10 key components of a post-discharge care model
Written by Steve Counsell, MD, Executive Director, GRACE Team Care | June 18, 2015

Today's hospitals have more than a casual interest in ensuring that inpatient care is complemented by an effective post-discharge care management program, especially as it pertains to the health of our nation's elderly.

That's because just such a program can stem the flow of readmissions, decrease excess healthcare use, minimize the need for nursing facility placement, and substantially reduce emergency department visits. All of this results in positive financial and quality implications for the hospital, the patient and the healthcare system itself.

One model that is proving to be successful revolves around the creation of a high intensity care-team headed by both a nurse practitioner and a social worker. This team works in tandem to support the primary care physician and, following best practice protocols, fully address a patient's health conditions so as to help achieve a patient's goal from the convenience and security of their own home.

As validated in an independent study from Avalere Health, such a program can be especially effective when managing a high risk Medicare population, and particularly for the 20 percent of seniors who have chronic conditions and who need help with activities of daily living. These seniors represent 40 percent of all healthcare spending by those over age 65 who are living in the community and outside a nursing home setting. It is clear that for them, and others, something is needed beyond traditional medical care and care coordination.

Currently, a select number of hospitals around the country have implemented a new and more highly-focused model of care management as pioneered by the GRACE program at Indiana University School of Medicine. From their collective experience of serving thousands of older adults and working in conjunction more hundreds of primary care physicians, here are ten things a hospital should do in creating and implementing a program of this nature:

1. **Assure that there is close and trusted interaction between the outpatient care team and the hospital discharge planners** (and other hospital staff) to optimize a smooth care transition. This includes communicating baseline status, care plan, patient history, psychological considerations, medication management, availability of caregiver/family support, and any other information that can impact a successful recovery.

2. **Begin the patient-interaction portion of the program with a post-discharge in-home assessment** conducted by the nurse practitioner and social worker. This meeting is critically important to laying the foundation for the care management program that will follow, for setting benchmarks that can monitor progress, and for providing the flexibility to make needed adjustments to the care plan.

3. Once the in-home assessment has been conducted, the nurse practitioner and social worker should **meet with the primary care physician** to develop a pro-active care management plan that is consistent with the participant's goals. Some patients, particularly within the elderly population, will have limitations relative to what they can and can't achieve in recovery...and what their lifestyle will look like. The goal should be for each patient to be able to live their life to their fullest, whatever that potential may be.

4. **Conduct weekly interdisciplinary team conferences** involving not only the nurse practitioner and social worker but also the care team's geriatrician medical director, pharmacist and mental health liaison. Being sure to gain input to the care plan and coordinate care between these critical disciplines and the primary care physician is a sure formula for success.

5. **Provide specialized care and considerations for common geriatric conditions**. A great many Medicare beneficiaries receive treatment annually for five or more chronic conditions such as diabetes, heart failure,
depression, chronic pain, and diminished physical and/or mental capacities, including falls and dementia. Quality care for these patients requires the development and implementation of individualized, coordinated plans. Such plans often call for further evaluation, treatment, referrals, and patient or caregiver education. In addition, coordination usually involves managing care transitions across settings, working with primary and specialty care providers, and arranging community-based services as appropriate. Make sure these resources are all available to you and the patient.

6. **Consider the unique physical and psychosocial needs of low-income seniors including dual eligibles.** This population represents a particularly complex and high-cost group of older adults who often suffer from socioeconomic stressors and low health-literacy (potentially including language barriers). In addition, low-income seniors often have multiple chronic conditions for which they typically fail to receive the recommended standard of care. Your program needs to be prepared to sensitively and effectively address this growing population.

7. A recent Avalere Health study reported that to be successful in today's environment, there needs to be a focus not only on treating a person's medical condition but for managing a broad array of care needs across multiple settings. In short, a program like this has many components and relies on all of the parties and pieces working in one smooth rhythm. That means making sure that services such as home health care are implemented as planned. So too, it is critical to coordinate with specialty physicians, the emergency department, hospitals, skilled nursing facilities, and a broad array of community support services and community agencies (including independent resources) to make sure the patient has the tools and support they need to succeed.

8. **Ensure that your program includes a focus on patient education.** This should include teaching patients about their disease and learning how to recognize symptoms, along with the importance of adherence to diet, exercise and medication regimens. Few care providers can be at a patient's side 24/7 and no matter how good a program, there still remains a fair degree of accountability from the patients themselves if they are to optimize their health and well-being.

9. **Have the information technology infrastructure in place** necessary to support this high-intensity care management program. This includes a web-based care-management tracking tool along with an integrated electronic health record for documentation. In all facets of care, information is key and this program is no exception.

10. **Continue to monitor the patient's progress** and report on new developments and overall status at frequent team meetings as well as to the patient's primary care physician. Over time, care management programs established upon hospital discharge will likely need to be altered as the patient ages and/or physical conditions and social supports change. Good care management means being able to adapt to these changes so the patient always receives the best care and attention for their needs at that moment in time.

America's senior population now represents the fastest growing demographic in the country with 10,000 men and women turning 65 every day. How our nation addresses the health and lifestyle needs of these citizens is already a central issue of major concern. The movement towards population health is a good first step in broadening our thinking about the larger role that healthcare providers can play. Just as we have seen a generational shift from office-based care to patient-centered medical homes, evidence has shown that the time has come to embrace a high intensity and proactive care management approach to managing high-risk Medicare populations.

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