While “transition of care” broadly applies to any time a patient moves from one care setting to another, this abstract focuses on Presbyterian’s programs for providing more focused care coordination during a discharge from hospital or skilled nursing facility (SNF) to the patient’s home, specifically for patients/members who have been qualified as high risk for hospital readmission.

The Essentials

- A Nurse from a PHS Transition of Care Program makes a series of visits to the patient being discharged from hospital or SNF, who has qualified as high risk for readmission.
- This care coordination provides an extra layer of support that may decrease readmissions and increase patient satisfaction.

Program Success

Since April, 2015, Presbyterian's Transition of Care Program has been instrumental in preventing hospital readmissions. In January through June 2016, Nurses from the Transition of Care Programs contact an average of 340 patients per month.

What We Know About Post-discharge Transitions of Care

When patients move from one care setting to the next, they benefit most when the transfer of care from Provider to Provider happens in a coordinated, seamless manner.

Even the best acute care practices and discharge planning do not always prevent readmission. Factors that can affect readmission are:

- Patients and/or caregivers do not understand the treatment plan
- Patients do not follow the right medication regimen
- Patients do not follow up with a physician visit

Numerous programs for reducing readmissions have been tested. These programs invested in post-discharge care coordination, patient education and self-management support, scheduled outpatient visits, and/or telemedicine. Even when an intensive post-discharge program is found effective in preventing readmissions, it may be prohibitively expensive to provide such an intervention to an entire patient cohort. However, net savings may be achieved when the same interventions are applied selectively to a population of patients identified as high risk for readmission.

How the Transition of Care Programs Work

Presbyterian’s Transition of Care (TOC) Programs aim to support the patients in the CDS, who have been identified as higher risk for
readmission, during their transition of care from hospital or SNF to home.

The TOC Nurse provides care coordination through a series of visits, pre- and post-discharge. Prior to discharge, the TOC Nurse visits the patient in hospital (or SNF). During this visit, the TOC Nurse reviews the patient’s discharge plan, provides education, assesses caregiver support, and identifies any risk factors that may lead to readmission. The Nurse coordinates with the inpatient care team to provide additional interventions, as appropriate. Within 48 hours after discharge, the TOC Nurse visits the patient at home. During the home visit, the TOC Nurse conducts a post-discharge assessment, performs medication reconciliation, provides patient/caregiver education as needed, and ensures that the patient is ready and able to attend his/her follow up appointment with the Provider. If the patient refuses an in-home visit, the TOC Nurse may conduct a post-discharge assessment via phone call. After completion of the post-discharge assessment, the patient receives three weekly phone visits (within a time period up to 30 days) to monitor the post-discharge care objectives.

All patients seen by Transition of Care Nurses have LACE scores between 10 and 19 (strata 3 and 4). Additionally, a patient may be referred to a program based on the recommendation of the Transition of Care Manager in collaboration with the Hospitalist, Discharge Call Center Nurse, PMG Complex Care Case Managers, and/or members of the PHP SNF Prior Authorization team.

For more information about LACE scoring and risk stratification, see the [Approach to Preventing Readmissions](#).

There are three Transition of Care Programs:

**Inpatient to Home**
Discharge care coordination and 30 day monitoring for patients discharged from a hospital to home, for PMG/PHP capitated members, age 55 or older, with a LACE score of 12 or higher.

**SNF to Home**
Discharge care coordination and 30 day monitoring for patients discharged from a SNF to home, for PMG/PHP capitated members, age 18 or older, with a LACE score of 10 or higher.

**Readmission Prevention**
Discharge care coordination and 24-48 hours post-discharge home visit for all patients discharged from a PHS hospital to home, age 55 or older, with a LACE score of 12 or higher; members with lower LACE scores may be referred by Clinic Complex Case Manager or Social Worker.

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>TECHNOLOGY</th>
<th>PEOPLE</th>
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<tbody>
<tr>
<td>Pre-discharge nurse visit</td>
<td><strong>Epic (EHR):</strong> identifying patients, patient care documentation, communication and collaboration with care team, and reporting</td>
<td>Process Owner: Manager, Transition of Care Programs (Valerie Lotz, BSN, RN, CCM)</td>
</tr>
<tr>
<td>Post-discharge nurse (home) visit and phone calls</td>
<td></td>
<td>Care Coordination Assistant (CCA)</td>
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<td></td>
<td></td>
<td>Transition of Care (TOC) Nurses</td>
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## Measures of Success

<table>
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<tr>
<th>Objective</th>
<th>Measure</th>
<th>Aligns with Aim</th>
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| Reduce readmission and utilization            | • Readmission rate for TOC patients readmitted to any PHS facility within 30 days  
                                            | • ED utilization for TOC patients visiting PHS ED with 30 days of discharge | Better Health                  |
|                                               |                                                                        | Exceptional Experience           |
| Complete 30 days of coordinated care for all eligible hospitalized patients (for Inpatient and SNF programs) | • Number of face to face visits prior to discharge  
                                            | • Number of refusals             | Better Health                  |
|                                               | • Number of home visits                                                | Exceptional Experience           |
|                                               | • Completion rate                                                      |                                  |

The Transition of Care Programs reports these metrics quarterly.

### Process and Responsibilities

The diagram below summarizes the patient referral and visit process.

![Diagram](image)
Future Work

Data Analysis
Program data -- total number of patients eligible for TOC/Number seen; number of those patients receiving a home/telephone visit within 48 hours of discharge -- are being collected to determine the effectiveness of the intervention at reducing readmissions and ED utilization and to articulate a baseline for completion rates for each program.

ACG System
The Johns Hopkins ACG® System is being piloted at PHS as a model for stratifying risk and identifying patients who would benefit from care management. We anticipate this will be the preferred method over LACE scoring.

Moderately at Risk Patients
Initial findings of the TOC Nurses have indicated that interventions with the LACE scored 10 and 11 patients tend to have the most positive impact on patient health. These individuals are only moderately at risk for readmission, compared to the high risk (LACE scored 12-19) individuals who are older, more frail, with health that is more likely to be on the decline, and who tend to be enrolled in prevention programs already. Nurses will work proactively with the LACE 10 and 11 patients because they tend to benefit most from focused care coordination, which can significantly reduce the risk that these patients will suffer a catastrophic event that would require another episode of acute care or ED utilization.

Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>LACE Score</td>
<td>Derived in 2010 by a group of clinicians in Ontario, Canada, the LACE index is an objective measure used widely to predict the risk of unplanned readmission or death within 30 days after hospital discharge in both medical and surgical patients. It includes the length of hospitalization stay (“L”), acuity of the admission (“A”), comorbidities of patients (“C”), and emergency department use of patients (“E”). Studies of the LACE index have shown that a higher LACE score predicts a higher probability of patient readmissions; the scale is 0 to 19.</td>
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<tr>
<td>medication reconciliation</td>
<td>Whenever new therapy is ordered or new information becomes available, the patient’s medication regimen may be evaluated, with the goal of reducing potential harm related to medication utilization. This comparison addresses duplications, omissions, and interactions. This process may occur at any time during the patient’s care, including transitions when new medications are ordered and when existing orders are rewritten or adjusted.</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>A nursing facility that provides 24-hour non-acute nursing, medical, and rehabilitative care. SNFs are recognized by Medicare and Medicaid as meeting long term health care needs for individuals who have the potential to function independently after a limited period of care, as compared to the residential nature of a long-term care facilities or nursing homes. Most patients are admitted to a SNF facility after a hospital discharge to facilitate access to intensive rehabilitation services and/or ease their transition home. Presbyterian Kaseman Hospital has two inpatient SNF units.</td>
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Strata

To facilitate care coordination, Presbyterian’s Integrated Care Solutions team has objectively stratified LACE scores into four risk profiles, low (1) to high (4); PHS patients are offered post-discharge interventions based upon the stratum in which they are classified. For example, patients assigned to stratum 4 have the highest LACE scores (from 12 to 19) and the highest (≥97%) probability of readmission. These patients would be provided the most intensive interventions, such as in-home care within 24 hours plus Case Management services. Patients assigned to stratum 3 (LACE 9 to 11) have a fairly high probability of readmission (88%-96%), and would be eligible for high-level interventions, such as Case Management services. The most appropriate intervention for patients in stratum 2 (LACE 6 to 8) may be supported self-care. The stratum 1 (LACE 0-5) patients are generally low-risk, healthy patients who may need the least amount of post-discharge care.

transition of care

A transition of care, sometimes called a “hand-off”, occurs any time a patient leaves one care setting (i.e. hospital, skilled nursing facility, assisted living facility, primary care physician care, home health care, or specialist care) and moves to another setting or back to the patient’s home. This transition often involves several people, including the patient, family or other caregivers, nurses, social worker, case manager, pharmacist, physician, and other Providers. Transitions of care affect not only the patient but the health care professionals as well.

Additional References

PHS Clinical Care Model

- Approach to Preventing Readmissions

Additional Resources

- Care Transitions Intervention (CTI)®
- Johns Hopkins ACG® System
- National Transitions of Care Coalition (NTOCC)