Safer Transitions of Care

Real-Time Patient and Family Centered Handover Communication:

Personal Health Journal

Massachusetts STAAR Learning Session
Framingham, Massachusetts
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Transitions of Care (TOC) Project

- **Program Goals**
  - Improve safety of care transitions
  - Improve patient/caregiver satisfaction with care discharge process
  - Relieve caregiver isolation and improve knowledge
  - Reduce avoidable acute readmissions
- **Program Concepts****
  - Engage and empower patients and families
    - Setting goals, care planning, post-acute choices
  - Improve provider and patient/family communication at transition points
    - Identify Nurse Transition Liaisons (TL) at each site
    - Direct TL communication within 24 hours of transition
  - Provide personal medical journal for patient/family
    - Communication tool

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** Reference: based on Care Transitions Model, Eric Coleman, MD and others

Transitions of Care - Approach

- **Assessment of Readmitted Patients**
  - Sep 2009 - Readmission assessment questionnaires; Root causes of readmission: Patient, family, caregiver perceptions
- **Initiate Tests of Change**
  - Oct 2009 – first patients with TOC liaison and medical journal, piloted on 7C and 6/7 S/E
  - Dec 2009 – Involve post acute care teams with care and discharge planning meetings for medically complicated patients.
  - Dec 2009 – Develop and initiate case management 30 day readmission assessment tool
  - Dec 2009 – Implement telephonic surveys for patients and families participating in the TOC
  - Feb 2010 – Physician orientation to TOC
  - March 2010- Roll out to all units and education to nursing staff
  - January 2011: Approximately 130 patients on program

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Selection Criteria for Program

- **High Risk Patient Criteria**
  - Patients readmitted within 30 - 90 days
    - Identify reasons for readmission
      - Needs supplemental support structure to remain in community
      - Failing current community care plan
  - Age>80
  - Multiple co-morbidities, active functional deficits
  - Complex medication regimen
  - Complex treatment plan
  - Lives alone, with elderly or part-time caregiver
  - Identification of caregiver distress

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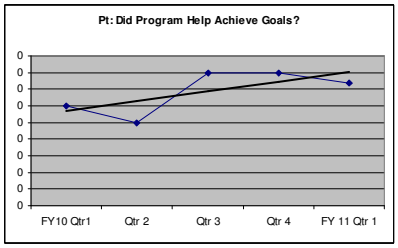
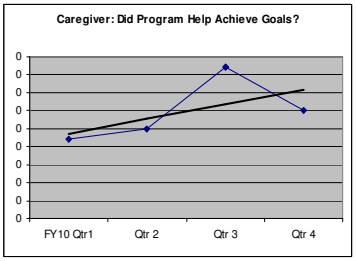
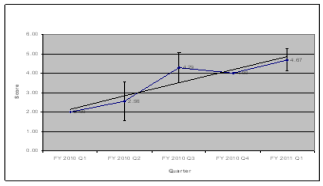
Transitions of Care: Patient and Caregiver Feedback

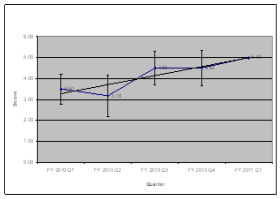




Pt: Find Journal Helpful



Pt: Understand Medications, Dosage, Changes?



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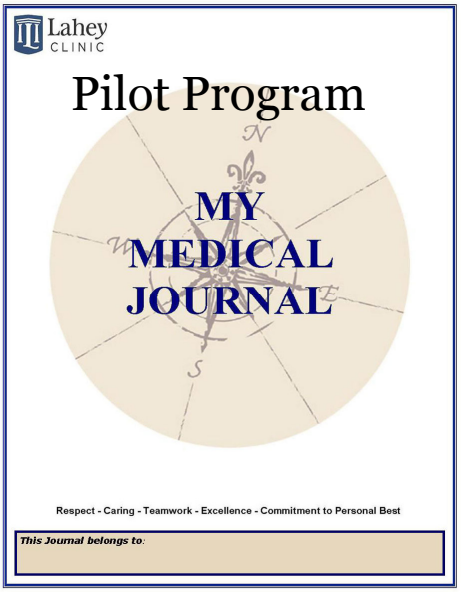
Empowering Patients and Families: Personal Medical Journal



This *Patient Medical Journal will be your guidebook for your health care information. Always bring it with you to any physician visits. The journal will be invaluable in the following ways:*

- Keeps all health information in one place and helps you stay organized
- Keeps track of health information and medication changes that occur over time
- A place to write down questions to ask your health care team
- Assists in planning ahead for physician or other health care appointments
- Allows you to update any information in this journal that you wish to remember or pass on to your care providers
- Allows you to check your medication profile to be certain it is updated and complete, and reminds you to bring your medication list (s) to your visit.

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Improving Care: Reducing Readmissions

- **Patient #1:** (Very first patient chosen for TOC pilot)
  - Elderly male, lived alone, multiple medical problems, considered by caregivers and PCP to be medically fragile and very 'non-compliant' with medical plan of care
  - Repeated hospitalizations: 7 within 8 months; many ED visits in-between
  - Grudgingly accepted the program:
    - "This is stupid, I'll do this just to show you how dumb it is"
    - "I'll keep this book and take it to the Dr's office – he'll say it is stupid too"
    - VNA nurse worked with pt and Lahey Transition Liaison, kept updating his goals, care plan, communications with PCP in journal
    - Patient improved adherence to medical plan of care, wrote his own progress notes and questions for each PCP visit,
  - Remained out of hospital for >3 months

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Stories

Patient #2
- 83 y.o, lives with dtr
- History: 2009 and 2010 prior to September: 10 inpt stays;
- Started on TOC in September 2010
  - Caregiver uses journal daily, takes to every medical appointment

Patient remained out of hospital for >4 months

Patient #3
- 72 y.o. female, with COPD, CHF, CAD, CRF; lives with caregiver husband
- History: 2010: 4 inpt admissions in 6 months
  - Enrolled in TOC June 2010;
  - Close communication with Liaison, uses journal

Patient has had one admission in > 7 months

Patient #4
- 70, CHF, COPD, S/P CVA, CVHD
- History: 2010: 6 inpt stays in 7 months
- Enrolled in TOC
  - Patient and caregiver use journal, work with VNA

Patient remained out of hospital for >4 months

Patient #5
- 81 y.o male, lives alone; CHF, frequent falls, functional deficits
- History: 2010: 4 inpt stays in 3 months
- Enrolled in TOC October 2010
  - Uses journal, works with VNA

Patient had one admission in >3 months

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Continued and Next Steps

- Further refine and expand criteria for TOC program selection
  - Increase # high risk patient enrollment in Transition of Care program
  - Expand involvement of Lahey Transition Liaison nurses
    - Identify resources and allocation changes needed
- Work with post-acute agency partners to expand case finding for Lahey patients
- Improve engagement primary care physicians regarding use of patient journal as a communication tool

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