Provide Person-Centered Transitional Care for Individuals with Complex Needs

Transitional care programs — where a multidisciplinary team comprehensively assesses a patient's medical and psychosocial needs, addresses modifiable barriers, and links them to primary care — can help address critical gaps in care for people with complex needs moving between locations of care, such as from hospital to home. These programs vary widely, both in terms of what services they provide, and whether services are delivered before hospital discharge, after discharge, or as part of a "bridging" intervention with both pre- and post-discharge components. A comparative effectiveness trial of a patient-centered transitional care intervention at Northwestern Medical Group in Chicago demonstrated that transitional care emphasizing post-discharge services for patients with complex needs who do not have a usual source of care reduced inpatient admissions. This play can help you develop an integrated, person-first approach to transitional care post-discharge.

What is a Play?

If you are not a sports fan, then the concept of a "play" may be unfamiliar. Yet the idea is simple: a play is a plan designed to help deliver a win through highly coordinated teamwork. This idea can be applied to help redesign systems to better serve individuals with complex health and social needs. Explore additional plays on the *Better Care Playbook* at bettercareplaybook.org.

Delivering Integrated, Person-First Transitional Care

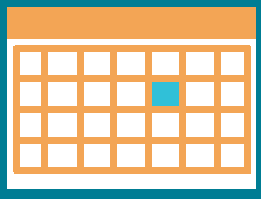
1

Initiate a multi-disciplinary, transitional care practice appointment within 10 days post-discharge.

2

Develop a person-centered, individually tailored care plan.

3



Schedule follow-up appointments, as needed.

4

Connect patient to community-based primary care providers when ready to leave the transitional care practice.

How to Run the Play

1. The patient should be seen by the multidisciplinary, transitional care team within 10 days of their hospital discharge. The multidisciplinary team ideally includes a social worker, medical provider, health advocate, and pharmacist to assess the patient with a comprehensive, holistic perspective. The patient sees all team members during his or her initial visit.
2. The initial visit includes the creation of a step-by-step care plan that is developed by the entire care team, including the patient, and addresses both health and social needs. Interventions to address social determinants of health, connections to community resources, mental health supports, and medication management strategies are initiated at the first visit.
3. Schedule follow-up visits every 1-2 weeks to support healthy behaviors, and provide ongoing encouragement and education to empower patients to increase skills and work toward a sustainable self-monitoring plan.
4. Connect the patient to a community-based primary care provider (new provider or existing relationship if present) when he or she has been identified as ready to leave the transitional care practice. Upon discharge from transition care, the PCP should be alerted and sent a medical summary.

Implementation Considerations

Initial Visit

- The patient first meets with a social worker to review their history, insurance status, and identify any unmet social needs. Collected information is accessible to the entire care team so the patient does not have to repeat information during subsequent follow-up visits.
- The patient then meets with the medical provider. In addition to a physical assessment, the provider and patient can discuss each of the patient's concerns and create a step-by-step plan to address each one.
- Each member of the care team reviews, provides input to, and approves the patient's care plan.
- Following the medical provider visit, the pharmacist reviews and updates the patient's medication list, applies for pharmaceutical assistance plans if needed, loads medications into a pill box, and provides the patient with education about the medications.
- The visit concludes with the health advocate exploring opportunities to address unmet social needs.
- The health advocate ensures that the patient has transportation to the next appointment.

Follow-up Visits

- Patients may benefit from psychiatric evaluations or therapy sessions in conjunction with medical, pharmacy, and care coordination supports.
- Many patients benefit from weekly visits. Face-to-face nurse home visits may be used for wound care, medication management (e.g., pill box loading), and educational support between primary care visits.
- Depending on patient needs identified at primary care and/or home visits, telephonic contact between visits by a health advocate, clinic nurse or pharmacist can be help address targeted needs, e.g., check on medication adherence, follow up on food stamps, etc.

Connect to Primary Care and Assess Long-Term Benefits

- Create a network of community-based primary care providers for referring patients to post-transitional care.
- Think about supporting the health and well-being of the patient for the longer term to incentivize outcomes beyond 30 days post discharge.

Additional Resources

- **Effects of a Transitional Care Practice for a Vulnerable Population: A Pragmatic, Randomized Comparative Effectiveness Trial** – This article summarizes results from a patient-centered transitional care intervention serving patients with complex health needs that lack a usual source of care at Northwestern Medical Group in Chicago. The intervention was found to reduce the likelihood of inpatient admissions within 90 and 180 days post-discharge by at least 35 percent in a randomized comparative effectiveness trial.
- **Transitional Care Programs for Vulnerable Populations: New Evidence on the Benefits of a Person-Centered Approach** – This blog post includes an interview with Christine Schaeffer, MD, medical director of Northwestern Medicine Transitional Care, who shared key considerations for health systems interested in implementing person-centered transitional care to address gaps in care and reduce costs.
- **The Care Transitions Intervention** –This resource describes the Care Transitions Intervention, which provides patients and caregivers with the skills and tools necessary for individuals to assume a more active role in their care.
- **So Many Options, Where Do We Start? An Overview of the Care Transitions Literature** – This resource includes a systematic review of transitional care interventions that reported hospital readmission as an outcome. Ten reviews of mixed patient populations consistently showed that enhanced discharge planning and hospital-at-home interventions reduced readmissions.

About the Better Care Playbook

The Better Care Playbook is an online resource center designed to help health care stakeholders find the best in evidence-based practices and promising approaches to improving care for people with complex health and social needs. It is made possible by six leading health care foundations — The Commonwealth Fund, The John A. Hartford Foundation, Milbank Memorial Fund, Peterson Center on Healthcare, the Robert Wood Johnson Foundation, and The SCAN Foundation — that are working together to accelerate health system transformation. To learn more, visit **bettercareplaybook.org**.