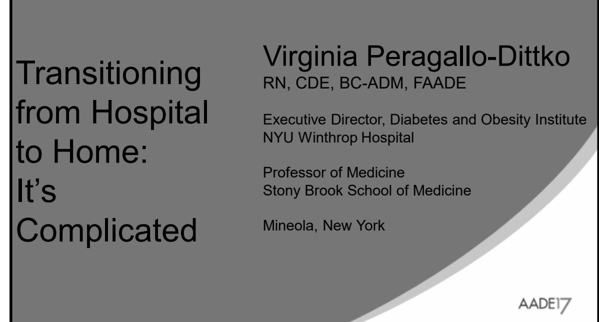

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  - Learners must attend the full activity and complete the evaluation in order to claim continuing education credit/hours
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How do you interpret Transition?

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What to Expect

- Health care trends that impact transition
- It's complicated
- Creative systems
- Where to start
- Your challenge

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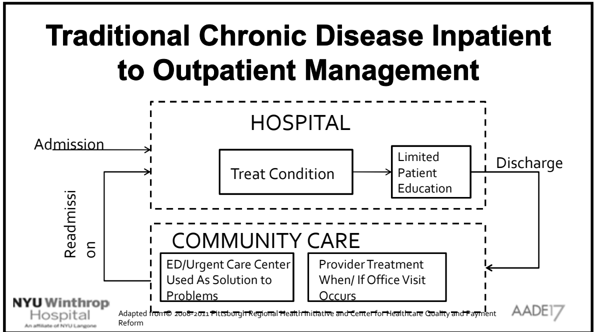
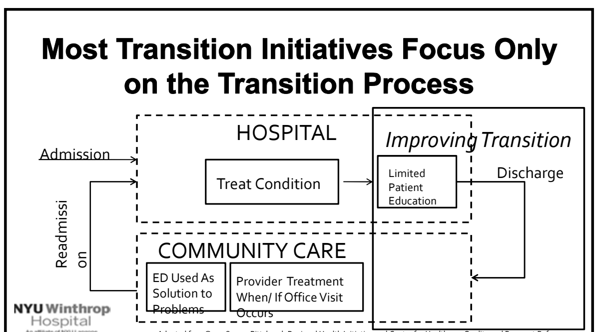
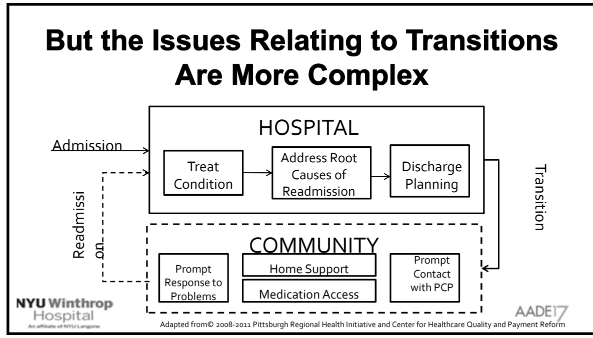
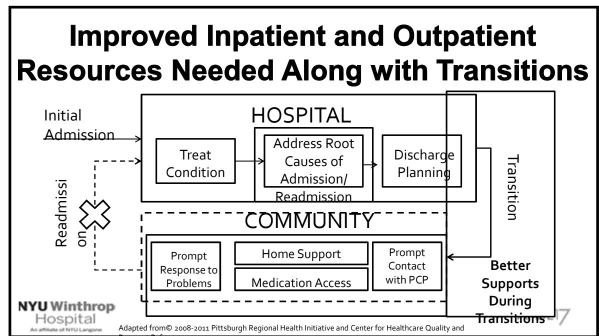
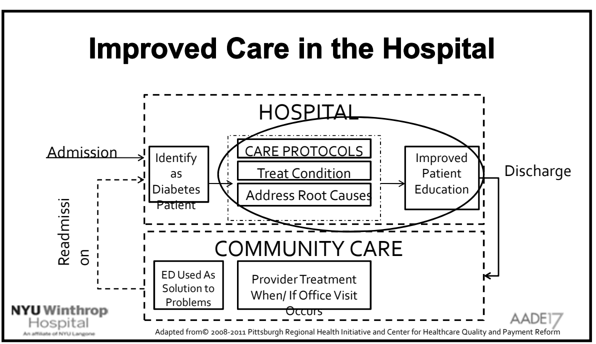


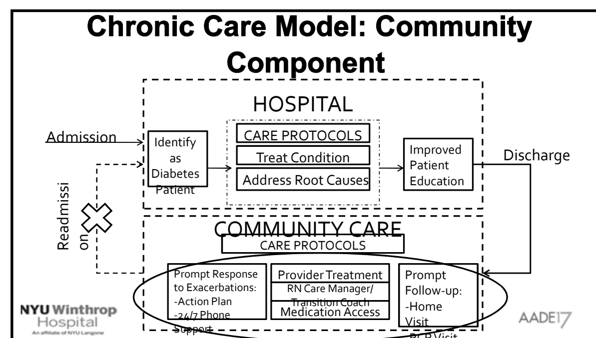




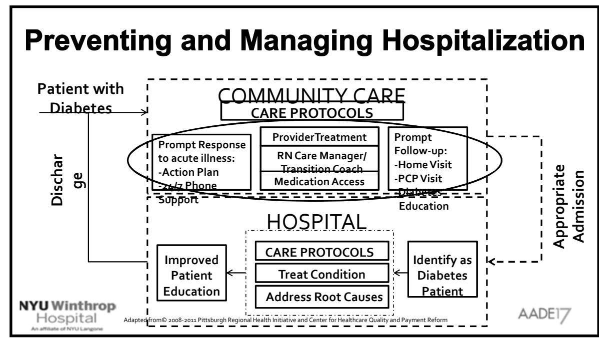




Chronic Care Model: Community Component



Preventing and Managing Hospitalization



Health Care Trends that Impact Transition

Insurance barriers

- First fill rate for insulin prescriptions
- Copay and cost
- E-prescribe (65% more likely) and prescription abandonment(insulin most likely)
- Some mail order pharmacies: 2 weeks to get meter

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Focus on Readmission Linked with Reimbursement

Section 3025 of the Affordable Care Act

- Hospital Readmissions Reduction Program, which requires CMS to reduce payments to hospitals with excess readmissions
- Defined readmission as an admission to a hospital within 30 days of a discharge
- Adopted readmission measures for the applicable conditions of Acute Myocardial Infarction, Heart Failure and Pneumonia

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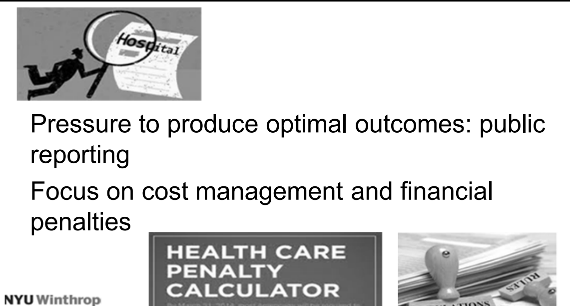
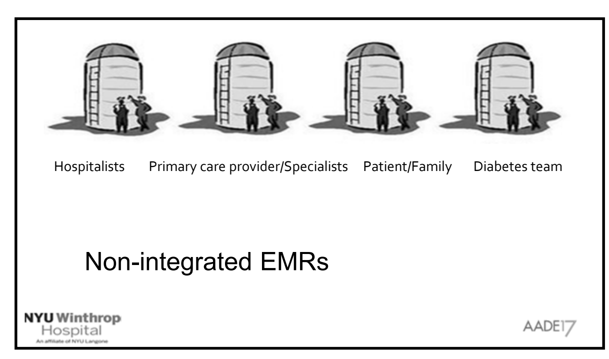


Pressure to produce optimal outcomes: public reporting

Focus on cost management and financial penalties



Non-integrated EMRs

Call for transparency, accountability, patient and family-centered care and patient feedback

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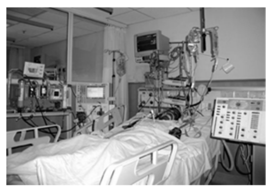
Pressures of the Environment



Patients with diabetes over age 35, accounted for 1 in 3 (31%) hospitalizations in California in 2011

Imperial County 40%

UCLA Center for Health Policy Research 2014

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Social issues
- Social support
- Limited resources

Not available vs not capable

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Discharge Instructions

- Patients are ready to go home and may not listen to discharge instructions
- Patients may not be comfortable asking questions
- The patient's family or primary caregiver may not be present
- Too much information given

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Patients with a clear understanding of their discharge instructions are 30% less likely to be readmitted or to visit the ED.

Jack BW reengineered hospital discharge program to decrease re-hospitalization: a randomized trial. Ann Intern Med 2009

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What Do We Know About the Inpatient to Outpatient Transition of Diabetes Care?

- Not much--it is understudied
- Numerous studies have examined outcomes of different discharge strategies
- While diabetes inpatients have been included in these studies, hospital discharge studies for diabetes patients are lacking

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Shepperd S, Parkes J, McClaren J, Phillips C. Discharge planning from hospital to home. *Cochrane Database Syst Rev.* 2004(1):CD000313.

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Current Challenges

Problems with glycemic control can begin once a patient gets discharged
- Changes in diet composition and physical activity at home
- Incorrect prescriptions
- Incomplete supplies
- Barriers to family involvement
- Underdeveloped community care systems and protocols

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Norhammer A et al. *Lancet*. 2002;359:2140-2144.
Lavernia F. *Medscape J Med*. 2008;10:216-233.

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Vulnerability of Patients after Hospital Discharge

- Study of 400 patients, 3 weeks post-discharge
- 19% had an adverse event
- 66 % were drug-related and 17% were procedure-related

Forster AJ et al Ann Intern Med 2003

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See…It's Complicated

- Diabetes as a secondary diagnosis
- Specialty care: How many doctors can a patient see after discharge? Transportation, time off…

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Creative Systems

- Telehealth
- Good-to Go: Audio-discharge instructions accessed via phone (Vocera)
- Peer visits

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Care Transitions Intervention

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PATient Navigator to rEduce Readmissions (PArTNER)

- PArTNER is a transitional care model for Minority-Serving Institutions (MSIs) from the hospital through their transition home.
- Was designed in collaboration with patients and caregivers.
- Is delivered by a community health worker acting as a patient navigator and peer coach.
- Some studies have found an increase in readmissions
- Findings to be published 2017

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Society of Hospital Medicine (SHM) Univ of Illinois Chicago

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Models

- Project Red
- IDEAL (AHRQ)
- Project BOOST
- The Care Transitions Program (Coleman)
- Transitional Care Model (University of Pennsylvania)
- IHI STAAR
- Homecoming Transitional Care Program (San Francisco - serves low-income seniors with no support system)

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Project RED Re-Engineered Discharge

Tool Kit

1. Make follow up appointments
2. Plan for follow up of pending test results
3. Organize post-discharge outpatient services and medical equipment
4. Identify correct medicines and plan to obtain them
5. What to do if problem arises
6. Provide telephone reinforcement of the Discharge Plan

Recently expanded Tool Kit includes a chapter about enhancing the role of family caregivers

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Transitional Care Model (University of Pennsylvania)

- Daily hospital visits
- Home visits
- Accompany to doctor visits
- Available by phone 7 days per week
- RCTs- well studied

(current Medicare reimbursement policy does not pay for transitional care)

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Transitional Care Model Impact on Readmission Rates

% of Patients	TCM Group	Control Group
within 6 weeks*	10%	23%
within 24 weeks**	28%	56%
at 52 weeks***	48%	61%

Naylor MD et al. J Am Geriatr Society 2004

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Project BOOST Better Outcomes by Optimizing Safe Transitions

- Toolkit
- Face-to-face training and Mentoring Program
- Data Center to store and benchmark data
- Online Community

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The Care Transitions Program

- 4 Pillars
  - Medication Self-management
  - Dynamic patient centered record
  - Follow up
  - Red flags
- Discharge Preparation Checklist
- Transition Coach

Eric Coleman

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Preventing Readmissions

- Most effective interventions are complex and support patient capacity for self-care
- Contacted the patient frequently
- Used home visits

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Leppin AL et al.Preventing 30-day hospital readmissions: a systematic review and meta-analysis of randomized trials JAMA Intern Med 2014

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Where to Start?

- Low hanging fruit
  - Elevated A1c
  - Transition to insulin
  - Needs meter
- Risk-based approach
- Analyze
  - Diagram your current care delivery processes
  - Identify steps that should become targets for improvement efforts
  - Select metrics for evaluating key components of your program

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Challenge

- Vulnerable time period
- Individualized approach with risk-based resource use
- One approach does not work for all patients
- Include patients/families in system planning
- Transitional care, not ongoing

One patient
One unit
One community

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