Transitional Care Management: *A Game Plan for Success*

March Madness is here, and like winning basketball teams, the nursing home care team doesn't count on luck when it comes to care transitions. Instead, they strategize carefully, plan for many possible scenarios, communicate with the entire team, and have partners on and off the court. In the most recent episode of the Spoonful of Sugar podcast, "Bringing Health Home: The Transitional Care Management Model," guest William Mills, MD, senior vice president of medical affairs for BrightSpring Health Services, offered a game plan for successful transitions.

Winning for the Resident Takes Teamwork

The transitional care management (TCM) model has been growing in popularity in long-term care as more residents seek to stay healthy at home with the person-centered support they need, and several new programs allow Medicare and Medicaid-funded services at home or in the community.

As residents discharge from nursing homes, the TCM approach affords facilities the opportunity to play an active role in managing care for residents transitioning out of the facility. Using TCM, the nursing home team can realize things like lower costs, increased medication adherence, reduced hospitalization rates, and improved clinical and quality outcomes.

Dr. Mills stressed the importance – and the challenges – of getting transitions right the first time. He said, "Any time there is an older adult transitioning from one care setting to another, it represents a time of significant vulnerability for that person. A safe, effective transfer is about communication and understanding the risks for that residents, as well as knowing what resources they may or may not have available as they transfer between settings."

A Game Plan for Success

Dr. Mills suggested ways to set people up for success as they head home after a nursing home stay:

Pre-discharge interventions. This includes identifying risks and determining how to manage them. It also involves finding out where the person will go after discharge and what they will need to be successful there – such as assistance with things like transportation, shopping, or assistive devices and/or adjustments to the home environment. Dr. Mills added that an initial medication reconciliation is important to ensure they're getting the medications they need now and address with them how this differs their previous regimen. He said, "We need to consider how they will get these medications. For instance, will they get the necessary meds to take home with them, or will there be another step such as a stop as the pharmacy to get a prescription filled?" He also recommended scheduling a follow-up visit with their primary care or other physician.

Post-discharge interventions. Efforts such as home visits and follow-up phone calls have proven effective. Dr. Mills said, "Early in the 20th century, most medical care was received in the home setting, but that went away with the advent of managed care. Now we're starting to see that the home visit is valuable and a best practice for overall care management."

A Checklist to Avoid Readmissions

These pre- and post-discharge interventions will help keep residents safe as they move along their journey. But to avoid readmissions, Dr. Mills suggested additional steps:

1. **Think about the type of risks each patient faces as they head home.** He said, "This is the best initial step for the skilled nursing facility care team to put their energy into." There are many standardized risk assessment tools that may be helpful.
2. **Build an external team in the community.** Identify home care agencies, Meals on Wheels programs, and other organizations and entities that can help provide the supports and services necessary to keep people safe at home.
3. Make care transitions multifaceted. Address all aspects of the resident's needs and gaps that must be filled to keep them safe and functioning. "A multifaceted recipe can help decrease readmissions as people go from care setting to care setting," Dr. Mills said.

When transitions involve detailed planning, effective communications, and strong partnerships, the odds of readmission are diminished considerably, and residents have the team they need to win – wherever they are in the care continuum.

The Spoonful of Sugar podcast is an innovative partnership between PharMerica and McKnight's. In each program, co-hosts T. J. Griffin, Vice President of Long Term Care Operations & Chief Pharmacy Officer at PharMerica, and John O'Conner, Vice President, Associate Publisher/Editorial Director of McKnight's, address the latest issues in long-term care with leading experts and frontline providers, practitioners and others. Listen to this and all Spoonful of Sugar podcasts **here.** And **join Illuminate** to get notified of new monthly episodes on emerging trends, issues, and the future of the skilled nursing industry.