



Best Practice: Transitional Care Coordination

Nurse Track



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Nurse Track

This best practice intervention package track is designed to educate nurses in transitional care coordination as it relates to their daily clinical practice and in supporting the goal of reducing avoidable hospitalizations.

Objectives

After completing the activities included in the Nurse Track of this **Best Practice Intervention Package—Transitional Care Coordination** the learner will be able to:

1. Describe transitional care coordination and the role of home health
2. Describe how previous Home Health Quality Improvement Best Practice Intervention Packages support optimal transitional care coordination
3. Recognize the relationship with more active participation of patient and caregiver and reduction of acute care hospitalization
4. Identify clinical practices that promote effective care transitions

Complete the following activities for the **Nurse Track**:

	Activity	Location	Estimated Time
<input type="checkbox"/>	Read “Transitional Care Coordination: Key Points for Clinicians”	Page 35	5 minutes
<input type="checkbox"/>	Review “The Four Pillars of Care Transition Activities”	Page 36	5 minutes
<input type="checkbox"/>	Read Building Upon the Basics	Page 37	5 minutes
<input type="checkbox"/>	Review Medication Reconciliation and Personal Health Record sections	Page 38	10 minutes
<input type="checkbox"/>	Read “Care Transitions: Joe’s Story”	Page 41	5 minutes
<input type="checkbox"/>	Listen to Transitional Care Coordination podcast	Page 42	20 minutes
<input type="checkbox"/>	Read Example of Excellence	Page 43	10 minutes
<input type="checkbox"/>	Complete the nursing evaluation and post-test online for free CNEs for RNs and certificate of participation for LPNs/LVNs	See link below	10 minutes
	Total time for completion		70 minutes

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 of the Web site](#) on www.homehealthquality.org for available packages and links for evaluations/post-tests.

Apply for **free** 1.2 Continuing Nursing Education units for completing the Nursing track activities. **Complete evaluation/post-test online at:** <http://www.zoomerang.com/survey.zgi?p=WEB227DSP6LWXJ>



Transitional Care Coordination Key Points for Clinicians

BUILDING UPON THE BASICS

Definition:

Transitional Care Coordination: A set of actions designed to ensure the **coordination** and **continuity** of health care as patients transfer between different locations or levels of care within the same location (Coleman and Berenson, 2004).

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 Colorado).

Transitional care 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. This handover is more than just an exchange of information. During handovers, professional responsibility necessitates that both the sender and the receiver ask questions to ensure full understanding of the information being transferred. Transitions can also be between the interdisciplinary team, as well as in community settings.

Acute Care Hospitalization Connection:



Care transition interventions, designed to encourage patients and their caregivers to assume a **more active role during care transitions, may reduce avoidable re-hospitalization rates.** Research studies have shown if patients and caregivers are encouraged to be active in their care transitions there is a significantly reduced rate of rehospitalization. The findings suggest that the patient was able to utilize the new skills and tools that were provided. Meeting the needs of chronically ill older patients and their caregivers during care transitions may reduce the rates of subsequent avoidable rehospitalization (Coleman, et al., 2006).

The Four Pillars of Care Transition Activities

The care transitions intervention by Dr. Eric Coleman's Care Transition Program has been built on four pillars or conceptual areas that include:

- 1) **Medication Self-Management**
- 2) **Patient Centered Record**
- 3) **Physician Follow-Up**
- 4) **Red Flags**

The illustration on the next page shows the Four Pillars concepts 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.



What can “I” do to support transitional care coordination?

The simplest and most effective way to improve care transitions is by consistently utilizing and fine-tuning the processes of the best practice interventions your agency has in place.

Build upon the Basics!



- Collaboratively develop an emergency care plan with patients/caregivers that identifies who and when to call with changes in health status.
- Reconcile medications during transitions from hospital to home.
- Ensure that patients follow up with their physician appointments.
- Help patients prepare for physician appointments by assisting them to prepare questions and concerns in advance.



- Utilize the SBAR method to improve communication.
- Ask patients about their personal health record and encourage them to keep it up-to-date.
- Communicate effectively with other interdisciplinary team members to ensure smooth patient transitions from one discipline to the other.



Note: For more information about any of these previous topics see the nursing track at www.homehealthquality.org

Several key tools are available to assist with care transitions that were developed by Dr. Eric Coleman's Care Transitions Program. The Medication Discrepancy (Reconciliation) Tool and the Personal Health Record will be addressed in this track.

Medication Discrepancy (Reconciliation) Tool

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



Key: Patient and caregiver education has been the hallmark of improving oral 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	
✓ Causes and Contributing Factors : Check all that apply <small>• 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 choose not to."</small>
<input type="checkbox"/> Intolerance	<input type="checkbox"/> Non-intentional non-adherence (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>"*Single someone showed me, but I can't demonstrate to you that 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>Taking 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/hearing limitations not recognized

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.

Personal Health Record

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

- 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)



A reduced-size sample of a personal health record is on the next two pages. The full-size version is available on www.homehealthquality.org under Transitional Care Coordination, Associated Resources.

Care Transitions: Joe's Story

Joe is a 72 year-old retired farmer. He lives with his wife in a modest rural home. His wife takes responsibility for managing Joe's diet and medications. Joe recently experienced his first bout of heart failure, for which he was hospitalized. He has a history of COPD and osteoarthritis. He was actively followed by home health for physical therapy prior to this hospitalization. The following depicts optimal **care transition activities** that should occur during **handovers** between health care practitioners and settings. Note the focus on the four pillars of care transitions:

1. **Assistance with medication self-management**
2. **Patient-centered health record owned and maintained by the patient**
3. **Timely informed primary care physician (PCP)/specialist follow-up**
4. **Knowledge of red flags indicative of worsening condition and instructions on how to respond**

Handover: Home to Hospital

- Joe takes his personal health record with him to hospital
- Home medications are reconciled on admission to hospital

Hospital Prepares for Discharge to Home

- Wife is identified as primary caregiver/learner
- Patient-friendly discharge instructions are provided specific to diet, medication, daily weights, when to see PCP, cardiologist and reasons to seek medical help, including numbers to call
- Personal health record is updated by patient with coaching from hospital discharging clinician as needed



Handover: Hospital to Home Health

- Referral to home health services includes Joe's condition, functional status, medical history and all medications and instructions provided
- Medications are reconciled on admission to home health
- Admitting home health clinician reviews personal health record and hospital discharge instructions with Joe and his wife
- A patient emergency care plan is collaboratively established with information on when to call agency or seek emergency care
- Home health clinician ensures that Joe or his wife schedules and keeps follow-up appointments
- Home health clinician updates PCP on Joe's status, including self-management goals

Handover: Home Health to Physician

- Wife prepares list of questions and concerns to discuss at physician appointments with coaching by home health nurse as needed
- Joe takes personal health record to PCP and cardiologist visits
- Joe updates personal health record with coaching by physician office staff as needed





Transitional Care Coordination Multi-Media Activity Podcast*

Transitional Care Coordination Clinician Podcast Instructions:

Title	Description	Link
Transitional Care Coordination for Clinicians	<ul style="list-style-type: none">This 20-minute audio recording discusses Transitional Care Coordination and the role of home care.A review of previous Best Practice Intervention Packages to reduce avoidable acute care hospitalizations is also included.	The podcast link is located at http://www.homehealthquality.org/hh/hha/interventionpackages/tcc.aspx

*A podcast is a digital media file, for use on a home computer or personal digital recording device for convenience.

There are several ways to listen to the podcast:

- Visit the link above and listen directly through the Web site
- Download the podcast by right clicking on the audio file and selecting "Save Target As ..." This will save the file to your hard drive. Once you have saved the file, you can listen to it on your computer or can save the audio file to a CD or MP3 player

*None of us can deny the power that certain words carry in a conversation and when describing a situation. This fact is illustrated quite poignantly when it comes to the word discharge which loosely translated means "to dump" or "to release from confinement or duty." It is no surprise to me that the feeling that "they just dumped this patient on us with little, to no information" is a common place across the healthcare continuum. However, innovative healthcare leaders are now suggesting that merely **replacing the term "discharge planning" with the phrase "care transitions"** creates a different dichotomy for case management functions. According to Webster's dictionary, a transition refers to a passage from one place to another, suggesting that both the referring and accepting entity have heightened accountability to ensure the safe transfer of our shared patients across health care settings.*

Ellen Aliberti, RN, MS, CCM
Director of Post Acute Care Services, Sierra Health Services

Examples of Excellence

St. Peter's Home Care Improves Communication, Resulting in More Efficient Transitional Care Coordination



St. Peter's
HEALTH CARE SERVICES

Based in Albany, N.Y., St. Peter's Home Care is a division of St. Peter's Health Care Services. The culture throughout the organization is one of constant improvement, so it's no surprise that St. Peter's Home Care has a Continuous Quality Improvement (CQI) team, constantly looking for ways to improve the services they provide. The CQI team, a multidisciplinary team made up of 12 home care employees, noticed that referrals were not always complete and that communication throughout patient transitions was not as good as it could be. The CQI team saw an opportunity for improvement!

The CQI team brainstormed ideas to improve communication at the time of patient transfers. A sub-group of the team headed by the CQI chairperson was formed to meet with discharge planners and operations managers in acute care to look closely at the transition process and how it could be improved.

The St. Peter's Home Care team decided to use a target population for implementing any changes in transitional care. Since the U.S. Department of Health and Human Services (DHHS) was in the midst of a big push to improve cardio management, the team decided to focus on the congestive heart failure (CHF) population. The project rapidly developed from a communication process into a cross-setting care delivery model.

St. Peter's Home Care focused its education on promoting self management and providing consistency across settings in what patients were being taught. The team worked hard to make sure patients heard the same message from their hospital, home care, physician office and other involved care settings, answering questions and conveying educational material in the same manner. The team also developed an interactive patient education/discharge sheet and incorporated it into the discharge process from acute care to ensure consistency in communication to the patient in transition between settings.

Being structured as a department of St. Peter's Hospital has been an advantage in the operational implementation of the project. St. Peter's Home Care, in collaboration with members of the St. Peter's Hospital heart failure specialist team, developed a patient education notebook, divided into two sections: education and a monthly calendar. The notebook is intended for patient's to carry with them to various health care visits and share with the different health care providers. By doing so, communication between the health care providers would improve and each would know what type of care had been provided previously.

The patient education notebook is given to all hospital patients, which they then share with their physician or home health nurse. However, if a new patient comes to St. Peter's Home Care from an outside facility, the notebook is provided to them and then the patient is encouraged to share with it their various health care providers.

Other tools were also developed, including standardized orders for admissions, parameters for physician notification and a CHF-specific telephone follow-up form. During Congestive Heart Awareness Month (April) 2006, St. Peter's held a kick-off campaign. Along with implementing the patient notebook and offering education, a dietician was offered to every CHF patient – in a standardized approach.

The results have been noteworthy! St. Peter's Home Care had a five percent decrease in their acute care hospitalization (ACH) rate for the CHF population, dropping from 20 percent (April 2005) to 15 percent (December 2006). There has been a significant impact on patient self-management and satisfaction. Patient surveys revealed 90.9 percent (Q2 2007) of CHF patients feel confident that they can manage their care and take care of themselves, up from 83 percent (April 2006). There was also an increase in the measure of patient satisfaction with the overall quality of care and services, which went from 94 percent (April 2006) to 100 percent (Q4 2007).

Recently, the project was taken a step further when the New York Quality Improvement Organization, IPRO, hosted an Institute for Healthcare Improvement (IHI) home care driven collaborative on care transitions. The six-week cross-setting collaboration included two other home care agencies along with St. Peter's Home Care. Involvement in this initiative provided opportunities for further learning and sharing of best practices. For instance, the "teach-back" method has been adopted to ensure patient comprehension of instructions given.

With the targeted improvements achieved, St. Peter's Home Care now has plans to use the same methodology with their chronic obstructive pulmonary disease (COPD) population in 2008.

"Communication is the key to consistency of patient care," said Carol Ann Thomas, Manager of Patient Safety and Quality Improvement at St. Peter's Home Care. "This undertaking taught us to look at all sides of patient care – not just the home care perspective. It is not a one-sided process."

Data in this article was provided by Carol Ann Thomas at St. Peter's Home Care.





Nursing Post-test Transitional Care Coordination




Clinician _____

Date _____

RNs may apply for 1.2 FREE CNEs and LPN/LVNs may apply for certificate of participation by following directions on page 34.

Directions: Choose the ONE BEST response to the following questions. Circle your answer that identifies the ONE BEST response.

1. Transitional care coordination is a set of actions to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location.
 - A. True
 - B. False
2. Home care can support transitional care coordination by the following actions **except**:
 - A. Developing and maintaining an emergency care plan with the patient/caregiver
 - B. Reconciling medications
 - C. Encouraging physician follow-up appointments
 - D. Coordinating nursing and therapy visits to provide one service only on a calendar day
 - E. Initiating/educating on a Personal Health Record
3. The following statements are true related to medication reconciliation **except**:
 - A. It is vital for successful medication management
 - B. It is more than medication education to patient/caregiver
 - C. It identifies an accurate medication list
 - D. It includes only physician ordered medications
 - E. It compares physician and/or hospital discharge orders with medications patient is currently taking at home
4. The “Four Pillars of Care Transition Activities” includes the following categories **except**:
 - A. Hospitalization Risk Assessment
 - B. Medication Self-Management
 - C. Patient-Centered Record
 - D. Physician Follow-Up
 - E. Red Flags

- 
5. Transitional Care includes the handover between a variety of settings including hospitals, home, skilled or rehabilitation facilities, physician offices, hospice and community.
- A. True
 - B. False

Answers to Post-test are located in the Leadership Section page 30.