UTMB Health System

Inpatient Care Transitions

Texas Healthcare Transformation & Quality Improvement Program

Regional Healthcare Partnership, Region 2

Transitions of Care: 094092602.2.6

Geriatric Transitions: 094092602.2.4

Patient Advocacy Navigation: 094092602.2.5

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Background

- Poor transitions from inpatient settings can result in:
 - Hospital readmissions
 - Adverse medical events
 - Mortality
- UTMB Health System's response, with the support of the Texas Medicaid 1115 Waiver Healthcare Transformation and Quality Improvement Program, to the identified need to improve care transitions:
 - Three transitions programs targeting high-risk patient populations
 - Transitions of Care, Geriatric Transitions, and Patient Advocacy Navigation were created to support effective care transitions and provide safe, effective, and efficient care once discharged from the hospital



Goals

- Expected outcomes
 - Decrease preventable readmissions
 - Increase positive health outcomes
 - Decrease health care costs
- Transitions model in DY6 and moving forward
 - Three transitions projects under one operational model
 - Increase care coordination and facilitate improved patient outcomes



Transitions of Care

- Discharge type: routine
- Age: Adult
- •Insurance: uninsured, Medicaid, dual eligible, Medicare
- Counties: Galveston and Brazoria
- •Diagnosis: CHF, CAD, PNA

Identify Qualifying Patients

Patient Enrollment

- •Collaborate with stakeholders in discharge planning
- Initial patient disease education

- Home, telephone, and/or clinic follow-up visits for 30-days postdischarge
- Coordinate follow-up care
- Identify barriers and facilitate obtaining medication and necessary supplies
- Assess functional/ADL status and provide education on fall prevention
- Teach "red flags" that may arise and signal a potential for readmission

Routine Discharge



Geriatric Transitions

- Discharge type: NH, SNF, or rehab
- Age: 65+
- Insurance: any
- Counties: Galveston and Brazoria
- Diagnosis: CHF, COPD, PNA

Identify Qualifying Patients

Patient Enrollment

- Disease education prior to discharge
- Post-discharge service planning

- Coordinate and educate patient care team on early identification and management of rehospitalization risks
- Provide disease management education

Discharge to Health Care Facility



Patient Advocacy Navigation

- Discharge type: routine, outpatient, post-acute care, home care
- · Age: Adults
- · Insurance: any
- Counties: any
- Diagnosis: not trauma, hospice, pedi, OB, or TDJC

Identify Qualifying Patients

Patient Enrollment

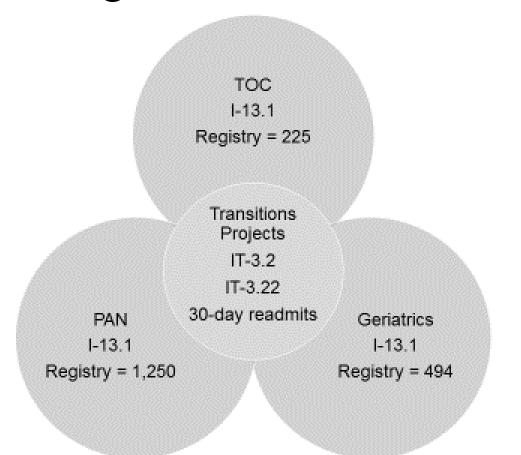
- Initial patient contact and disease education
- · Coordinate follow-up care
- Communicate with healthcare team to promote safe, smooth and sustainable care transitions

- Provide telephonic follow-up care and support
- Identify and follow-up with care team regarding any patient issues
- Monitor patient readmission status and healthcare needs

Inpatient Discharge

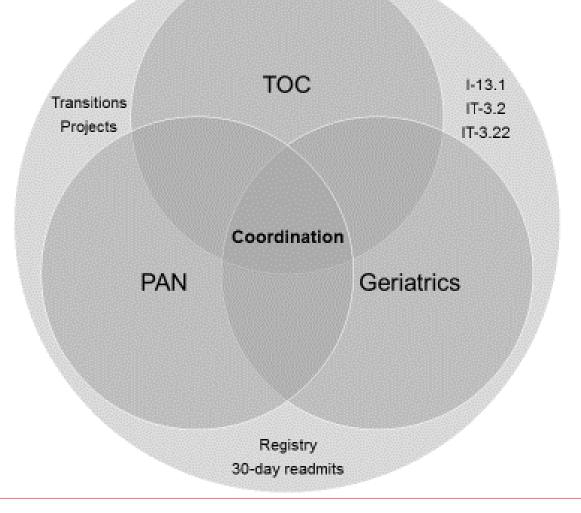


Transitions of Care Projects – Current DY5 State





Transitions of Care Projects - Future State





Questions and Comments

