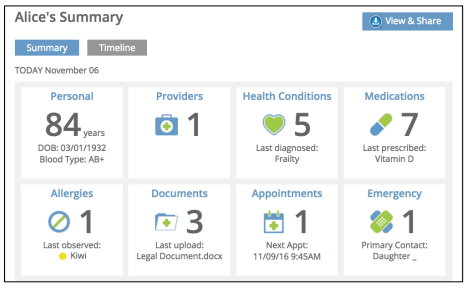
Improving Care Transitions

Post-Acute Care Transitions

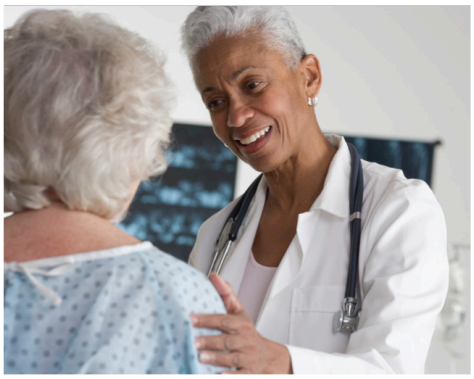
Care transitions are some of the most vulnerable times for older adults and their families. This is especially true when older adults are being transferred from hospital to home, or from hospital to another level of care. These transitions often involve handing off patient care to other clinical staff, or to the older adults to manage themselves. Below are some projects that I have been working on to better understand how technology can improve these important care transitions.

Effectiveness of PHRs for Home Health Encounters



For aim 3 of my dissertation, I am exploring whether PHR use can impact Medicare home health patient satisfaction and clinical outcomes. For this analysis, I am using the new Home Health Value Based Purchasing measures that are currently being piloted in 9 states including Washington.

30-day Readmission Reduction



As a performance improvement consultant at University of Chicago Medicine, I led several projects to reduce 30-day readmission rates on different patient populations. One project looked at the care transition of older adults from hospital to skilled nursing facility. Our team enacted several procedures to improve the handoff between hospital and SNF nurses, ensure pain medications were available prior to transfer, and reduce after hour and weekend transfers.

Related Publications and Presentations:

- **Kneale, L**. The University of Chicago Medicine's Readmission Reduction Program. Joint Commission Resources National Pacing Event, Chicago, Illinois, 1 Apr. 2013.
- **Kneale, L**. The University of Chicago Medicine's Readmission Reduction Program. Joint Commission Resources All National Hospital A.D.E and Readmissions Event, Chicago, Illinois, 4 Mar. 2013.