Care Transitions from Acute Care to outpatient: Improving Patient Experience through Best Practices

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Objectives

- Improve health care quality for patients by coordinating care transitions throughout the continuum of care
- Reduce avoidable cost during care transitions
- Reduce preventable readmissions
Goals

• Improve the patient experience
• Ensure the best possible outcomes
WHAT WE HAVE HERE

is a failure
to communicate
Comprehensive Discharge Planning

- Prior to discharge organize follow-up services and address barriers utilizing community resources.
- Stratify patients into transition pathways.
- Daily huddle with consistent care teams.
- Designated hospital staff to call patient 2-3 days after discharge.
Daily Huddle & Patient Identification

• UPON ADMISSION sort patients into four pathways

• EACH SUBSEQUENT DAY review patient progress

• FOCUS ON AVOIDABLE DAYS
Patient Sorting Criteria

• **RED:** Needs palliative Care

• **Orange:** Complex home discharge or is a readmit

• **Green:** Transferring to another facility after discharge

• **Blue:** Meet and Greet- No significant needs
Complete and timely communication of information

- Providers ensure that discharge summary is issued within 2-3 days to outpatient provider.

- Use standard format of discharge summary.
Medication Reconciliation

- Reconcile medications at each transition
- Check for accuracy and look for contraindications
- Assess Financial Barriers
- Provide up to date medication lists to patients
72% of post-discharge adverse events are related to medications.

40% of medication errors are attributed to inadequate handoffs.

20% of hospitalized patients are subject to at least one medication error per day, about 20% of which will result in harm.
Prompt follow-up visit with an outpatient provider after discharge

- Hospital staff schedule follow-up visits prior to discharge

- Services: Ongoing symptom and medication management, 24/7 phone access
Lost Revenue

- Hospital follow up visit within 7 days of discharge: Additional $156 on top of visit charge

- Hospital follow up visit within 14 days of discharge: Additional $104 on top of visit charge
Patient/Caregiver education using the “teach back” method
Teach Back Method

“Take with meals? No problem I eat all of the time!”
Open communication between providers

- Occurs between each setting and among multidisciplinary teams
- Discharge provider confirms the subsequent provider received discharge summary
Successful Programs: Evidence-Based

• The Care Transitions Intervention

• The Transitional Care Model

• Project RED
Key Points

• Discharge starts on admission
• All Patients are called within 7 days for medication reconciliation
• All patients have a scheduled face-to-face visit with a provider within 14 days and high risk patients within 7 days
• Discharge Summary completed within 2-3 days of discharge
Reference


• Burke, R.E. & Coleman, E.A. (2013). Interventions to Decrease Hospital Readmissions: Key for Cost-Effectiveness. *JAMA Internal Medicine*.


