EXPLORING CARE TRANSITIONS

CARE TRANSITIONS

The movement patients make between health care practitioners and settings as their condition and care needs change during the course of chronic or acute illness.

Paths of Transition

Over the course of an acute exacerbation of an illness, it is possible for a patient to cross paths with multiple healthcare professionals, in various healthcare settings.

Each of these changes in care providers and settings is defined as a care transition.

Transition Settings

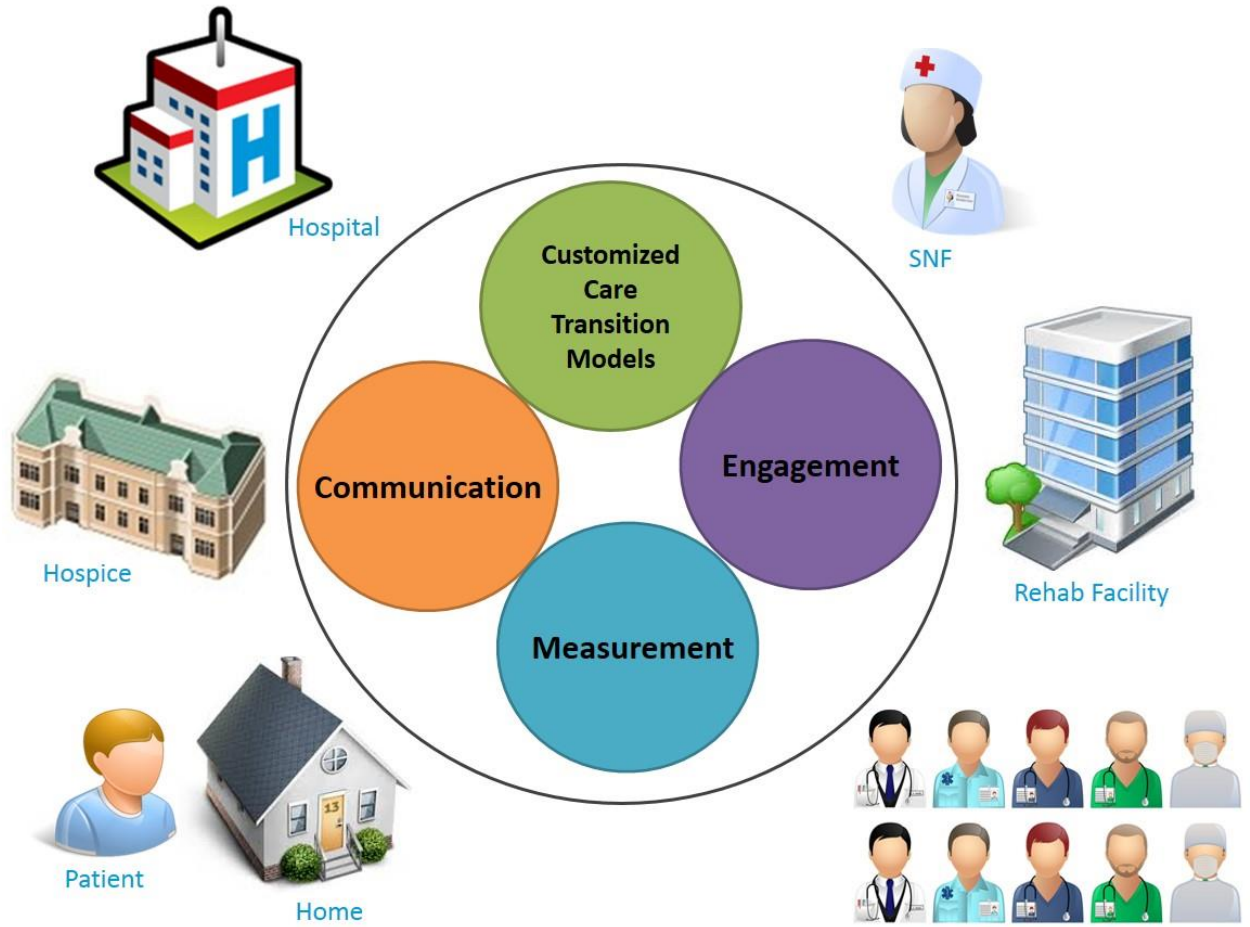
- Hospitals
- Sub acute and post acute facilities
- The patient's home
- Primary and specialty care offices
- Long term care facilities

Components of Care Transitions

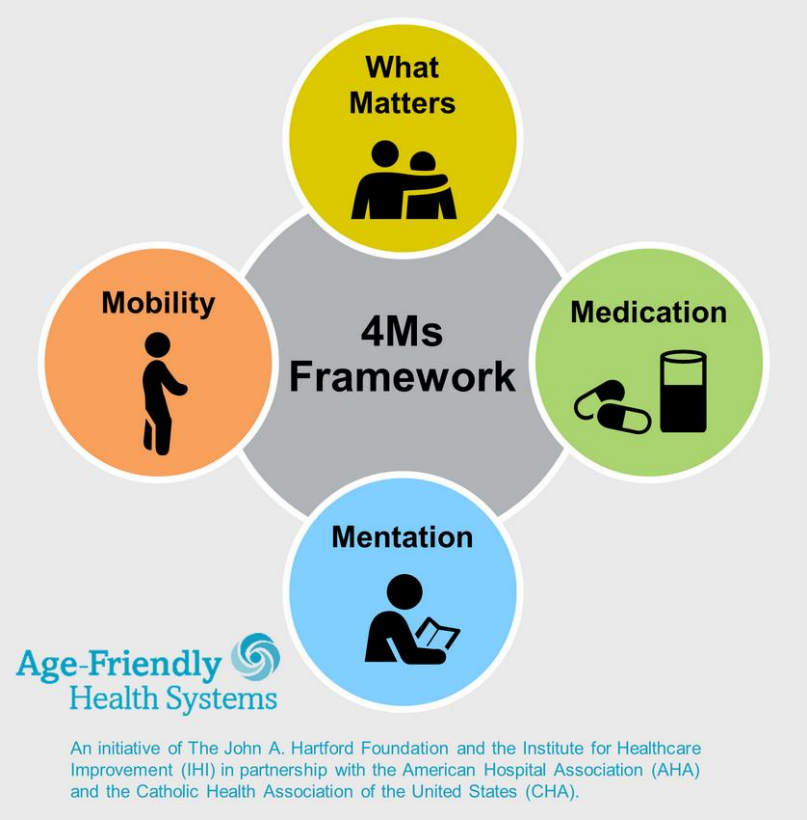
- Transitional care is based on a comprehensive plan of care and the availability of health care practitioners who are appropriately trained to meet acute and chronic healthcare needs of the patient.

- It includes logistical arrangements, education of the patient and family, and coordination among the health care professionals involved in the transition.

- Encompasses both the sending and the receiving aspects of the transfer; essential for persons with complex care needs.


Hospital
SNF
Customized Care Transition Models
Communication
Engagement
Measurement
Hospice
Rehab Facility
Patient
Home

4 Ms Framework



Consideration of all components of the 4Ms framework in transitional care for older adults leads to efficient, evidence based delivery of effective care.

Care Transition Models

A variety of Care Transition Models have emerged over the past decade. These models are supported by research and evaluation, with the expectation to:

- Improve coordination and communication between health care providers.
- Empower individuals to take charge of their health care.

Care Transitions Intervention Model

- CTI is an evidenced based model created by Dr. Eric Coleman, MD MPH.
- Unique focus on self-management skills for older adults and caregivers as they move across care settings.
- Focused on imparting a set of self-management skills.
- Transition Coaches collaborate around the individual's identified goal.
- Coaching equates with skill transfer.
- Helping older adults move from back seat, to passenger seat, to drivers seat.

CTI Background and Overview

- OU Nursing Care Management is currently supporting a Care Transitions (CT) contract with OU Medical Center (OUMC) to reduce hospital readmissions.
- OUMC seeks to improve CMS 30-day hospital readmission rate.
- Root cause analysis found transitional support was the underlying limitation leading to hospital readmissions.
- Coleman Care Transition Intervention® (CTI) was selected as evidence-based practice model for Care Transition Program at OUMC.
- OU Nursing Care Management selected by OUMC to implement Care Transition Program due to over 20 years history of providing transitional care services under the ADvantage program as well as existing Care Managers who are certified as Transition Coaches by the Coleman CTI®.

Evidence

- Patients receiving a care transition intervention are less likely to be readmitted to a hospital in general and for the same condition that prompted their index hospitalization at 30, 90, and 180 days versus control patients (Parry, 2009).
- Patients who receive the care transition intervention were more likely to achieve self-identified personal goals concerning symptom management and functional recovery (Coleman, 2013).
- The inclusion of a family caregiver is associated with a greater rate of completing the care transition intervention for post discharge coaching, particularly among men (Epstein-Lubow, 2014).

Transition Coaching

- Model and facilitate new behaviors, skill transfer, and communication strategies for patients and families to build confidence to successfully respond to manage common problems that arise during care transitions.
- Work with patients to develop a reliable approach to medication management and encourage them to co-own their medication list utilizing Personal Health Record.

Care Transitions Intervention

- Initial visit conducted in hospital (where possible – this is desirable but not essential) to discuss concerns and to engage patients and caregivers.
- After discharge, Coach makes a home follow-up visit and accompanying phone calls designed to increase self-management skills, personal goal attainment and provide continuity across the transition.

Four Pillars of CTI

- Medication Management
- Red Flags
- Medical Care Follow-up
- Personal Health Record (PHR)

Outcome of Care Transition Intervention

- Significantly less likely to be readmitted to a hospital.
- Less likely to incur further high cost utilization.
- More likely to achieve self-identified personal goals around symptom management and functional recovery.

Transition Coaches

- OU College of Nursing is committed to care management!
- We have Coleman Model trained Transition Coaches!

Living Choice Program

- Also referred to Money Follows the Person (MFP) at a federal level.
- Designed to transition individuals with disabilities and long-term illnesses from the institution back into their homes in the community.
- Designed to transform the current long-term care system by promoting community-based services instead of institutional services.