STATE OF TENNESSEE

Health Link: Transitional Care

12/6/2018

Andrea Westerfield

- Andrea Westerfield serves as Director of Care Management for Mental Health Cooperative (MHC) and is responsible for managing all Care Management programs including daily operations, quality of care, and program oversight.
- Andrea began her career at MHC in 2008 where she served as a Care Manager for children, youth, and families. Andrea has been instrumental in building and nurturing MHC's Care Management service, focused solely on persons with serious behavioral health challenges. Andrea led and guided MHC through a successful transition to a Tennessee Health Link provider in December of 2016.
- Andrea received her Bachelor's degree in Social Work from Murray State University and her Master's in Social Work from the University of Tennessee. She is a Licensed Clinical Social Worker.

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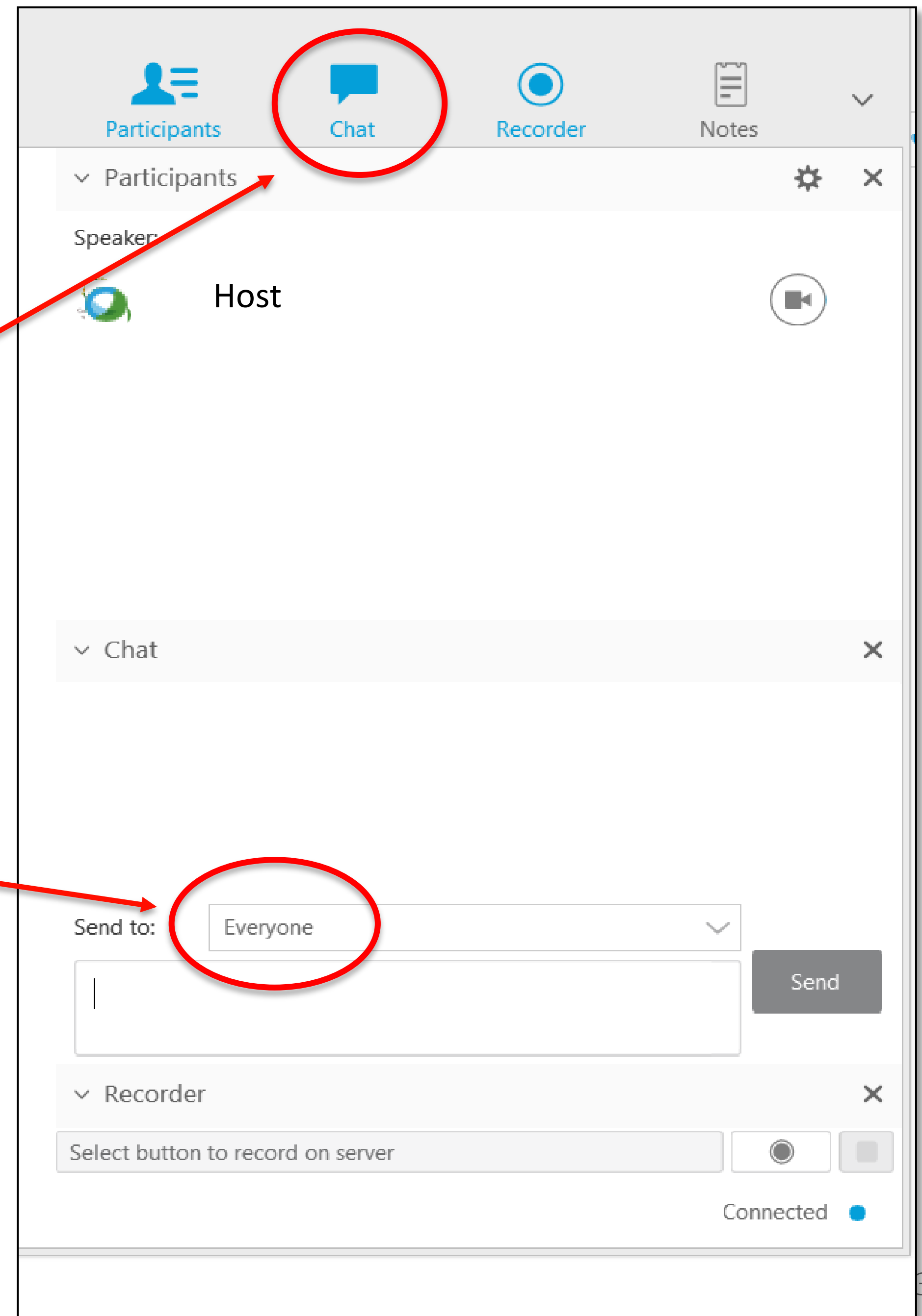
Interactive Webinar

Communicating during the webinar:

- For questions or comments during the presentation, please click on the **chat box** function.
- Select “Everyone” and enter your question or comment
- This will also be used during all Q&A portions of the presentation



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Polling Feature

- A polling panel will display
- Select your response(s)
- Click on **Submit**

Participants | Chat | Notes | Polling

Participants

Polling

Time elapsed: 0:05 Time limit: 1:00

Poll Questions:

1. What is your current role?

- A. Care Coordinator
- B. Clinical Care Coordinator
- C. Health Link Administrator
- D. Representative from an MCO
- E. Clinician
- F. Other

Submit

Your answer may be recorded.

Connected

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POLL #1

What is your current role?

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Agenda

- ✓ Transitional Care Definition
- ✓ Provision of High Touch Support
- ✓ Scheduling Follow-up Care
- ✓ Direct Member Contact
- ✓ Engagement
- ✓ Agency Considerations

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Transitional Care Defined

Provide additional high touch support in crisis situations, participate in development of discharge plan for each hospitalization, develop a systematic protocol to assure timely access to follow-up care post discharge, establish relationships, and communicate and provide education.

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Tennessee Health Link and its
collaborative efforts with
hospitals creates
a story of hope
where science and a belief in
human potential
come together for
positive outcomes.

Why Transitional Care?

- Ensures coordination and continuity of care
- Reduces the risk for readmission
- Improves overall health outcomes
- Decreases costs
- Creates opportunity for member education and engagement
- Allows for collaboration with systems of support

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POLL #2

What percentage of patients have a medication discrepancy upon being discharged from the hospital?

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Transitional Care Stats

Individuals with chronic conditions—a number expected to reach 125 million in the U.S. by 2020—may see **up to 16 physicians in one year.**

One study found that, on discharge from the hospital, **30% of patients have at least one medication discrepancy.**

According to another study, **one in five U.S. patients discharged to their home from the hospital experienced an adverse event within three weeks of discharge.** Sixty percent were medication related and could have been avoided.

On average, **19.6% of Medicare fee-for-service beneficiaries who have been discharged from the hospital were readmitted within 30 days and 34% were readmitted within 90 days.** According to MEDPAC, hospital readmissions within 30 days accounted for $15 billion of Medicare spending.

* From the National Transitions of Care Coalition (NTOCC). "Improving Transitions of Care"

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POLL #3

What are the greatest barriers to transitional care that you face?

(Choose as many as applicable)

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Provision of High Touch Support

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#1 Discharge planning begins at point of admission

- Develop and maintain relationships with area hospitals
- Monitor Care Coordination Tool (CCT) Admissions, Discharges, and Transfers daily for alerts of hospitalization
- Collaborate with hospital treatment team
- Obtain discharge paperwork prior to discharge

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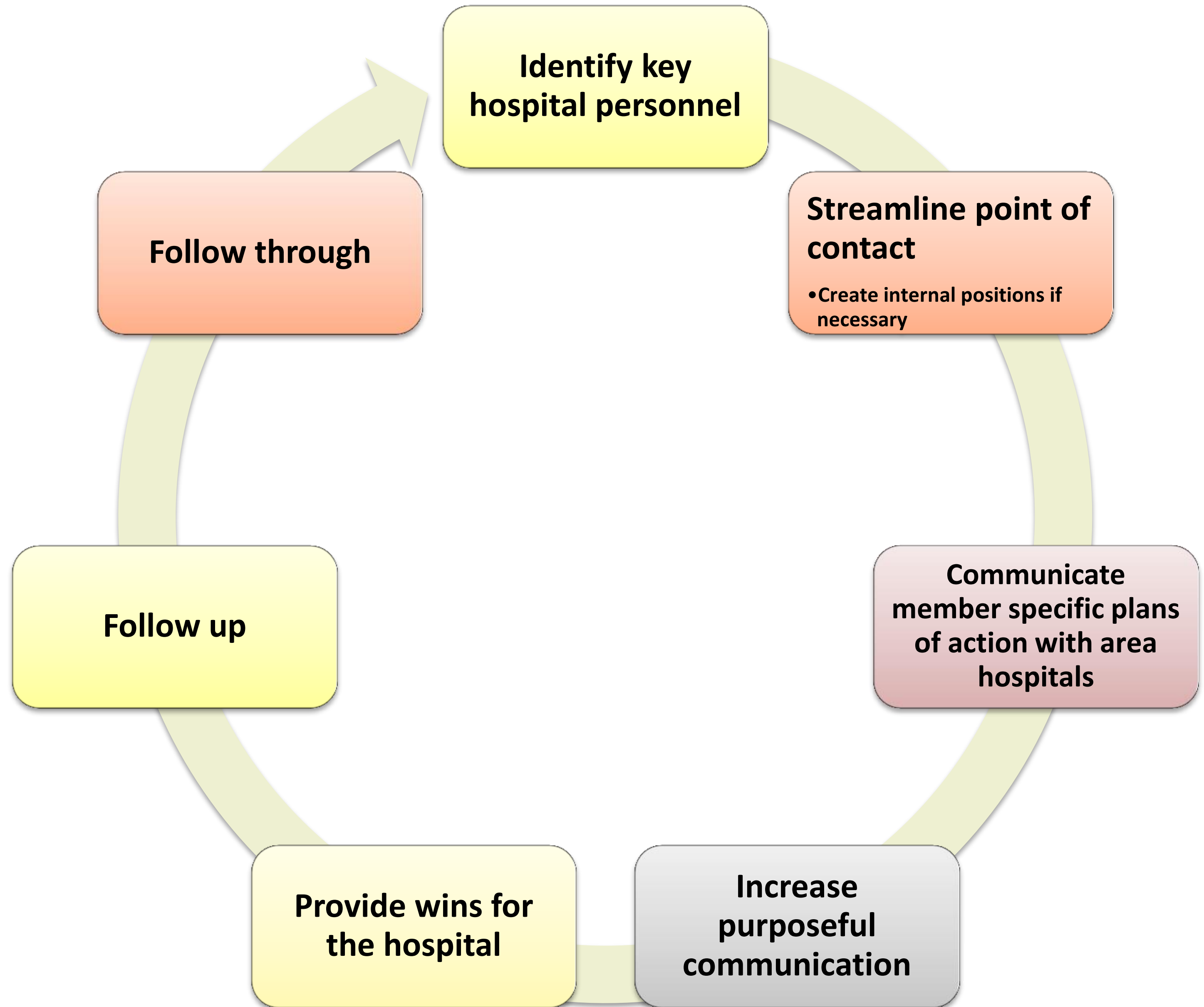
Tips: Developing Hospital Relationships



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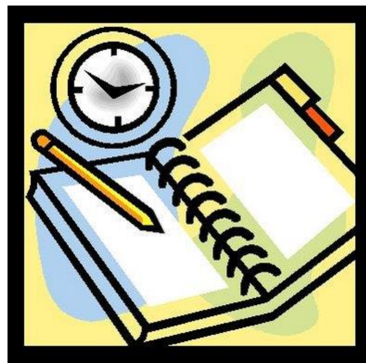
Scheduling Follow-up Care



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#2 Schedule 7-day follow-up visits

- Schedule this appointment before the member leaves inpatient care
- Schedule the appointment at the 3 or 4 day mark to allow for a margin of error
  - Plan for those at risk of no-showing
  - Utilize telehealth appointment
- Provide education regarding the importance of follow-up care
  - Develop educational materials specific to your population

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POLL #4

Does your organization use telehealth for follow-up appointments?

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Direct Member Contact

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#3 Provide high touch support

- Increase face-to-face THL contact for at least 90 days post hospitalization
- Increase collateral contact following hospitalization
- Increase phone call support for 6 months post hospitalization

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Tips: Barrier Reduction

- **During high touch visits address the following:**
  - Appropriate use of ED/hospital
  - Explore reasons for ED use and/or hospital admission
  - Plan to address psychosocial factors for hospitalization
  - Review individualized care plan and update as necessary
  - Address member’s plan for transportation for 7 day follow-up visit
  - Address gaps in care before they become critical issues
  - Asses the member's connection or lack of with a primary care physician
  - Discuss medication changes, refills, side effects, etc.

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Engagement

#4 Education for positive health outcomes

- Utilize educational materials
- Offer transportation
- Consider educational campaigns
- Use technology for appointment reminders and member engagement
- Utilize Motivational Interviewing

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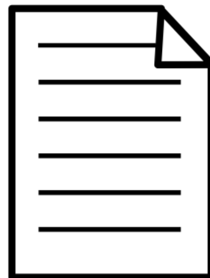
Review Outcomes



#5 Review agency outcomes and make course corrections

- Use data to guide decisions
- Monitor THL reports to determine where risks and opportunities are present
- Hold THL Care Coordinators accountable for adequate member transitional care

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Agency Considerations

- Develop agency wide best practices across multi-disciplinary departments
  - Streamline communication amongst departments
- Consider what job titles or roles are necessary for your patient population
- Offer telehealth appointments for follow-up care
- Ensure individualized care plans are multidimensional and visible by all team members

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Best Practices

MHC Care Management
Best Practice: Follow Up from Hospitalization 12.14.2017

Objective:

The objective is to ensure that a Consumer is seen in MHC Clinic within 7 days of hospital discharge. To also ensure MHC team establishes communication and engagement with Consumers, Guardians, Psychiatric Hospital Staff, and Treatment Team from point of C's hospital admission. This will provide increased support and continuity of care for the consumer, and facilitate a smooth transition back to MHC outpatient supports.

Scheduling Return from Hospital (RFH) Appointment within 7 days

AA/OC Responsibilities

1.

Work Flow

CM Responsibilities

1.

CM Supervisor Responsibilities

1.

Nursing Responsibilities

1.

Regarding RTF no-shows:

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Risk Assessment

- **Conduct an Internal Risk Assessment:**
  - Look for weaknesses or breaks in communication: both internal and external
  - Do you have relationships with the right partners
  - Take a root-cause analysis of readmission reasons/rates
  - Develop solutions as an agency
  - Monitor and audit progress

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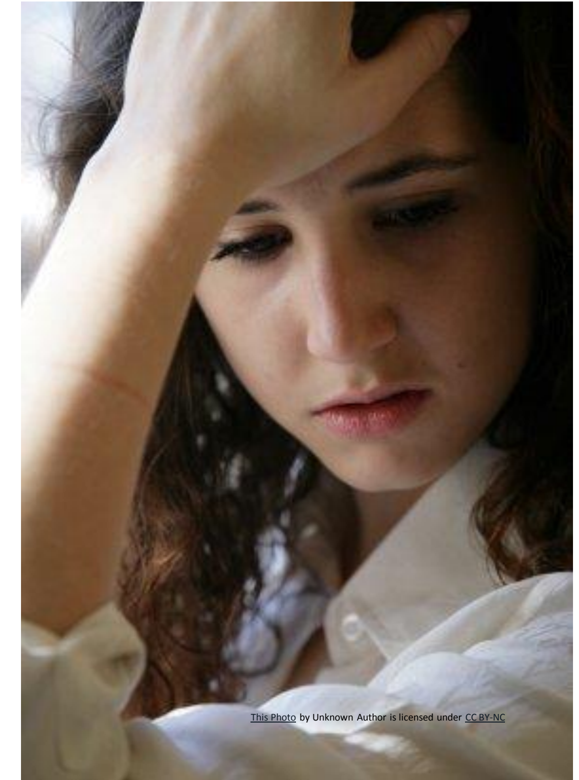
Case Example

- 30 year old female, hospitalized for uncontrolled diabetes and diabetic ketoacidosis, LOS 4 days
  - Discharged to home with outpatient follow up
  - Readmitted 14 days later with same diagnoses
  - ED visits occur between hospitalizations
  - Co-morbid diagnosis of Major Depressive Disorder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Case Presentation

- Provision of high touch supports
- Schedule follow up care
- Direct member contact
- Engagement
- Review of outcomes
- Tangible takeaways

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Q&A

Thank you!

Andrea Westerfield, LCSW
Director Care Management
Mental Health Cooperative
awesterfield@mhc-tn.org

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