of incidents, and two-thirds of these communication issues were related to handoff issues

The use of sign-out sheets for communication between physicians is a common practice, yet one study found errors in 67 percent of the sheets.

The errors included missing allergy and weight, and incorrect medication information

In another study, focused on near misses and adverse events involving novice nurses, the nurses identified handoffs as a concern, particularly related to incomplete or missing information

CHASING AFTER TEAM MEMBERS

Acute care hospitals have become organizationally complex, contributing to difficulty communicating with the appropriate health care provider

Due to the proliferation of specialties and clinicians providing care to a single patient, nurses, case managers, and doctors have reported difficulty in even contacting the correct health care provider

One study found that only 42 percent of nurses could identify the physician responsible for the patient in their care. This study highlights the potential gaps in communication among health care providers transferring information about care and treatment

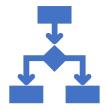
IMPLEMENTATION EXPECTATIONS FOR EFFECTIVE HAND-OFFS



Interactive communication allowing for the opportunity for questioning between the giver and receiver of patient information.



Up-to-date information regarding the patient's care, treatment and services, condition and any recent or anticipated changes.



A process for verification of the received information, including repeat-back or read-back, as appropriate.

IMPLEMENTATION EXPECTATIONS FOR EFFECTIVE HAND-OFFS

An opportunity for the receiver of the hand-off information to review relevant patient historical data, which may include previous care, treatment and services.

Interruptions during hand-offs are limited to minimize the possibility that information would fail to be conveyed or would be forgotten.

DISCHARGE AND TRANSITION STRATEGIES

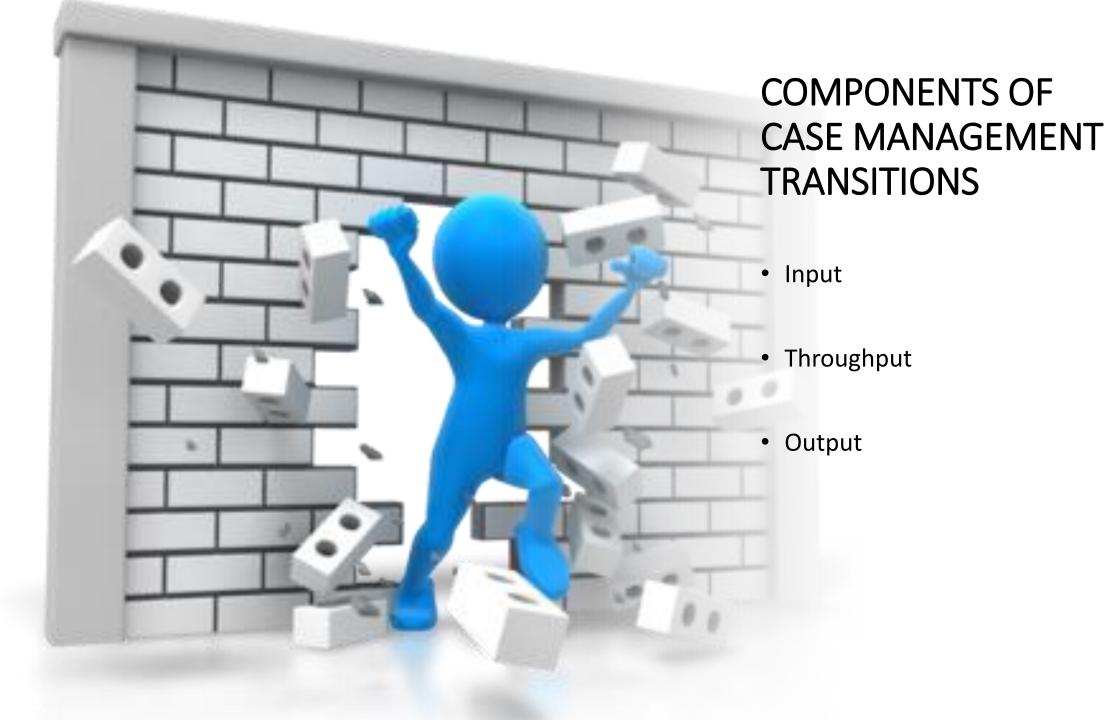
Understand the influences on the transition

- Patient, family and/or caregiver
- Case management processes
- Hospital and post-acute care processes
- Physicians

Understand which patients are part of alternative payment models and how to collaborate with those case managers

- Bundled payments
- Accountable Care Organization collaboration
- Patient Centered Medical Home

Develop strategies for your department during staffing challenges or with new case management staff



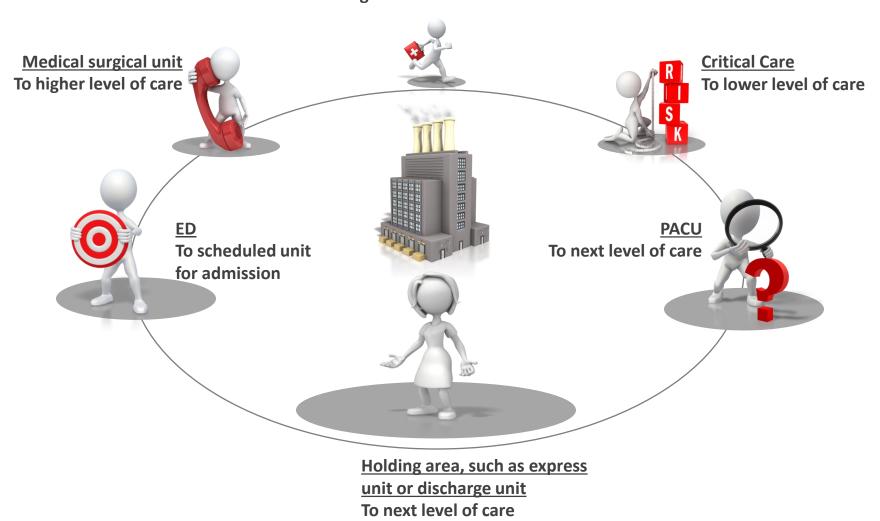
TRANSITION COMPONENT #1: INPUT

- Transfers-In
- Patients Waiting For Admission
 - ED
 - · Admission Office (scheduled and non-scheduled)
 - Physician Office
 - Radiology Special Procedures or Cath Lab
 - Surgical sites such as ambulatory surgery, same day surgery
 - Outpatient clinic
- Long term care settings
 - LTAC
 - Nursing Home
 - SNF
- Acute Rehab

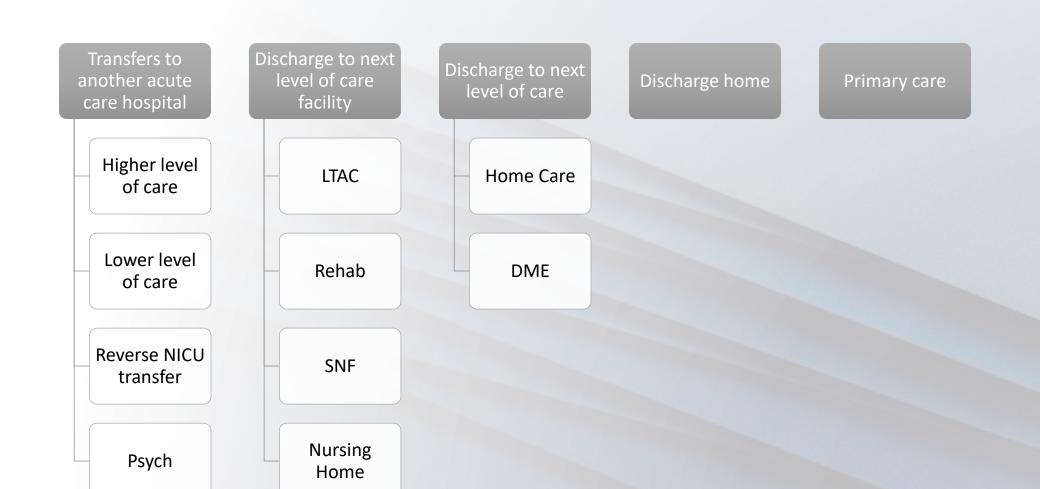


TRANSITION COMPONENT #2: THROUGHPUT (intra-hospital transfers)

Telemetry (intermediate area) To higher or lower level of care



TRANSITION COMPONENT #3: OUTPUT



INFLUENCES ON THE PATIENT'S TRANSITION RELATED TO PATIENT/ FAMILY

Agreement with plan

Perception of word "discharge"

Timeliness in decisions

Decision making process, including end of life decisions

Family dynamics

Geography

HANDLING TRANSITIONS – PATIENTS AND FAMILIES

- Can be upsetting, disruptive, confusing
- Each transition brings:
 - New providers
 - New rules and regulations
 - New financial requirements
 - New care plans



CARE COORDINATION, TRANSITIONS AND FAMILIES

Family caregivers are the unsung heroes of the healthcare system. Studies show that about 44 million Americans provide 37 billion hours of unpaid, "informal" care each year for adult family members and friends with chronic illnesses or conditions that prevent them from handling daily activities such as bathing, managing medications or preparing meals on their behalf.

Nurse Advocate



WHO ARE FAMILY CAREGIVERS?

Those who care for ill or frail family members or friends

Can take place in any setting

- Home
- Hospital
- Rehab unit
- Long-term nursing home

A PERSON IS A CAREGIVER IF THEY

1

Take care of someone who has a chronic illness or disease

2

Manage medications or talk to doctors and nurses on someone's behalf

3

Help bathe or dress someone who is frail or disabled 4

Take care of household chores, meals or bills for someone who cannot do these things alone

FAMILY CAREGIVERS AND HEALTH CARE PROFESSIONALS

- Must work together
- Times of care transition (change in care setting) are particularly important
- Communication is key!
- See them as part of the healthcare team!





WHAT CAREGIVERS NEED

- A basic understanding of how things are expected to work in the new setting
- A chance to ask questions when they are ready to ask them
- Guides and materials
- Acknowledgement that they are a family caregiver!

IT IS **IMPORTANT** THAT THEY SEE **THEMSELVES** AS A FAMILY CAREGIVER

- So that the person can act on their rights and authority
 - The right to get information about their family member's condition
 - The right to be involved in decision making about care
 - To be an essential partner on the health care team and be educated in how to provide care

INFLUENCES ON THE PATIENT'S TRANSITIONS RELATED TO PHYSICIAN PRACTICE PATTERNS

- Planning
- Perception of the word "discharge"
- Critical thinking skills
- Financial incentives for timely transitions
- End of life communication with family
- Delays (consultants)
- Hospitalist impact
- Investment in post-acute care facility/ provider



INFLUENCES ON THE PATIENT'S TRANSITIONS RELATED TO PAYER AND REGULATIONS

PAYER

- Managed care
 - Choice of vendors for next level of care
 - Delays, especially with DRG reimbursed patients
 - Timeliness of next level of care approvals
 - Timeliness of on-site reviewers
 - Contractual agreement or requirements
- Type of reimbursement
- Self pay/flat rate 'gone bad"
- Contractual limitations post discharge

REGULATIONS

- Balanced Budget Act of 1999: The hospital, as part of the discharge planning process must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post hospital care services and must, when possible, respect patient and family preferences when they are expressed
- Important Message from Medicare Medicare Discharge Notification Appeal
- 1–2-day stays Observation and MOON Medicare Outpatient Observation Notice
- 3-Day Stay Rule

INFLUENCES ON THE PATIENT'S TRANSITION RELATED TO HOSPITAL ISSUES

- Delays in service
- Hospital acquired conditions
- Patient safety events
- Communication among team members
- Incomplete documentation
 - Physicians
 - Nurses
 - Other team members
- Collaboration delays and/or omissions by not having:
 - Walking Rounds
 - Huddles
 - Interdisciplinary care conferences
 - Interdisciplinary team conferences
- Ineffective hospitalist service
- Ineffective Physician Advisor



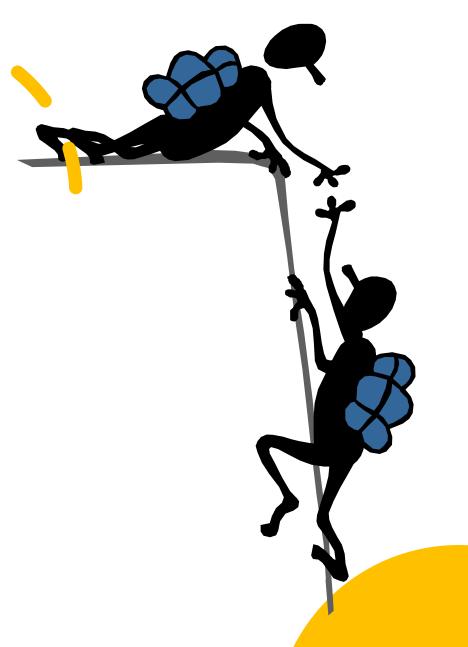
INFLUENCES ON THE PATIENT'S TRANSITION RELATED TO CASE MANAGEMENT DEPARTMENT

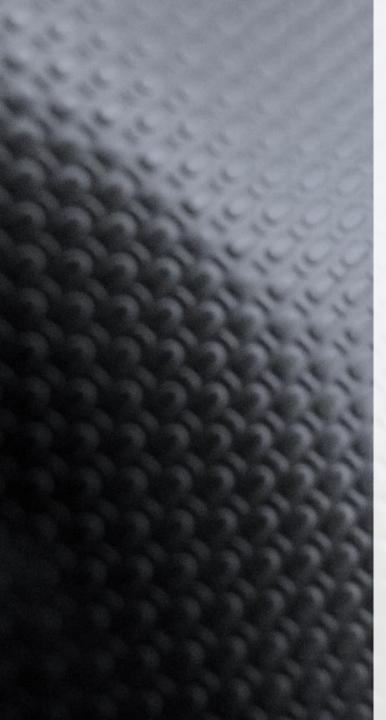
- Processes, including delays
- Staffing Model
- Case Manager/Social Worker Relationships
- Case Manager or Social Worker
 - Critical thinking skills
 - Sense of urgency
 - Case management intelligence
 - Skill sets
 - Workload
- Manager/Director
 - Outcomes focused
 - Data driven/influenced
- Lack of integration across the continuum



EFFECTIVE CASE MANAGEMENT AT ALL PATIENT TOUCH-POINTS

- Admission case manager
- ED case manager
- Peri-operative case manager
- In-patient case manager
- Community case manager
 - Patient-Centered Medical Home
 - Sub-acute
 - Home Care
 - Long-term care





TRANSITIONS CASE MANAGER

Follows high risk patients while in the hospital and during the first thirty days after discharge in the community

Community patients followed telephonically

If community case manager available, interfaces with the CM as well as the primary care provider, home care, etc.

Assesses patients for high-risk criteria

Frequent readmissions

Specific diagnoses – particularly chronic conditions

INFLUENCES ON THE PATIENT'S TRANSITION RELATED TO NEXT LEVEL OF CARE ISSUES

- Appropriate use of next level of care
 - Physicians
 - Family
 - Patient
 - Payer
- Next level of care providers
 - Nursing home use of SNF days
 - Not accepting patients on the weekends
 - HH delays in seeing patient
 - Delay in DME delivery to patient



COORDINATING WITH POST-ACUTE CARE

- We can no longer refer to a post-acute care provider (facility or home care) without providing the patient with complete information regarding the quality of the provider
- Post-acute care facilities/home care must prove their "worth" to receive referrals
 from us
- We must expect high quality care and outcomes for our hospital-owned or system-owned acute care providers
- We must be aware of any other network in which the patient may be involved
 - ACO
 - Bundled payment
 - PCMH
 - Population health

EXPECTED RESULTS FROM **EFFECTIVF** POST-ACUTE CARF **TRANSITIONS**

Not just in the hospital, but across the continuum Decreased ED utilization

Decreased readmissions

Decreased costs

Improved quality

Improved patient satisfaction

MOVING TO THE FOUNDATIONS OF EFFECTIVE DISCHARGE AND TRANSITIONAL PLANNING

Interdisciplinary team involvement

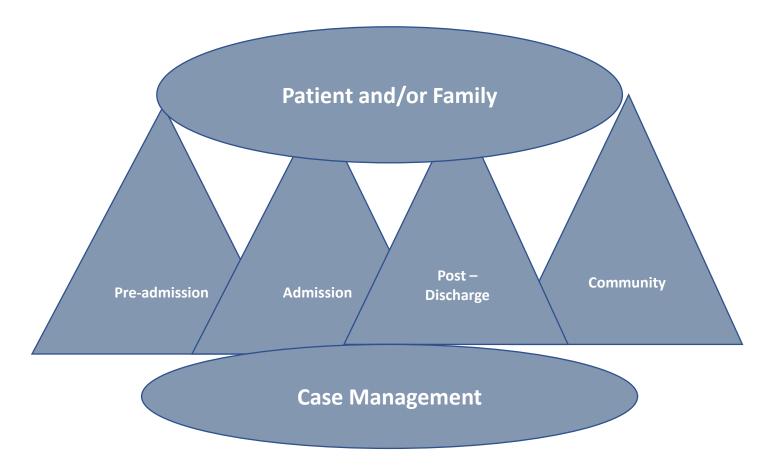
Least restrictive environment identified that can meet patient's needs

Patient and/or family included timely in discharge planning process

Patient and family educated about community resources that can help maintain maximum potential and independence

Safe discharge plan established

Patient's benefit plan evaluated, along with choice (for home health and skilled nursing facilities)



ALIGN BEST PRACTICE CASE MANAGEMENT STRATEGIES ALONG THE CONTINUUM

- Provide post-discharge follow-up phone calls
- Connect patient to PCP if they do not already have one
- Ensure that essential discharge information is transmitted to the next provider of care and caregiver
- Standardize the discharge process, including off-hours and weekends

- Actively engage patients and families to realistically assess discharge potential, participate in discharge planning and achieve successful care continuity when the patient returns home
- Identify end-of-life issues earlier during an in-patient admission and address them prior to discharge, including connecting patients to community end-of-life care services

- Connect patients who require complex care to a medical home or other program that can provide support and resources to patients and their caregivers 7 days per week, 24 hours per day
- Implement ED case management with case managers and social workers who coordinate patients' return to nursing homes or other post-acute services; identify whether patients need to be admitted and to what level
- Work with local PCPs, nursing homes and other providers to discuss and develop strategies to prevent 'avoidable' readmissions and contributing factors (poor communication, infections, end-of-life issues)

- Examine whether readmitted patients have access to a primary care physician
- Improve timeliness of discharge summaries to referring physicians regarding continuing care and diagnostic testing and results
- Develop standard actions for transitions from hospital to next levels of care including MD office
- Improve the standardization of the discharge process, especially on weekends and off-hours
- Improve the delivery of discharge instructions to patients, especially those who
 do not speak English or have low literacy rates
- Improve the medication reconciliation process

DESIGNING CASE MANAGEMENT AS AN "ACROSS THE CONTINUUM" MODEL



Create one seamless department

- •In-patient
- •Community

2

Have one director for each level who report to the same person/department



Consider in-patient as episodic



Manage high-risk patients from the community



Provide hand-offs as patients transition across the continuum



Create one single database for all patients

FEEL FREE TO CONTACT ME!

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RESOURCES

- Robert Wood Johnson's Care about Your Care on transitioning from hospital http://www.rwjf.org/en/library/research/2013/01/care-about-your-care-discharge-checklist---are-transition-plan.html
- Care Transitions from Hospital to Home; Agency for Healthcare Research and Quality http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy4/index.html
- CMSA The Practice of Hospital Management: A Whitepaper (2019)
- Transitions of Care: World Health Organization
 https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf;jsessionid=E3B2DEAE9F07F96BFD0B941377E2B86A?sequence=1
- American Hospital Association: Private-Sector Hospital Discharge Tools https://www.aha.org/system/files/content/15/15dischargetools.pdf
- CMS Revision to State Operations Manual Appendix A Interpretive Guidelines for 42 CFR 482.43,
 Discharge Planning May 17, 2013

RESOURCES

- CMS: Your Discharge Planning Checklist (For patients and caregivers preparing to leave a hospital, nursing home or other care setting) https://www.medicare.gov/pubs/pdf/11376-discharge-planning-checklist.pdf
- Family care givers <u>www.caregiving.com</u>
- Care Conversations http://careconversations.org/understand-care-needs
- IDEAL Discharge Planning AHRQ <u>https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy</u> <u>4/Strat4 Tool 1 IDEAL chklst 508.pdf</u>
- Important Message from Medicare: Discharge Appeal Rights http://www.cms.gov/Medicare/Medicare-Medicare-General Information/BNI/HospitalDischargeAppealNotices.html
- Center for Medicare Advocacy: Discharge Planning <u>www.medicareadvocacy.com</u>
- Care Transitions from Hospital to Home; Agency for Healthcare Research and Quality http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy4/index.html
- 90 Day Care Transitions; National Association for Home Care and Hospice http://www.nahc.org/news/90-day-transition-plans-a-safer-journey-to-living-safely-at-home

RESOURCES

- <u>Society for Social Work Leadership in Health Care</u> 866-237-9542 <u>www.sswlhc.org</u> Dedicated to promoting the principles of social work within the health care system
- <u>United Hospital Fund 212-494-0700 www.uhfnyc.org</u> Publisher of *Always on Call: When Illness Turns Families into Caregivers*
- Federal Register, April 7, 2011. Update of provisions in Section 302 of Affordable Care Act
- Area Agencies on Aging (AAAs) Help adults age 60 and older and their caregivers. To find the AAA in your area, call The Eldercare Locator at 1-800-677-1116 weekdays from 9:00 a.m. to 8:00 p.m. (EST), or visit www.eldercare.gov.



A Resource Center for Today's Case Manager

Q&A



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A Resource Center for Today's Case Manager

Closing Remarks



Teresa M. Treiger, RN, MA, CCM, FABQAURP Chair Commission for Case Manager Certification

Thank you!

Commission for Case Manager Certification

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