Integrated Transitional Care

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Transitional Care

“A set of actions designed to ensure the coordination and continuity of healthcare as patients transfer between different locations of care”
Desired Outcome

Optimal health and quality of life at a reasonable cost

“I get the best possible chance to achieve what is most important to me.”
Classification of Transitional Care

• **By location**: Hospital to home, hospital to SNF, SNF to home, others

• **By intervention**: Education in hospital, discharge planning, home visits, care management by telephone, special clinics, digital technology

• **By population**: Heart failure, elderly, dementia, diabetes, renal failure, stroke, transplant
Which Models are Effective?

• Summary of 17 systematic reviews included
  – 100s of individual studies of TC through 2014
  – Tests of numerous models:
    • Different settings
    • Different combinations of interventions
    • Different populations

Kansagara D et al. *Hospital Medicine* 2016
Successful Programs

Programs that improve re-admission rates and “patient-reported outcomes” (e.g., quality of life, independence):

• Include several interventions
• Span hospital and post-hospital phases of care
• Flexible enough to meet individual patients’ unique needs.
Remaining Uncertainties

• Which patients?
• Which staff?
• Which combinations of interventions?
• Which types of follow-up (phone or visit)?
• Which models in which healthcare systems?
How Can I Create a Successful Transitional Care Program?

• To improve outcomes, the new program must close gaps in the present system of care.
• To be flexible and comprehensive and to span hospital and post-hospital locations, the program must be integrated across providers and organizations.
Which Elements Are We Doing Now?

• In the hospital:
  – Creating comprehensive discharge plans
  – Engaging the patient and carer(s) in the planning
  – Teaching, training, confirming, instilling confidence
  – Arranging equipment, supplies, meds, transportation, follow-up appointments for after discharge

• After discharge
  – Monitoring the patient and carer (early and often)
  – Providing access to helpful clinical assistance 24/7/365
  – Communicating clinical information among providers
  – Obtaining feedback from patients
Which Elements Do We Need to Add or Improve?
HOW SHOULD WE LAUNCH OUR INTEGRATED TRANSITIONAL CARE PROGRAM?
Understand your Foundation

Collaborative Organizational Relationships

Economic Incentives

Political Environment
## Organizational Capabilities

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*Evans JM et al., IJIC 2016, “Context and Capabilities for Integrating Care” (CCIC) Model*
Appraise your Local Assets

- Specially Trained Professionals
- Strong Management – Patient Partners
- Capacity to Share Clinical Data

- Collaborative Organizational Relationships
- Economic Incentives
- Political Environment
Define the Clinical Elements

• Select the location(s) for transitional care
• Identify the population(s) at risk
• Select the elements of the intervention:
  – In the hospital
  – After discharge
• Describe the details
  – What will be the role of each organization?
  – What will be the specific tasks for each provider?
  – What will be the case load for each provider?
  – How frequently will providers communicate with patients? For how long after discharge?
  – What medium will providers use to communicate with patients? With each other?
Implementing Your Model

“The Model”

- Appropriately Trained Providers
- Excellent Management with Patient Partners
- Capacity to Share Clinical Data

Organizational Capabilities

Economic Incentives

Political Environment
Implement your Model

• Leverage the strengths of your *foundation*: political, economic, organizational

• Deploy all available *assets*: training of providers, management with patient partners, information sharing

• Launch your clinical program, including quality improvement processes

• Measure and report the program’s results regularly

• Plan to adjust the program frequently