



Best Practice: Transitional Care Coordination

Leadership Track



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Leadership Section

Objectives

The purpose of the **Transitional Care Coordination Best Practice Intervention Package** (BPIP) is to assist home health agencies to:

1. Understand the concept of transitional care coordination and its potential role as a best practice in decreasing avoidable acute care hospitalizations
2. Recognize the necessity for home health to assert its role in the evolution of transitional care coordination
3. Implement transitional care coordination strategies to promote collaboration with other providers to improve care coordination

Post-hospital care transitions are common among Medicare beneficiaries and patterns of care vary greatly. A significant number of beneficiaries experience complicated care transitions- a finding that has important implications for both patient safety and cost-containment efforts.

(Coleman, E., Min, S., J, Chomiak A., & Kramer, A., 2006).

How to use this package

- Review the Leadership Track
- Look at previous BPIPs and how they correlate to Transitional Care Coordination (see page 20)
- Utilize the Agency Assessment and Action Items to establish your agency Action Plan (page 21)
- Review the Hospital and Physician Connection pages (page 26 & 27)
- Display the HHQI Poster (page 28)
- Review and encourage the use of the clinical tracks and continuing education opportunities
- Listen to the Clinician podcast and Medical Social Worker/Home Health Aide podcast
- Read/discuss the Example of Excellence and how your agency can apply their successes (page 44 in the Nurse Track)
- Review the Personal Health Record (page 17) and Medication Discrepancy (Reconciliation) Tool (page 18) and compare to your agency's current forms (or lack of forms)
 - Consider adopting and/or modifying the sample forms
 - Consider arranging a meeting with local hospitals, nursing homes, large physician groups, etc. to initiate a **collaborative pilot** to begin improving transitions of care



After the HHQI Campaign

This is the final of twelve monthly Best Practice Intervention Packages (BPIPs) that Quality Insights of Pennsylvania has provided for agencies participating in the Home Health Quality Improvement (HHQI) national campaign to assist agency leadership with implementing and optimizing the top twelve best practices for reducing hospitalizations.

Even though this year-long campaign is concluding, the resources will remain available and continue to be pertinent. The BPIPs and associated resources will remain available on www.homehealthquality.org through 7/31/08 and will also be available in early February 2008 on <http://www.medqic.org> (under Home Health). There was a significant amount of information in each BPIP that agencies can **continue to use for ongoing quality improvement activities**. Listed below are some suggestions on evaluating future activities:

- Take time to reflect on the interventions and changes that you have already implemented to assist with reducing ACH
- Evaluate compliance and consistency with interventions and changes that your agency has implemented
- Evaluate the BPIP topics that your agency has identified as a focus area and review the package again, selecting additional action items
- Review the full BPIPs if your agency only used the Fast Track version
- Incorporate BPIP action items into the annual quality improvement plan
 - Use the Care Tracks for orientation and staff trainings or competencies
 - Develop a competency fair using the resources from the packages
 - Collect all packages together in a resource binder



NOTE: All continuing education for the Best Practice Intervention Packages will come to a close as of February 29, 2008! Go to the continuing education section on the campaign Web site on www.homehealthquality.org for available packages and links for evaluations/post-tests.

Transitional Care Coordination: A best practice for reducing hospitalizations

Introduction:

This Best Practice Intervention Package (BPIP) – Transitional Care Coordination is the twelfth and final in a series that has focused upon best practice strategies to assist home health agencies in reducing avoidable hospitalizations and improving their publicly reported acute care hospitalization (ACH) rates.

This package continues to build upon the previous BPIPS. As you review this package, you will note the importance of previous best practices in designing an effective care transitions coordination program. The interventions containing special significance to transitional care include the following:

1. **Hospitalization Risk Assessment**
2. **Emergency Care Planning**
3. **Medication Management**
4. **Phone Monitoring and Frontloading Visits**
5. **Physician Relationships**
6. **Patient Self-Management**
7. **Disease Management**

Transitional Care Coordination: What does this mean?

Transitional Care Coordination - Sharing both directions

Sending  Receiving

Transitional care coordination is a multi-dimensional best practice intervention. One must understand the individual concepts of **care transitions** and **care coordination** and combine the meanings to formulate this best practice – **transitional care coordination**. The understanding of these concepts which will assist in decreasing avoidable ACH. A brief review of care transitions and care coordination will also assist with developing an understanding of **transitional care coordination**.

Home health care is a component of the health care industry uniquely positioned to improve transitional care and outcomes for the growing population of older adults with continuous complex needs (Naylor, 2006).

Transitional Care Coordination



Ensures the coordination and continuity of care



Care Transitions

The Care Transitions ProgramSM

The term “**care transitions**” refers to the movement patients make between health care practitioners and settings as their conditions and care needs change during the course of a chronic or acute illness.

The primary goal of improved care transitions is to provide patients with tools and support that promote knowledge and self-management of their transition as they move from one setting to another (Care Transitions Program, University of ColoradoSM).

<http://www.caretransitions.org>

The research findings of **Dr. Eric Coleman and The Care Transitions Program** at the University of Colorado - Denver and Health Sciences Center have suggested that effective care transition intervention leads to improved self-management knowledge and skills for many patients, primarily in the areas of: **(1) medication management, (2) condition management, and (3) patient confidence** during the transition and beyond (Coleman, et al., 2006).

Care Transitions InterventionSM

During a four-week program, patients with complex care needs receive specific tools, support from a “Transition Coach” and learn self-management skills to ensure their needs are met during the transition from hospital to home.

The Care Coordination Model is composed of: 1) Personal Health Record; 2) Discharge Preparation Checklist; 3) Patient Self-activation and Management Session with a transition coach; and 4) Transition Coach follow-up visits in a skilled nursing facility or home and accompanying phone calls designed to sustain the first three components and provide continuity.

(Care Transitions Program, University of ColoradoSM)

The term “**care coordination**” targets the chronically ill who are at risk for increased use of health care services and assists in filling the gaps in our traditional, reactive system. Care coordination combines the best elements of home health, disease management and case management to organize a personalized health care system to keep the chronically ill and elderly as healthy as possible while reducing the use of costly services such as the emergency room and inpatient hospitalization (Meckes, 2005).

Transitional Care Coordination

The formal definition of Transitional Care Coordination includes the concepts from care transitions and care coordination. Transitional care has been defined as a set of actions designed to ensure the **coordination** and **continuity** of health care as patients transfer between different locations or different levels of care within the same location (Coleman and Berenson, 2004).

Focusing on the critical transitions of patients and their caregivers across health care settings and among providers is a promising approach to enhancing care coordination and improving quality (Naylor, 2006).

Transitional care which addresses the brief period that begins with preparing a patient to leave a setting and concludes when the patient is received in the next setting poses challenges that distinguish it from other types of care.

The [American Geriatric Society](#)

(2006) stated that transitional care encompasses both the **sending** and **receiving** aspects of the transfer and is essential for those with complex care needs. Effective transitional care is based on a comprehensive plan of care and the availability of health care practitioners who are well educated in chronic care and have current information regarding the patient's goals, preferences and clinical status.



Transitional Care Model



Mary D Naylor, PhD, FAAN, RN serves as the Marian S. Ware Professor in Gerontology at the University of Pennsylvania School Of Nursing and has been leading a team to test and refine the Transitional Care Model (TCM) since 1988. This Model provides for effective, comprehensive, cost-effective, evidence-based, in-hospital planning and home follow-up for chronically ill, high-risk, older adults.

The TCM was developed to address the negative quality and cost outcomes associated with breakdowns in care with older adults with complex care needs, when transitioning from an acute hospital setting to other care settings, including the patient's home.

The model begins at the point of the acute care hospitalization when the patient is assigned to an advanced practice nurse who follows the patient during the admission and develops and implements an intensive plan for home follow-up. There are ten core elements of the TCM model. These elements are summarized in a table on the next page with a crosswalk to HHQI Best Practices or current home care practices. (Naylor, et al., 2004)

For more information on this model see

www.nursing.upenn.edu/centers/hcgne/science_TRIP.htm.

Crosswalk Transitional Care Model and HHQI and Home Care Best Practices

TCM Ten Core Elements	HHQI Best Practices or Home Care Practices
1. In-hospital assessment, preparation, and development of an evidence-based plan of care	Hospitalization Risk Assessment; all BPIPs
2. Consistency of provider across entire episode with a transitional care nurse as the primary coordinator of care	Primary Nursing
3. Regular home visits with telephone support for an average of two months	Home care visits; Phone Monitoring and Frontloading Visits
4. Transitional care nurse accompanying patients to first follow-up visit	SBAR communication with physician
5. Comprehensive, holistic medicine practices focus on patient's needs, including primary and coexisting events	Disease Management BPIP
6. Active engagement of patients, families and caregivers including education and support	Patient Self-Management and Self-Management Support
7. Education regarding early identification and response to health care risks and symptoms and avoidance of adverse and untoward events	Emergency Care Planning; Patient Self-Management
8. Multidisciplinary approach to care that includes patient, family and caregivers as a team	Patient Self-Management and Self-Management Support; Case Conferencing
9. Physician-nurse collaboration	Physician Relationship BPIP
10. Communicate to, between, and among the patient and family, informal caregivers and health care providers and professionals	SBAR for interdisciplinary health care communications; Self-Management BPIP

(Naylor, et al., 1994, 1999, 2004)

**Transitional Care
Coordination:
Handoff/Handover**

Agencies face the daily challenge of care transitions or what may be termed **handoffs or handovers**.

Both terms, handoff and handover, are being used in health care and are related to transitions of care. We will be using the term **handover** in this package to represent transitions of care of the patient to and from settings.

**Care Transitions =
Handovers in Care**

A handover is a significant patient safety issue. **Handovers are error-prone and variable, creating a vulnerable gap in patient care.** Handovers are more than just an exchange of information. Both the sender and the receiver are responsible for asking questions during handovers to ensure full understanding through the transfer of information.

Joint Commission National Home Health Patient Safety Goal
(Jan. 1, 2006)
Implement a standardized approach to handoffs' communication, including an opportunity to ask and respond to questions.
www.jointcommission.org/GeneralPublic/NPSG/06_npsg_ome.htm

A handover implies **transfer of information** as well as **professional responsibility** to both deliver the information and assure it is understood.

Home health referrals typically come from facility-based care settings, such as hospitals or nursing homes. The home health agency then becomes the **receiver** of the transferred patient. It is a known fact that many of these transitions lack the ingredients for what would be defined as an optimal transition or handover. Home health becomes the **sender** in a patient/caregiver transition or handover when the patient is transferred to the emergency room, the physician office or other care setting. Home health does not always communicate effectively to the receiving setting.

The role of handovers is to:

- Exchange vital information
- Communicate the patient status
- Exchange information and assume or pass on responsibility
- Support patient safety



Key points:

- ❑ Care transitions are **not** optional
- ❑ Handovers between health care settings and providers occur daily
- ❑ Transitional care coordination should be the **standard of care**

**Transitional Care
Coordination:
The ACH
Connection**



Care transition interventions are designed to encourage patients and their caregivers to assume a **more active role during care transitions to help reduce re-hospitalization rates.**

Studies have shown that if patients and caregivers are encouraged to be active in their care transitions, there can be a significantly reduced rate of rehospitalization. The findings suggest patients are able to utilize new skills and tools that promote self-management. Meeting the needs of chronically ill older patients and their caregivers during care transitions may reduce the rates of subsequent rehospitalization (Coleman, et al., 2006).

University of Pennsylvania studies (Naylor, et al., 1994, 1999, 2004) have demonstrated that the Transitional Care Model improves outcomes for chronically ill high-risk elders. These studies have not only shown a reduction in hospital readmissions, but also lengthened the time to the first readmission, improved post-discharge outcomes, and enhanced patient and family satisfaction while decreasing the cost of care.

“There is no doubt that home care is essential in the quest for decreasing rehospitalizations. We need to improve our efficiency in transferring information to the health care team, allowing for more effective care.

The home care venue can provide for a smoother transition from the hospital by understanding and addressing some of the main issues that often lead to readmissions:

- *Patient expectations in taking medicines*
- *The disease process itself*
- *Impact of comorbid conditions on patient’s functional status*

All venues of care need to look at their core processes involved in transitions and collaborate across those venues to bring about safer and more effective care.”

Timothy Robert Gutshall, MD

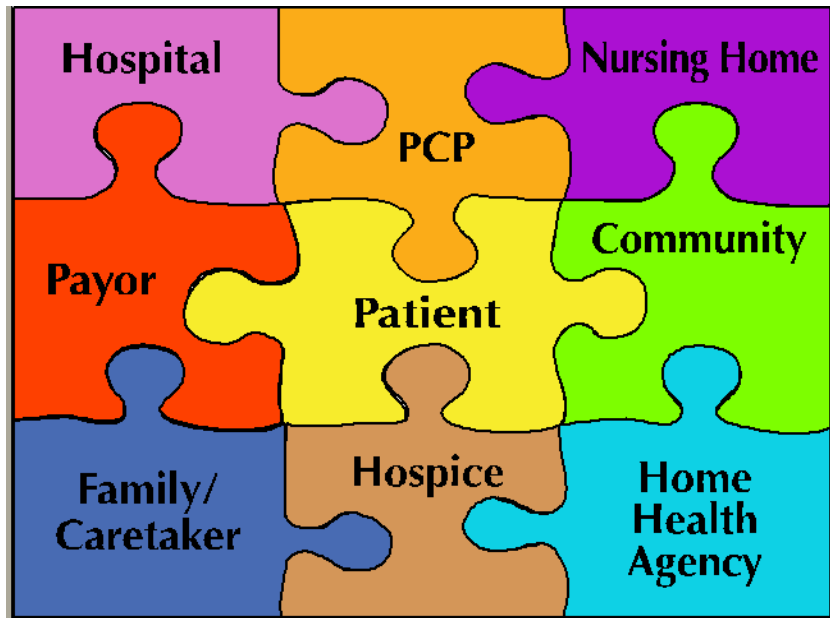
ER Staff Physician - Iowa Methodist Medical Center and Iowa Lutheran Hospital; Clinical Coordinator - Iowa Foundation for Medical Care

Effective transitional care potentially improves patient safety and reduces avoidable acute care hospitalizations.



Transitional Care Coordination: Putting the Pieces Together

Patients cross many settings for health care. Our handovers must be **consistent**, **detailed** and **appropriate** for each setting. Transitional care coordination is putting pieces of the puzzle together to improve personal health care and to reduce avoidable acute care hospitalizations. Home health agencies have the responsibility to assist the patient to have a smooth transition by initiating the connection from home health to another care provider and effectively communicating the patient's clinical condition. Transitions will also occur between the agency's interdisciplinary team, as well as with community settings.



The Four Pillars of Care Transition Activities

The Care Transitions Intervention created by Dr. Coleman's team has been built on four pillars, or conceptual domains, which include: **1) Medication Self-Management; 2) Patient-Centered Record; 3) Physician Follow-Up; and 4) Red Flags.**

Agencies may work on one or more pillars at a time until all of the pillars are incorporated for improved care transition processes. The illustration on the next page shows the four pillars concept from a home health perspective.

The Four Pillars of Care Transition Activities

1. Medication Self-Management

Goal: Patient is knowledgeable about medications and has a medication management system

Home Health Activities:

- Discuss importance of understanding medications and having a system in place.
- Reconcile medication regimens after any handover; Identify and correct any discrepancies.
- Assist with medication simplification to support a manageable system.

Follow-Up: Answer any remaining medication questions.

2. Patient-Centered Record

Goal: Patient understands and utilizes a personal health record (PHR) to facilitate communication and ensure continuity of care planning across settings; The patient manages the PHR

Home Health Activities:

- Explain PHR and its components.
- Review and update PHR after any handover.
- Encourage patient to update and share the PHR with primary care practitioner (PCP) and/or specialists at follow-up visits.

Follow-Up: Discuss outcome of visits with PCP and/or specialists.

3. Physician Follow-Up

Goal: Patient schedules and completes follow-up visit with PCP/specialist and is empowered to be an active participant in these interactions

Home Health Activities:

- Emphasize importance of the follow-up visit and the need to provide PCP with recent health status information.
- Practice and role play questions for PCP/specialist.

Follow-Up: Provide advice in getting prompt appointments, if necessary.

4. Red Flags

Goal: Patient is knowledgeable about indicators that their condition is worsening and how to respond

Home Health Activities:

- Collaboratively develop an emergency care plan (ECP).
- Discuss signs and symptoms of impending changes in health status.
- Reinforce whom to call and when.

Follow-Up: Update and review ECP with every patient contact.





Operationalizing the Four Pillars

According to Parry, Coleman, Smith, Frank and Kramer (2003), the four pillars are operationalized through two mechanisms:



How does home health fit within the patient/caregiver-coaching model?

In home care, there is typically not an external coach available, therefore, to optimize the quality and effectiveness of care transitions, **the home health clinician needs to function as the patient/caregiver coach** by:

- Educating patients/caregivers about and encouraging the use of a personal health record
- Facilitating the interdisciplinary collaboration and care continuity while coaching the patient/caregiver(s) to play an active and informed role in the execution of the patient-centered care plan
- Providing information and self-management support to assist the patient in identifying concerns, problems and building relationships with all health care providers
- Tailoring the content from the four pillars to the needs and priorities of the patient during each encounter whether it is a face-to-face visit, a phone encounter or a telehealth encounter during a transition to or from the home health setting
- Focusing on specific content and appropriately promoting patient self-management capability

With the appropriate education, **home health practitioners** are in the perfect position to provide **patient-centered coaching** and promote the ongoing use of the personal health record during handovers to and from the home health provider.

We will be looking at two key tools from the Colorado Care Transitions Program: **1) Personal Health Record and 2) Medication Discrepancy (Reconciliation) Tool**. Initiating either one of these tools is a first step toward improving transitions of care.

Personal Health Record

The personal health record (PHR) is a dynamic record that includes the following patient information:

- Demographic and caregiver information
 - Health care provider information, including physicians and home care agency
 - Advance directive status
 - Medical history
 - Medications and allergies
 - Area to record test results, immunizations and physician appointments
 - Checklist of activities that should precede hospital discharge and aid in the follow-up at home
 - Area for patients to write questions for their health care providers
- (University of Colorado Health Sciences Center, 2003)

Home care agencies can independently, or collaboratively, work with local hospitals, physician practices, skilled facilities or community organizations (e.g. senior citizen centers) to implement Personal Health Records.



A sample personal health record is available on www.homehealthquality.org under *Transitional Care Coordination, Associated Resources* (also included in the MSW and Home Health Aide Tracks)

Comment following the Institute of Healthcare Improvement (IHI) “Hospital to Home” Series

*“A surprising realization for the Quality Improvement Organization Home Health team was the home health agency and hospital staff that came to the IHI Hospital to Home Program from the same health care system had not met each other prior to attending this program. The time we spent sharing patient related stories that occurred during the action periods provided them with an opportunity to consider the patient’s transition from another viewpoint. The influences that impacted the hospital’s patient’s discharge (transition) to another health care setting were foreign to the participants from the home care setting. This was a **culture change** for the settings involved. The importance of having home care, hospitals, nursing homes and even physician groups sit down together at the table and discuss the issues related to patient transitions was obvious.”*

**Christine Stegel RN, MS, CPHQ,
Performance Improvement Coordinator, IPRO**

Medication Discrepancy (Reconciliation) Tool

If the patient is unable to safely prepare and take medications, clinicians must identify possible underlying causes and intervene appropriately.



Key: Patient and caregiver education has been the hallmark of improving medication management. Education needs to move beyond traditional education to include medication **reconciliation**.

Reconciliation: Process of identifying the most accurate list possible of all medications a patient is taking – including drug name, dosage, frequency and route – and comparing that list against the physician and/or hospital discharge orders, with the goal of providing correct medications.

MEDICATION DISCREPANCY TOOL (MDT)	
MDT is designed to facilitate reconciliation of medication regimen across settings and prescribers	
Medication Discrepancy Event Description: Complete one form for each discrepancy	
<div style="border: 1px solid black; height: 40px;"></div>	
Causes and Contributing Factors - Check all that apply <small>i: italicized text suggests patient's perspective and/or intended meaning</small>	
Patient Level	
<input type="checkbox"/> Adverse Drug Reaction or side effects	<input type="checkbox"/> Intentional non-adherence <small>"I was told to take this but I chose not to."</small>
<input type="checkbox"/> Intolerance	<input type="checkbox"/> Non-intentional non-adherence (e.g. knowledge deficit) <small>"I don't understand how to take this medication."</small>
<input type="checkbox"/> Didn't fill prescription	<input type="checkbox"/> Performance deficit <small>"I might someone showed me, but I can't demonstrate to you what I can."</small>
<input type="checkbox"/> Didn't need prescription	
<input type="checkbox"/> Money/financial barriers	
System Level	
<input type="checkbox"/> Prescribed with known allergies/intolerances	<input type="checkbox"/> Duplication <small>Prescribing multiple drugs with the same action without any rationale.</small>
<input type="checkbox"/> Conflicting information from different informational sources <small>For example discharge instructions indicate one thing and pill bottle says another.</small>	<input type="checkbox"/> Incorrect dosage
<input type="checkbox"/> Confusion between brand & generic names	<input type="checkbox"/> Incorrect quantity
<input type="checkbox"/> Discharge instructions incomplete/inaccurate/illegible <small>Either the patient cannot make out the hand-writing or the information is not written in lay terms.</small>	<input type="checkbox"/> Incorrect label
	<input type="checkbox"/> Cognitive impairment not recognized
	<input type="checkbox"/> No caregiver/need for assistance not recognized
	<input type="checkbox"/> Sight/dexterity limitations not recognized

Home health agencies play a pivotal role in medication reconciliation. Specific actions according to defined processes must be in place for medication reconciliation to occur at admission, readmission and after any transition of care (e.g., physician visits) to ensure patient safety. Agency communication processes need to be evaluated simplified and standardized to aid in medication reconciliation. Look beyond just physician communication practices and evaluate interdisciplinary team and local pharmacy communication practices. Staff availability of "time" is often reported as a reason for not completing reconciliation accurately in a timely manner. Leadership needs to emphasize the **priority of reconciling medications immediately** with follow-through to ensure accurate medication regimens for patients. Leadership must also evaluate to determine if adequate staffing is in place to provide this essential patient safety intervention and adjust staffing as necessary.

A sample [Medication Discrepancy \(Reconciliation\) Tool](#) that was created by the Care Transition Program is available on www.homehealthquality.org under Associated Resources for this BPIP or go to www.medqic.org, under Home Health, Oral Medications, Tools.

"It is surprising that medication reconciliation can take up to two or three days to complete. Patients arrive home and are unclear if they are to finish the supply of their old medication or fill a new script, and filling a new script may not be possible on the day they arrive home. Consequently, patients could have inappropriately taken or missed significant medications, which may result in re-hospitalizations."

William Gardiner, CPHQ, Project Manager, IPRO



Transitional Care Coordination: Home Health Opportunities and Benefits

Home health sits in a pivotal position that may bridge the gap that occurs in transitions during patient episodes of illness exacerbations. Timely, effective and consistent interventions during these episodes are not only critical to the reduction of avoidable acute care hospitalizations and the achievement of quality outcomes, but also in the achievement of optimal quality of life for those living with chronic illness.

Agencies currently utilize tools and resources that can be viewed as a foundation for improving transitional care coordination. The **Building Upon The Basics** concept works to improve care transitions and care coordination while providing benefits to the agency through:

- Increased staff efficiencies
- Improved allocation of resources
- Improved patient safety
- Improved public reporting of quality measures - including reduced acute care hospitalizations and improved oral medication management
- Potentially increasing its referral base

The simplest and most effective way to improve transitional care coordination is by consistently utilizing and fine-tuning best practice interventions and associated processes your agency already has in place or plans to implement. Home health agencies across the country have implemented many of the

essential best practices that support effective, safe transitional care coordination. The table on the next page describes how best practices for decreasing hospitalizations can provide the foundation for an agency to promote transitional care coordination.

Transitional Care Coordination: Home Health Challenges

During a home health episode of care, there may be multiple patient handovers: from central intake to clinician, from clinician to clinician, when schedules change, discipline-to-discipline, clinician to on calls staff, etc. (Spath, 2007).

Practitioners often have no formal training in handover communication. Often, handover communication is learned on the job. Whatever process changes are made to improve the exchange of information during patient handovers, clinician training in communication techniques is essential. Safe and effective handover communication depends on the ability of practitioners to prioritize relevant information and transfer this information effectively and efficiently.

**Think “transitions”
not “discharges”!**

Transitional care coordination builds upon basic interventions. The table on the next page will show the connection to previous BPIPs.

Key point: By building upon the basic best practices for decreasing hospitalization, home health agencies can overcome many of the challenges for improving quality of transitional care coordination.

Best Practice Intervention	Connection to Transitional Care Coordination
Hospitalization Risk Assessment	<ul style="list-style-type: none"> • Hospitalization risk factors should be identified at time of referral and assessed at start of care and resumption of care • Interventions can then be implemented to minimize those risks and to allocate resources efficiently • Communicate those risks with patients, caregivers and physicians
Emergency Care Plan	Patients/caregivers who are instructed and understand their Patient Emergency Plan are more likely to contact the appropriate care setting
Medication Management	Promotes and supports medication reconciliation across all settings; Evaluates patient/caregiver understanding of medication side effects and interactions
Phone Monitoring and Frontloading Visits	Provides for more intense patient assessment and education early in the episode to smooth and stabilize the transition to home
Teletriage	Teletriage processes allow for the patient to either receive appropriate care in the current setting or be sent to another care setting with current patient status clearly communicated from home health clinician to the next provider
Telemonitoring	Allows for clinicians to have additional and timely data to report to the physician and all disciplines who are following the patient at home
Immunizations	Immunization status must be communicated between all settings and maintained in the Personal Health Record
Physician Relationships	<ul style="list-style-type: none"> • Consistent and appropriate communication from clinicians to physicians increases the accuracy of patient information (e.g., SBAR) • Clinicians should coach patients/caregivers on how to interact with physicians as well
Fall Prevention	<ul style="list-style-type: none"> • Communicate patient falls or fall risk between settings and at time of handovers • Educate patient/caregivers regarding fall prevention interventions
Patient Self-Management	Promoting patient and caregiver self-management through personal health records increases patient responsibility to give accurate health information to all care providers
Disease Management	Improved chronic illness management will enhance when care transitions do occur

BUILDING UPON THE BASICS

Transitional Care Coordination: Agency Assessment

Purpose of Tool

To provide parameters to assess your agency's current status with transitional care coordination as it relates to the **four pillars of care transitions** activities in home health as identified by the Care Transitions Program (www.caretransitions.org).

Bold red indicates tools/resources.

<i>Building Upon the Basics</i>	Yes	No
<p>Has your agency implemented at least three of the previous best practices introduced in the Home Health Quality Improvement Campaign that support transitional care coordination?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hospitalization Risk Assessment <input type="checkbox"/> Emergency Care Planning <input type="checkbox"/> Medication Management <input type="checkbox"/> Phone Monitoring and Frontloading Visits <input type="checkbox"/> Physician Relationships <input type="checkbox"/> Patient Self-Management <input type="checkbox"/> Disease Management 	<input type="checkbox"/>	<input type="checkbox"/>
<p>Do you have standardized forms, communication methodologies (SBAR, etc.) or health information systems that regulate and support effective care transitions?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Referral checklist <input type="checkbox"/> Transfer/discharge checklist <input type="checkbox"/> Personal Health Record <p>Have you performed chart reviews to assess whether information on the referral, transfer or discharge forms was accurate, complete and consistent?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Does your agency work collaboratively with local hospitals, skilled facilities and/or physician offices, etc. to utilize standardized teaching materials, personal health records, etc.?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Have you established expectations related to transitional care coordination for:</p> <ul style="list-style-type: none"> • Intake personnel? • Managers? • Clinicians? • On-call staff? • Medical social workers? 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<p>Have you identified the minimal information that should be communicated at handovers:</p> <ul style="list-style-type: none"> • Upon referral <i>to</i> home health services? • Upon transfer/discharge <i>from</i> home health services? • To physicians? • To interdisciplinary and on-call staff? 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<p>Have you implemented processes to:</p> <ul style="list-style-type: none"> • Inform hospital emergency department of patient's clinical condition? • Follow patient progress while in the hospital? 	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Transitional Care Coordination: Agency Assessment (cont.)

#1. Assistance with medication self-management	Yes	No
Are clinicians educated in patient self-management as it relates to medication management and adherence?	<input type="checkbox"/>	<input type="checkbox"/>
Do you evaluate clinician competency related to patient self-management and medication management?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have processes/tools to support medication reconciliation at admission, transfer and discharge?	<input type="checkbox"/>	<input type="checkbox"/>
#2. Support of a personal health record	Yes	No
Do you offer a personal health record to your patients?	<input type="checkbox"/>	<input type="checkbox"/>
Are patients encouraged to maintain a personal health record and instructed in the importance of taking it with them to all physician appointments?	<input type="checkbox"/>	<input type="checkbox"/>
Are clinicians educated in the use and value of a patient/caregiver maintained personal health record?	<input type="checkbox"/>	<input type="checkbox"/>
#3. Promoting timely informed physician follow-up	Yes	No
Do you have a standard format and defined content to consistently provide information for the physician prior to or during the patient visit?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a process for physician offices to provide information and changes in plan of care to home health related to the physician office visit?	<input type="checkbox"/>	<input type="checkbox"/>
Do agency clinicians educate and prepare patients for physician visits?	<input type="checkbox"/>	<input type="checkbox"/>
#4. Offering a list of red flags indicative of worsening condition and how to respond	Yes	No
Do clinicians collaboratively develop an emergency care plan with patients/caregivers, identifying who and when to call with changes in health status?	<input type="checkbox"/>	<input type="checkbox"/>
Do all clinicians review and reinforce the emergency care plan with patients/caregivers during each encounter?	<input type="checkbox"/>	<input type="checkbox"/>
Do you evaluate if patient called the home health agency with health status changes prior to seeking emergent care?	<input type="checkbox"/>	<input type="checkbox"/>

BUILDING UPON THE BASICS

Transitional Care Coordination: Action Items

Purpose of Tool

To provide suggestions for the development and/or enhancement of your agency's transitional care coordination practices and processes based upon your agency assessment. **Resources are indicated in red.**

Building Upon the Basics

Review selected HHQI Best Practice Intervention Packages at

www.homehealthquality.org:

- Hospitalization Risk Assessment
- Emergency Care Planning
- Medication Management
- Frontloading/Phone Monitoring
- Physician Relationships
- Patient Self-Management
- Disease Management

- Review handover protocols and forms to ensure they:
 - Are interdisciplinary
 - Use defined intervention standards
 - Include standardized processes, templates and/or checklists
 - Include a process for updating prior to handovers
 - Prompt for interactive questioning
 - Prompt receiver to read back to ensure accuracy
 - Support patient safety

- Develop/modify existing agency forms to support effective care transitions
 - Referral checklist
 - Revise discharge form (consider SBAR format)
 - **Personal Health Record** in Associated Resources

- Educate staff regarding expectations for supporting effective transitional care coordination including:
 - Intake personnel
 - Managers
 - o **The Four Pillars of Care Transition Activities**
 - o **Transitional Care Coordination: Key Points for Clinicians and “Joe’s Story” in Care Tracks**
 - o **Transitional Care Coordination podcasts**
 - Clinicians
 - Medical Social Workers
 - On-call staff
 - Home Health Aides

- Educate and encourage patients to prepare them for talking to their physicians and asking questions
 - **Quick Tips for Talking with your Doctor – Agency for Healthcare Research and Quality (page 28)**
 - **Talking with your Doctor – National Institute of Health – www.niapublications.org/pubs/talking/Talking_with_Your_Doctor.pdf**

- Create a care coordination team to identify the minimal information that should be communicated during a handover:
 - Upon referral **to** home health services
 - **Discharge Criteria Checklist in Associated Resources**
 - Upon transfer/discharge **from** home health services
 - To physicians

Transitional Care Coordination: Action Items (cont.)

<input type="checkbox"/> Review processes to: <ul style="list-style-type: none">• Contact emergency departments (ED) when patients are being transferred to ED• Inform hospitals of admitted patients that are currently receiving home health services• Inform hospice of transfers as early as possible• Follow patient progress while in the hospital• Monitor use of tools for accuracy, completeness and consistency
<input type="checkbox"/> Collaborate with local hospitals, skilled facilities or physician offices for use of standardized materials for patient education, patient transition, personal health records, etc.
#1. Assistance with medication self-management
<input type="checkbox"/> Identify process to enhance medication reconciliation at time of handovers
<input type="checkbox"/> Provide education to clinicians knowledgeable of patient self-management and medication management on www.homehealthquality.org : <ul style="list-style-type: none">• Medication Management Best Practice Intervention Package<ul style="list-style-type: none">○ Medication Discrepancy Tool○ Be Safe and Take Competency• Patient Self-Management Best Practice Intervention Package
<input type="checkbox"/> Evaluate annually clinician competency related to patient self-care management and medication management
#2. Support of a patient-centered personal health record
<input type="checkbox"/> Provide clinician education in the use and value of a patient/caregiver maintained personal health record
<input type="checkbox"/> Offer a patient-centered personal health record to your patients
<input type="checkbox"/> Offer a patient-centered personal health record to the community <ul style="list-style-type: none">• Personal Health Record
#3. Promoting timely informed physician follow-up
<input type="checkbox"/> Educate clinicians about how to prepare patients for physician visits
<input type="checkbox"/> Develop a standard format and defined content to consistently provide information for the physician prior to or during the patient visit
<input type="checkbox"/> Work with physician offices to define a process for offices to provide information and changes in plan of care related to the physician office visit to home health
#4. Offer a list of red flags indicative of worsening condition and how to respond
<input type="checkbox"/> Review visit documentation to verify if clinicians collaboratively develop an emergency care plan with patients/caregivers identifying who and when to call with changes in health status on www.homehealthquality.org : <ul style="list-style-type: none">• Emergency Care Planning Best Practice Intervention Package<ul style="list-style-type: none">○ My Emergency Plan
<input type="checkbox"/> Educate and encourage clinicians to review and reinforce the emergency care plan with patients/caregivers during each encounter
<input type="checkbox"/> Review records to determine if patient/caregiver called the home health agency with health status change prior to seeking emergent care

BUILDING UPON THE BASICS

Transitional Care Coordination: Action Plan

Purpose of Tool:

Using the Leadership Action Items, select and prioritize items to be implemented or modified. The development of an effective transitional care coordination program may be a yearlong (or more) effort.

Date	Action	By Whom	Status
	Establish a timeline for development/enhancement of your transitional care coordination plan		
	Review Care Tracks of Best Practice Intervention Package–Transitional Care Coordination and distribute		
	Plan clinician education programs regarding transitional care coordination		

Transitional Care Coordination

HOSPITAL



HOME HEALTH CONNECTION

The responsibility of the hospital medical social worker/discharge planner is to **ensure a positive and appropriate discharge** for every patient.

The responsibility of the home health agency is to foster **effective communication** with the hospital social worker/discharge planner to ensure that a positive/appropriate patient discharge occurs.

Developing standards of practice to maintain open and honest communication with discharge planners should be a home health priority to **reduce acute care hospitalizations**.

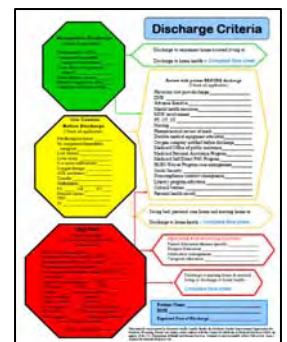
Build relationships with hospital social workers/discharge planners

- Introduce staff to discharge planners from referring facilities
- Ask discharge planners what challenges they face with discharges to home health to clearly understand the issues
- Plan annual meetings to include all community providers to foster networking
- Send discharge planners updates on home health personnel and policy changes
- Send a “thank you” to discharge planners after difficult patient transitions
- Voice concerns to them as soon as possible
- Arrange care team meetings for high-risk patients by inviting all disciplines to include physicians, pharmacists, therapists, etc.
- Use available external resources by developing relationships with hospital CEOs, Chiefs of Staff and referring physicians
- Invite your Quality Improvement Organization (QIO) to present at medical staff meetings

Educate social workers/discharge planners

- Develop presentations that focus on your agency’s admission packets, acceptance criteria tools, procedures, policies and practices
- Set a date with discharge planners for an educational/sharing session to discuss and “exchange” policies, procedures, tools, admission packets, discharge criteria and expectations
- Collaboratively develop a discharge system that will work for your agency and the appropriate staff at the hospital
- Institute a communication system for information exchange on all patients, i.e. SBAR – (Situation-Background-Assessment-Recommendation)
- Conduct case conference for referrals that are discharged late in the day and/or late Friday with little communication and are a high risk for hospitalization

Refer to Transitional Care Coordination Associated Resources:
Discharge Criteria and Face Sheet for sample educational resources



Developed by Gayla Brown, RN, BSN, NHA and Lalla Chadwick, B.S. from Mountain- Pacific Quality Health Foundation, the Medicare Quality Improvement Organization for Wyoming, Montana, Hawaii and Alaska.

Transitional Care Coordination The Physician Connection

American College of Physicians (ACP), Society of General Internal Medicine (SGIM) and Society of Hospital Medicine (SHM) are expected to release a consensus statement to address the **physician's role in information transfer, communication, accountability and risk management** during the first half of 2008.

**The physician is the quarterback in
care transitions!**



Current activities occurring in care transitions:

- **Society of Hospital Medicine**, with the support of the John A. Hartford Foundation and in collaboration with a coalition of national experts, is developing a toolkit to improve care transitions for older adults at the time of hospital discharge. A range of technical support programs will be available beginning in spring 2008 to facilitate adoption of the toolkit. Technical support and training programs will include a redesigned Care Transitions for Older Adults Resource Room and QI implementation guide, day-long Quality Pre-Course, yearlong mentoring program and an on-site consultation program. www.hospitalmedicine.org/Content/NavigationMenu/QualityImprovement/QICurrentInitiativesandTrainingOpportunities/QI_Current_Initiative.htm
- **The Care Transitions ProgramSM** under the leadership of Dr. Eric Coleman aims to improve the quality and safety of care handoffs for persons with complex care needs. www.caretransitions.org
- **National Transitions of Care Coalition** (NTOCC) was formed to bring together leaders and health care providers from various care settings to address improving the quality of care coordination and communication when patients are transferred from one level of care to another. The National Transitions of Care Coalition (NTOCC) is being led by the Case Management Society of America (CMSA) and is sponsored by sanofi aventis U.S. LLC. www.ntocc.org



Quick Tips— When Talking with Your Doctor

The single most important way you can stay healthy is to be an active member of your own health care team. One way to get high-quality health care is to find and use information and take an active role in all of the decisions made about your care. This card will help you when talking with your doctor.

Research has shown that patients who have good relationships with their doctors tend to be more satisfied with their care—and to have better results. Here are some tips to help you and your doctor become partners in improving your health care.

Give information. Don't wait to be asked!

- You know important things about your symptoms and your health history. Tell your doctor what you think he or she needs to know.
- It is important to tell your doctor personal information—even if it makes you feel embarrassed or uncomfortable.
- Bring a “health history” list with you, and keep it up to date. You might want to make a copy of the form for each member of your family.
- Always bring any medicines you are taking, or a list of those medicines (include when and how often you take them) and what strength. Talk about any allergies or reactions you have had to your medicines.
- Tell your doctor about any herbal products you use or alternative medicines or treatments you receive.
- Bring other medical information, such as x-ray films, test results, and medical records.

Get information.

- Ask questions. If you don't, your doctor may think you understand everything that was said.
- Write down your questions before your visit. List the most important ones first to make sure they get asked and answered.
- You might want to bring someone along to help you ask questions. This person can also help you understand and/or remember the answers.
- Ask your doctor to draw pictures if that might help to explain something.

- Take notes.
- Some doctors do not mind if you bring a tape recorder to help you remember things. But always ask first.
- Let your doctor know if you need more time. If there is not time that day, perhaps you can speak to a nurse or physician assistant on staff. Or, ask if you can call later to speak with someone.
- Ask if your doctor has washed his or her hands before starting to examine you. Research shows that handwashing can prevent the spread of infections. If you're uncomfortable asking this question directly, you might ask, “I've noticed that some doctors and nurses wash their hands or wear gloves before touching people. Why is that?”

Take information home.

- Ask for written instructions.
- Your doctor also may have brochures and audio tapes and videotapes that can help you. If not, ask how you can get such materials.

Once you leave the doctor's office, follow up.

- If you have questions, call.
- If your symptoms get worse, or if you have problems with your medicine, call.
- If you had tests and do not hear from your doctor, call for your test results.
- If your doctor said you need to have certain tests, make appointments at the lab or other offices to get them done.
- If your doctor said you should see a specialist, make an appointment.

Remember, quality matters, especially when it comes to your health. For more on health care quality and materials to help you make health care decisions, visit <http://www.ahrq.gov/consumer/pathqpack.htm>



www.ahrq.gov

AHRQ Pub. No. 01-0040a

Transitional Care Coordination

Do you support the four pillars of care transition activities in your daily practice?

Medication Self-Management

Goal: The patient is knowledgeable about medications and has a medication management system.

Patient-Centered Record

Goal: Patient understands and utilizes a personal health record (PHR) to facilitate communication and ensure continuity of care across settings. The patient manages the PHR.

Physician Follow-Up

Goal: Patient schedules and completes follow-up visit with PCP/specialist and is empowered to be an active participant in these interactions.

Red Flags

Goal: Patient is knowledgeable about indicators that their condition is worsening and how to respond.





Transitional Care Coordination Post-Test Answer Keys

Each track of the Best Practice Intervention Package has a post-test that providers may choose to complete after reviewing the track and completing the activities.

For the Transitional Care Coordination package, the post-tests are found on the following pages:

Nurse Track – page 45

Therapist Track – page 59

Medical Social Worker Track – page 74

Home Health Aide Track – page 90

Use the answer keys below to score the post-tests included with the **Best Practice Intervention Package – Transitional Care Coordination**.

Nursing post-test answers:

1. A
2. D
3. D
4. A
5. A

Therapist post-test answers:

1. A
2. D
3. D
4. A
5. A

Medical Social Worker post-test answers:

1. A
2. D
3. E
4. E
5. A

Home Health Aide post-test answers:

1. A
2. E
3. D
4. E
5. A

Transitional Care Coordination References

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