STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Transition of Care:
Hospitals to Community-Based Care

Transition of Care

Safe Approaches

OBJECTIVES:

At the end of the discussion today, participants will be able to:

Describe	Describe Transition of Care
Explain	Explain Discharge Planning
Explain	Explain how patient safety factors in to have transition of care without incident
Explain	Explain what an incident is
Identify	Identify the Care Transitions Intervention (CTI) method
Identify	Identify the Transitional Care Model (TCM) method
Identify	Identify the Reengineered Discharge (RED) approach
Identify	Identify the BOOST toolkit
Explain	Explain a multidisciplined approach
Know	Know how to Communicate with SBAR

Transition of Care

Transition of care is an intervention, or a group of interventions initiated prior to discharge with the aim of ensuring the safe and effective change from one location to a different location.
(one place to another place)

He's coming here? I know nothing about it!

- Why does the hospital do this?
- Why can't **they** do a better job?
- **They** changed everything from the time I talked with them an hour ago, to now when he got here…
- We don't have room for him…
- This is going to make so much more work for **me …**
- **Who** dropped the ball with getting the information out for discharge
- I don't know what I don't know!!!

Barriers Medicaid Health Plans Encountered

During **Hospital to Home** Care Transitions

Barrier	Percentage of Health Plans
Availability of in-home supports	67%
Caregiver support	50%
Coordination of community services in advance of transition	42%
Identifying and offering dedicated resources and support to caregivers	33%
Housing/ Bed availability	25%
Availability of respite care	25%
Data exchange	17%
Continuity of services	17%
Availability of hospice	17%

Source: Institute for Medicaid Innovation. "2022 Annual Medicaid Health Plan Survey."

Barriers Medicaid Health Plans Encountered

During **Nursing Care to Home** Transitions

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Continuity of services	17%
Availability of hospice	8%

Source: Institute for Medicaid Innovation. "2022 Annual Medicaid Health Plan Survey."

In a Perfect World …

- The Healthcare system would have completed discharge planning with the patient and care giver(s) starting when patient was admitted
- The receiving care giver would know - in advance- **all** that is needed – special DME, urinary catheter supplies, PEG Tube supplies, Medication changes, etc.
- The Caregiver would have the opportunity for planning and asking questions – prior to discharge
- The Release of Information consent would have been signed so the caregiver has access to anything - before and after hospitalization
- Screening process – the accepting institution would be able to do a complete screening, in a timely manner
- Hospital Staff – would be concerned about the challenge of the 30 day readmit process - and want to safely send the patient out
- The receiving location - would be TOTALLY prepared when patient enters
- Medications would be brought into the hospital to ensure all ordered medications are correct
- Patients would never leave the hospital on Friday Afternoon at 4pm! ☺
- The patient would understand everything about their health needs
- Transportation home would be timely
- Community resources are ready, DME is already delivered, caregiver knows how to do all that is needed.
- Patient Safety is the ultimate goal to attain when released from the hospital

Set up for Success!!!

What do you think YOU need?

Setting up for Success!!!

What are the basics to prepare for?

- Who is coming
- What time is he/she coming; when will he/she arrive,
- How will he/she arrive
- Where will he/she stay
  - Does he/she have environmental allergies
  - Does he/she need environmental adaptations
  - What is needed in his/her own space
- Why does he/she need this service
- What is needed for DME: hospital bed, over the bed table, walker, wheelchair, etc.
- Do I need to modify the home environment
- What is dietary needs
  - Does he/she have dietary allergies
- Behavioral Health factors: are there 'behaviors' to be prepared for
- Medications
  - What medications are new
  - What pharmacy fills the medications prescriptions
  - Will the patient have the medications when they arrive to the new location
  - Any allergies to medications
  - Are they able to swallow pills
- Who can provide me with the information needed

Set up for success!!!

Ask Questions

- Make a checklist that works in your situation
- Situations are different, patients may come to live in a home, where a private person cares for several- not a group home, or a nursing facility
- Why was the decision made so quickly and then the patient had to
- Most hospitals have discharge planners, contact them
- Models of care:
  - Care Transitions Intervention
  - Transitional Care Model
  - Reengineered Discharge
  - Better Outcomes for Older Adults through Save Transitions

Read the discharge instructions

- What is diet
- What is skin care
  - Do I have the dressings needed
- What are the medications
- Where do I get the medications
  - Will the medications come home
- Is there a follow up appointment scheduled
- What does the insurance allow
- What DME is the patient coming home with
- What DME does the patient need
- What if something changes with the patient, what needs to be done
- Are more testing that needs to be done

Approaches for Safe Transitions

Care Transitions Intervention (CTI)

With this approach patient engagement is enhanced and the patient and caregiver are involved in self-management

Transitional Care Model (TCM)

A transitional care nurse follows the patient from the hospital to home, facilitating communication with all outpatient service. Multidisciplinary approach

Reengineered Discharge (RED)

RED takes a multidisciplinary approach to patient care with a nurse discharge advocate

Better Outcomes for Older Adults through Safe Transitions (BOOST)

A team Based approach to transitions.

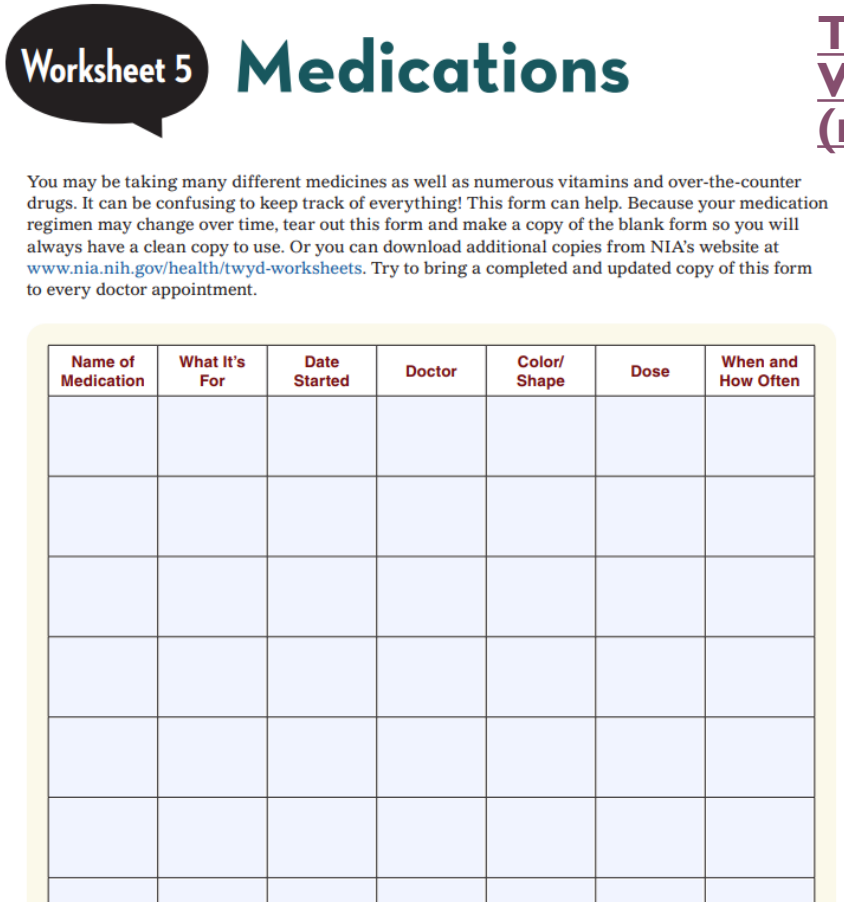
Multidisciplinary

Incident(s)

- An incident is likely to occur especially as a consequence dependent on something else
  - Some Incidents can be 'good' that it happened, even if the happening isn't planned
  - Other Incidents aren't 'good' and can lead to severe consequences
  - Usually want to prevent the incident from happening
  - Most incidents allow for learning from what happened

- When the plan is for a patient to make a safe transition, and instead the perfect world items do not happen, we can be prepared to make changes right away and attempt to prevent any negative outcomes.

Support to the Caregiver



Worksheet 5

Medications

You may be taking many different medicines as well as numerous vitamins and over-the-counter drugs. It can be confusing to keep track of everything! This form can help. Because your medication regimen may change over time, tear out this form and make a copy of the blank form so you will always have a clean copy to use. Or you can download additional copies from NIA's website at www.nia.nih.gov/health/twyd-worksheets. Try to bring a completed and updated copy of this form to every doctor appointment.

Name of Medication	What It's For	Date Started	Doctor	Color/ Shape	Dose	When and How Often

[Talking With Your Doctor Worksheet 5: Medications (nih.gov)]

- Medications:
  - Name
  - What is it for
  - Date Started
  - Doctor Prescribed
  - When and how often
  - Side effects
  - What to do if it causes unusual reaction
  - Administration- swallow, under tongue, in the nose, eye

Worksheet 4 Concerns

[Talking With Your Doctor Worksheet 4: Concerns (nih.gov)]

At each visit, your doctor will likely ask about your concerns. It's a good idea to think about what you'd like to talk about before the actual visit. This form can help you organize your thoughts.

Tear out this form and make a copy of the blank form so you will always have a clean copy to use. Or download additional copies from NIA's website at www.nia.nih.gov/health/twyd-worksheets. Then, after you make an appointment, take a minute to write down the name of the doctor and the appointment details (for example, the date, time, and address). Use the form to make a list (in order, from most important to least important) of the concerns you want to discuss.

Doctor:	**Appt. Date:**
Time:	
Address:	**Phone:**
Appointment Details (Most Important to Least Important)	
1.	
2.	
3.	
4.	

Transition of Care

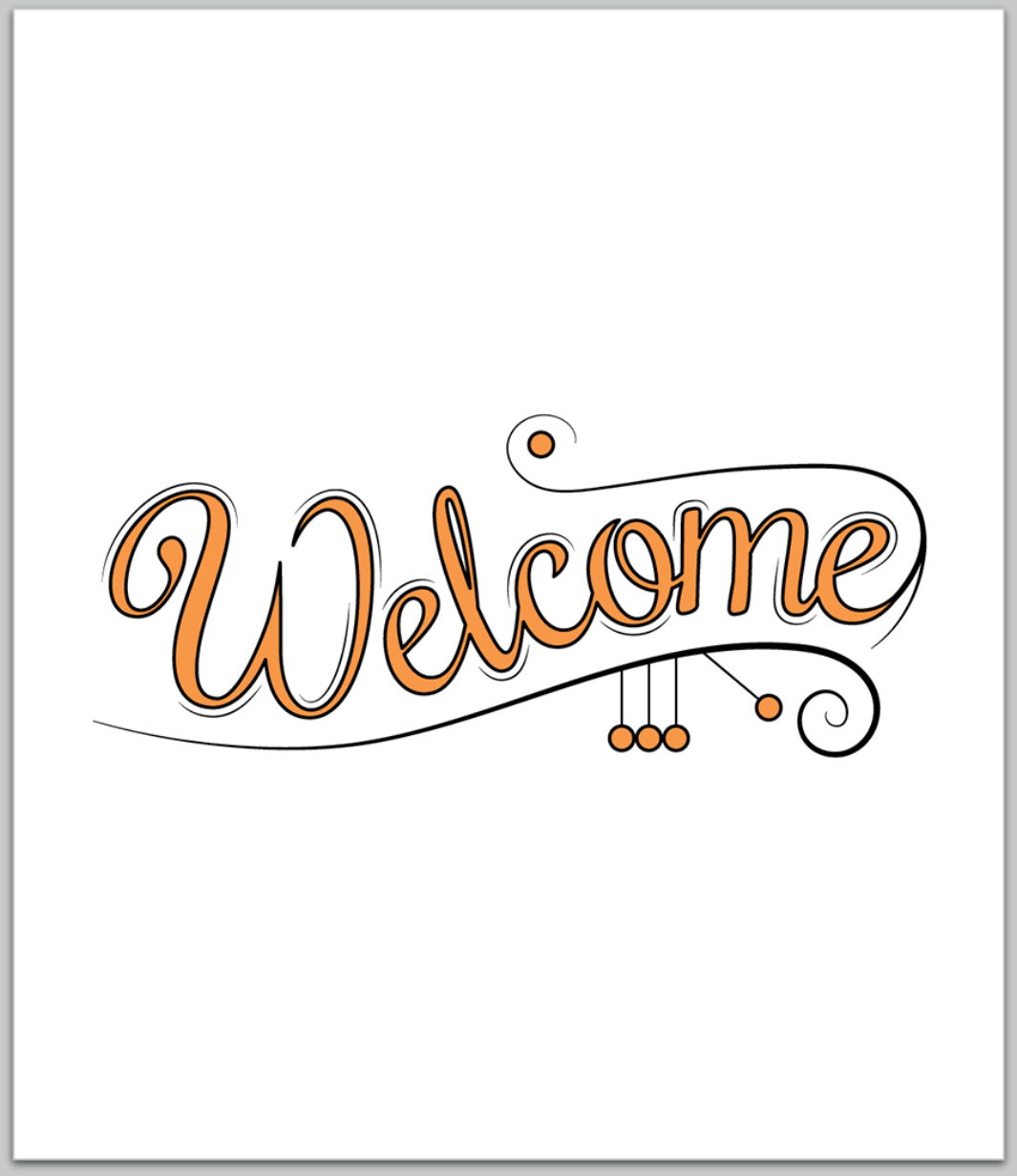
SBAR

- SITUATION: Tires, I think I need new tires
- BACKGROUND: I have 70, 000 miles on these tires
- ACTION: I go to the Tire Company they tire employee evaluates
- Recommendation: The tire company employee reports, there is still tread on the tires, likely can go another several miles. I aske that the tires be changed, winter is coming, and I am anxious. He is happy to take my money now

- SITUATION: Patient ABC, transferring from Behavioral Health Center
- BACKGROUND: Patient ABC, went into clinic with severe depression, a few months ago, ABC was overactive. Family and Friends have notices this and did an intervention with her prior to the hospitalization. I was contacted yesterday, agreed to receiving ABC to reside in my home for at least the next 6 months. No final plan was established. I have phoned 2 times to day to behavioral health center, was told I would be received all to finalize arrangements.
- ACTION: Patient ABC just showed up at my house.

Recommendations:

- Welcome the person!
- Be honest and Calm
- Ask the patient what information they have brought with them
- Call the discharging institution
- Go with the flow
- Make sure the person knows this is not their fault
- This isn't what we planned, but we can do this



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But I can find out!!!
We can't control others - - -
The world is built on good intentions to do a better job, but the workload at the hospital is the same as in the field.
I can get a release of information signed and get her records
I can call the facility she is coming from and converse with a discharge planner

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Resources

Improving patient transitions from hospital to home: Practic... : Nursing2022 (lww.com)

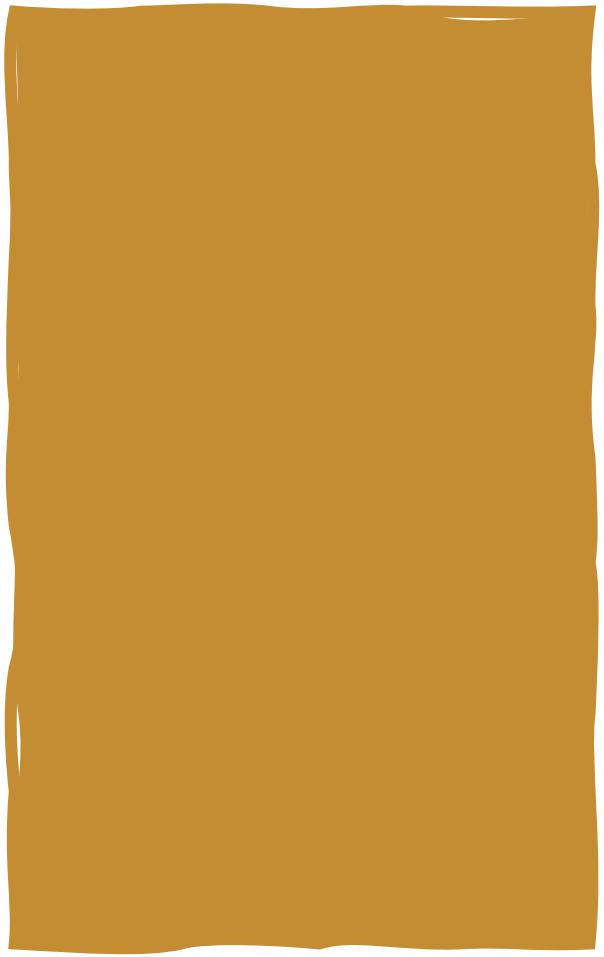
Transitional Care Strategies From Hospital to Home - PMC (nih.gov)

SBAR | ASQ

Annual Medicaid MCO Survey | Current Initiatives | Institute for Medicaid Innovation

Teach_Back_-_10_Elements_of_Competence.pdf (higherlogicdownload.s3.amazonaws.com)

Questions



Training Archive

https://dhs.iowa.gov/Providers/tools-trainings-and-services/CBT-for-LTSS/Archive

RECORDINGS AVAILABLE:

- Behavior Intervention Plan Development
- CMS Settings: State Transition Plan Update
- Introduction to Waiver Services in Iowa
- Positive Behavior Supports
- Mental Health Crisis Response
- Adopting a Trauma Lens in Children's Services
- Introduction to Motivational Interviewing
- Person-centered Planning
- Service Documentation (general and for HCBS Providers)

RECORDINGS COMING SOON:

- 2022 Self-Assessment for HCBS Providers

Upcoming Training:

NEXT

Quality Assurance and Quality Improvement for HCBS Providers
December 15, 2022, 11:00AM - 12:30PM | Virtual Training | *Registration open*
Understand quality assurance and improvement in ways that your agency can design policy and procedure in accordance with rules, regulations, and best practices.

Behavior Intervention – Getting Unstuck
January 2023. Date, time and location TBD.