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

Identify Qualifying Patients

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

Patient Enrollment

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

Routine Discharge

- Home, telephone, and/or clinic follow-up visits for 30-days post-discharge
- 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
Geriatric Transitions

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

Identify Qualifying Patients

Discharge to Health Care Facility

Patient Enrollment

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

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

Patient Enrollment
Patient Advocacy Navigation

Identify Qualifying Patients

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

Patient Enrollment

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

Inpatient Discharge

- 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
Transitions of Care Projects – Current DY5 State

- **TOC**
  - I-13.1
  - Registry = 225

- **Transitions Projects**
  - IT-3.2
  - IT-3.22
  - 30-day readmits

- **PAN**
  - I-13.1
  - Registry = 1,250

- **Geriatrics**
  - I-13.1
  - Registry = 494

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Transitions of Care Projects - Future State

Transitions Projects

TOC

I-13.1
IT-3.2
IT-3.22

Coordination

PAN

Geriatrics

Registry
30-day readmits

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Questions and Comments