Home Health Quality Improvement National Campaign

Best Practice Intervention Package - Transitional Care Coordination

This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number 8SOW-PA-HHQ07.468 App. 5/14/07.

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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 Program℠

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 Colorado ℠).
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 Intervention℠
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 Colorado ℠)

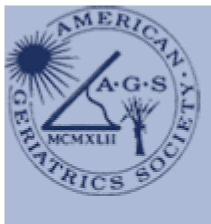
The term "**care coordination"** targets the chronically ill who are at risk for increased use of health care services and assists in filling the gaps in our traditional, reactive system. Care coordination combines the best elements of home health, disease management and case management to organize a 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*

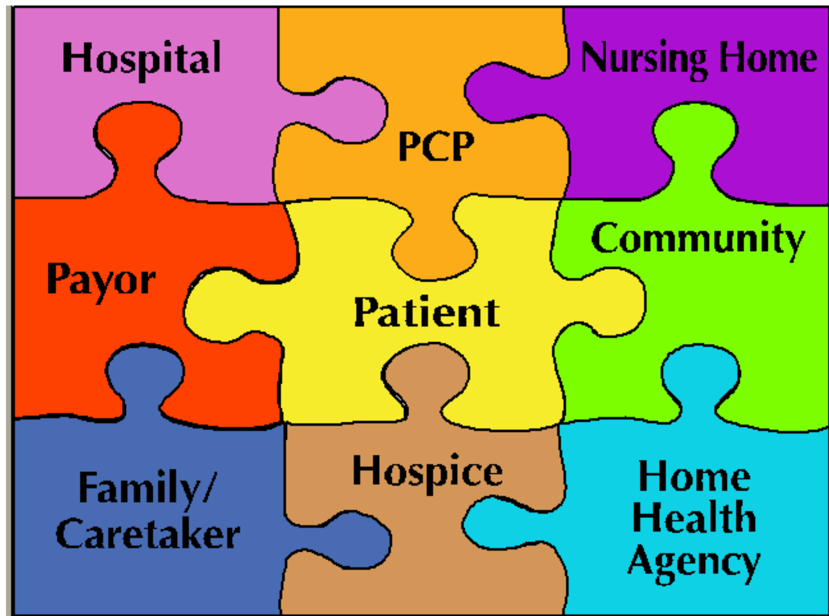
All venues of care need to look at their core processes involved in transitions and collaborate across those venues to bring about safer and more effective care."

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 hospitalizatons. 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 intersiciplinary 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:

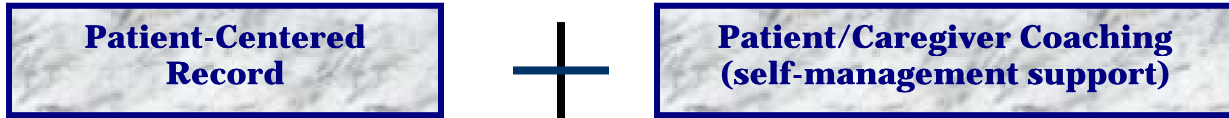
- Collaboratively develop an emergency care plan (ECP).
- Discuss signs and symptoms of impending changes in health status.
- Reinforce whom to call and when.

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

This material based on the Four Pillars of CTA developed by the University of Colorado Health Sciences Center, is adapted for home health by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization for Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number 8SOW-PA-HHQ07.715 App. 12/07.

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 <u>dynamic</u> 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 **<u>www.homehealthquality.org</u>** 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*

✓ **Causes and Contributing Factors :: Check all that apply**
:: *Italicized text suggests patient's perspective and/or intended meaning*

Patient Level

- ☐ Adverse Drug Reaction or side effects
- ☐ Intolerance
- ☐ Didn't fill prescription
- ☐ Didn't need prescription
- ☐ Money/financial barriers
- ☐ Intentional non-adherence *"I was told to take this but I choose not to."*
- ☐ Non-intentional non-adherence (ie:Knowledge deficit) *"I don't understand how to take this medication."*
- ☐ Performance deficit *"Maybe someone showed me, but I can't demonstrate to you that I can."*

System Level

- ☐ Prescribed with known allergies/intolerances
- ☐ Conflicting information from different informational sources. *For example, discharge instructions indicate one thing and pill bottle says another.*
- ☐ Confusion between brand & generic names
- ☐ Discharge instructions incomplete/inaccurate/illegible. *Either the patient cannot make out the hand- writing or the information is not written in lay terms.*
- ☐ Duplication. *Taking multiple drugs with the same action without any rationale.*
- ☐ Incorrect dosage
- ☐ Incorrect quantity
- ☐ Incorrect label
- ☐ Cognitive impairment not recognized
- ☐ No caregiver/need for assistance not recognized
- ☐ 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 aide 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 hospital-izations 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	• 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	• 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	• 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

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.

Building Upon the Basics	Yes	No
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? ❑ Hospitalization Risk Assessment ❑ Emergency Care Planning ❑ Medication Management ❑ Phone Monitoring and Frontloading Visits ❑ Physician Relationships ❑ Patient Self-Management ❑ Disease Management	❑	❑
Do you have standardized forms, communication methodologies (SBAR, etc.) or health information systems that regulate and support effective care transitions? ❑ Referral checklist ❑ Transfer/discharge checklist ❑ Personal Health Record	❑	❑
Have you performed chart reviews to assess whether information on the referral, transfer or discharge forms was accurate, complete and consistent?	❑	❑
Does your agency work collaboratively with local hospitals, skilled facilities and/or physician offices, etc. to utilize standardized teaching materials, personal health records, etc.?	❑	❑
Have you established expectations related to transitional care coordination for: • Intake personnel? • Managers? • Clinicians? • On-call staff? • Medical social workers?	 ❑ ❑ ❑ ❑ ❑	 ❑ ❑ ❑ ❑ ❑
Have you identified the minimal information that should be communicated at **handovers**: • Upon referral *to* home health services? • Upon transfer/discharge *from* home health services? • To physicians? • To interdisciplinary and on-call staff?	 ❑ ❑ ❑ ❑	 ❑ ❑ ❑ ❑
Have you implemented processes to: • Inform hospital emergency department of patient's clinical condition? • Follow patient progress while in the hospital?	 ❑ ❑	 ❑ ❑

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?	❑	❑
Do you evaluate clinician competency related to patient self–management and medication management?	❑	❑
Do you have processes/tools to support medication reconciliation at admission, transfer and discharge?	❑	❑
#2. Support of a personal health record	**Yes**	**No**
Do you offer a personal health record to your patients?	❑	❑
Are patients encouraged to maintain a personal health record and instructed in the importance of taking it with them to all physician appointments?	❑	❑
Are clinicians educated in the use and value of a patient/caregiver maintained personal health record?	❑	❑
#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?	❑	❑
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?	❑	❑
Do agency clinicians educate and prepare patients for physician visits?	❑	❑
#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?	❑	❑
Do all clinicians review and reinforce the emergency care plan with patients/caregivers during each encounter?	❑	❑
Do you evaluate if patient called the home health agency with health status changes prior to seeking emergent care?	❑	❑

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 -Clinicians -On-call staff -Managers -Medical Social Workers -Home Health Aides 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**
❑ 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.)

- ❑ Review processes to:
  - 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
- ❑ 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

- ❑ Identify process to enhance medication reconciliation at time of handovers
- ❑ Provide education to clinicians knowledgeable of patient self-management and medication management on **www.homehealthquality.org**:
  - **Medication Management Best Practice Intervention Package**
    - o **Medication Discrepancy Tool**
    - o **Be Safe and Take Competency**
  - **Patient Self-Management Best Practice Intervention Package**
- ❑ Evaluate annually clinician competency related to patient self-care management and medication management

#2. Support of a patient-centered personal health record

- ❑ Provide clinician education in the use and value of a patient/caregiver maintained personal health record
- ❑ Offer a patient-centered personal health record to your patients
- ❑ Offer a patient-centered personal health record to the community
  - **Personal Health Record**

#3. Promoting timely informed physician follow-up

- ❑ Educate clinicians about how to prepare patients for physician visits
- ❑ Develop a standard format and defined content to consistently provide information for the physician prior to or during the patient visit
- ❑ 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

- ❑ 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**:
  - **Emergency Care Planning Best Practice Intervention Package**
    - o **My Emergency Plan**
- ❑ Educate and encourage clinicians to review and reinforce the emergency care plan with patients/caregivers during each encounter
- ❑ Review records to determine if patient/caregiver called the home health agency with health status change prior to seeking emergent care

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.

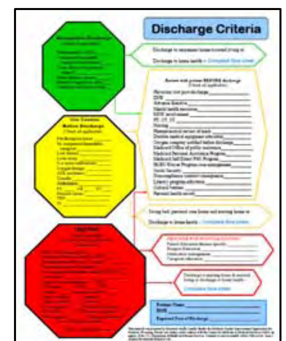
Developing standards of practice to maintain open and honest communication with discharge planners should be a home health priority to **reduce acute care hospitalizations.**

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_Initiativ.htm**

- **The Care Transitions Program℠** 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

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.

This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number 8SOW-PA-HHQ08.728 App. 1/08.

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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Best Practice: Transitional Care Coordination

Nurse Track

This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number: 8SOW-PA-HHQ07.468 App. 1/2008

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
❑	**Read "Transitional Care Coordination: Key Points for Clinicians"**	**Page 35**	**5 minutes**
❑	**Review "The Four Pillars of Care Transition Activities"**	**Page 36**	**5 minutes**
❑	**Read Building Upon the Basics**	**Page 37**	**5 minutes**
❑	**Review Medication Reconciliation and Personal Health Record sections**	**Page 38**	**10 minutes**
❑	**Read "Care Transitions: Joe's Story"**	**Page 41**	**5 minutes**
❑	**Listen to Transitional Care Coordination podcast**	**Page 42**	**20 minutes**
❑	**Read Example of Excellence**	**Page 43**	**10 minutes**
❑	**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.

This material based on the Four Pillars of CTA developed by the University of Colorado Health Sciences Center, is adapted for home health by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization for Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number 8SOW-PA-HHQ07.715 App. 12/07.

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!

Best Practice Intervention Package - Emergency Care Planning

- 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.

Best Practice Intervention Package - Medication Management

Best Practice Intervention Package - Physician Relationships

- 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.

Best Practice Intervention Package - Patient Self-Management

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**
:: *Italicized text suggests patient's perspective and/or intended meaning*

Patient Level

- ☐ Adverse Drug Reaction or side effects
- ☐ Intolerance
- ☐ Didn't fill prescription
- ☐ Didn't need prescription
- ☐ Money/financial barriers
- ☐ Intentional non-adherence
  "I was told to take this but I choose not to."
- ☐ Non-intentional non-adherence (ie:Knowledge deficit)
  "I don't understand how to take this medication."
- ☐ Performance deficit
  "Maybe someone showed me, but I can't demonstrate to you that I can."

System Level

- ☐ Prescribed with known allergies/intolerances
- ☐ Conflicting information from different informational sources.
  For example, discharge instructions indicate one thing and pill bottle says another.
- ☐ Confusion between brand & generic names
- ☐ Discharge instructions incomplete/inaccurate/illegible.
  Either the patient cannot make out the hand- writing or the information is not written in lay terms.
- ☐ Duplication.
  Taking multiple drugs with the same action without any rationale.
- ☐ Incorrect dosage
- ☐ Incorrect quantity
- ☐ Incorrect label
- ☐ Cognitive impairment not recognized
- ☐ No caregiver/need for assistance not recognized
- ☐ Sight/dexterity 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.

Your Personal Health Record

***Remember** to take this record with you to all of your medical appointments and hospitalizations*

Home Health
HHQIOSC
QUALITY INSIGHTS
Quality Improvement Organization Support Center

This material prepared by Dr. Eric Coleman, UCHSC, HCPR, and funded by the John A. Hartford Foundation and the Robert Wood Johnson Foundation, is provided by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number 8SOW-PA-HHQ07.714. App. 12/07.

The Personal Health Record of:

______________________________DOB: __/__/__

Personal Information

Address:________________________________

____

Home Phone: ______________________________

Alternate Phone: ___________________________

Caregiver Information

Name:____________________________________

Home Phone:______________________________

Alternate Phone:____________________________

Relationship:______________________________

Health Care Providers

Physician:____________________Ph:___________

Specialist:____________________Ph:___________

Specialist:____________________Ph: ___________

Home Care Provider(s)

____

____

ALWAYS take insurance cards with you!

Advance Directives

Advance Directives? Yes ☐ No ☐

Do Not Resuscitate ☐ Comfort Care ☐

Health Care Proxy ☐

Name of Proxy: ______________________________

Medical History

- ☐ Arthritis
- ☐ Abnormal Heart Rhythm
- ☐ Cancer
- ☐ Diabetes
- ☐ Hardening of the Arteries
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Hip Fracture/Replacement
- ☐ Lung Disease
- ☐ Medical/Surgical Back Conditions
- ☐ Pacemaker Serial #_____________
- ☐ Pneumonia
- ☐ Stroke

Other Diagnoses: _________________________

____

To better manage my health and medications, I will:

- Take this Personal Health Record with me to ALL doctor visits and future hospitalizations and in the event of evacuation.
- Call my doctor if I have questions about my medications or if I want to change how I take my medications.
- Tell my doctors about ALL medications I am taking, including over-the-counter drugs, vitamins and herbal formulas.
- Update my Medication Record with any changes to my medications.
- Know why I am taking each of my medications.
- Know how much, when and for how long I am to take each medication.
- Know possible medication side effects to watch out for and what to do if I notice any.

Recent Test Results

Date	Wt	BP	HR	BS	Lab Result

Wt = Weight BP = Blood Pressure HR = Heart Rate BS = Blood Sugar

Recent Test Results

Date	Wt	BP	HR	BS	Lab Result

Wt = Weight BP = Blood Pressure HR = Heart Rate BS = Blood Sugar

Immunizations

Immunization	Date Received
Flu Shot (every year)	
Flu Shot (every year)	
Flu Shot (every year)	
Pneumonia	
Tetanus	

Medications

y:_________________________________

Phone Number: ___________________________

Allergies:_________________________________

____

Medicines I Take

Name	Dose	When	Date Stopped

Medicines I Take

Name	Dose	When	Date Stopped

Medicines I Take

Name	Dose	When	Date Stopped

Medicines I Take

Name	Dose	When	Date Stopped

Notes:

Doctor Visits

Date	Doctor	Reason

Hospitalization Information

Admitted: ___/___/___ Discharged: ___/___/____

Hospital:____
Reason: ____

Admitted: ___/___/___ Discharged: ___/___/____

Hospital:____
Reason: ____

Admitted: ___/___/___ Discharged: ___/___/____

Hospital:____
Reason: ____

Admitted: ___/___/___ Discharged: ___/___/____

Hospital:____
Reason: ____

Admitted: ___/___/___ Discharged: ___/___/____

Hospital:____
Reason: ____

Hospital/Facility Discharge Checklist

Before I leave the care facility, the following tasks should be completed:

- ☐ I have been involved in decisions about what will take place after I leave the facility.
- ☐ I understand where I am going after I leave this facility and what will happen to me once I arrive.
  - Discharge to other facility
  - Discharge to a home health agency
  - Discharge home to care of self/family
- ☐ I have the name and phone number of a person I should contact if a problem arises during my transfer.
- ☐ I understand what my medications are, how to obtain them, and how to take them.
- ☐ I understand the potential side effects of my medications and whom I should call if I experience them.
- ☐ I understand what symptoms I need to watch out for and whom to call should I notice them.
- ☐ I understand how to keep my health problems from becoming worse.
- ☐ My doctor or nurse has answered my most important questions prior to leaving the facility.
- ☐ My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- ☐ If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

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

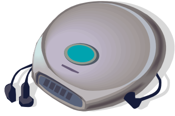
- Wife is identified as primary caregiver/learner
- Patient-friendly discharge instructions are provided specific to diet, medication, daily weights, when to see PCP, cardiologist and reasons to seek medical help, including numbers to call
- Personal health record is updated by patient with coaching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

This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number 8SOW-PA-HHQ08.735 App. 1/08.

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.

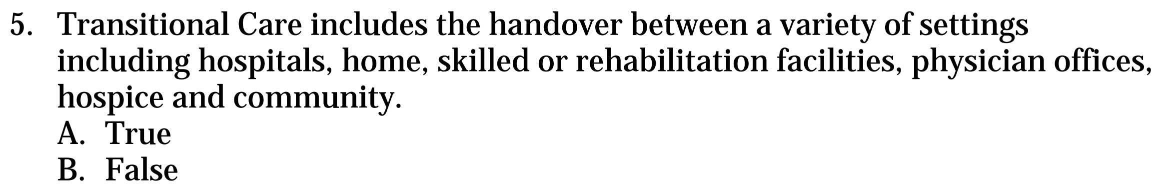
Directions: Choose the ONE BEST response to the following questions. Circle your answer that identifies the ONE BEST response.

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.

Best Practice: Transitional Care Coordination

Therapist Track

This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number: 8SOW-PA-HHQ07.468 App. 1/2008

Therapy Track

This best practice intervention package track is designed to educate therapists 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 Therapy 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 **Therapy Track**:

	Activity	Location	Estimated Time
❑	**Read "Transitional Care Coordination: Key Points for Clinicians"**	**Page 49**	**5 minutes**
❑	**Review "The Four Pillars of Care Transition Activities"**	**Page 50**	**5 minutes**
❑	**Read Building Upon the Basics**	**Page 51**	**5 minutes**
❑	**Review Medication Reconciliation and Personal Health Record sections**	**Page 52**	**10 minutes**
❑	**Read "Care Transitions: Joe's Story"**	**Page 55**	**5 minutes**
❑	**Listen to Transitional Care Coordination podcast**	**Page 56**	**20 minutes**
❑	**Read Example of Excellence**	**Page 57**	**10 minutes**
❑	**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.

Therapists (PT, PTA, OT, COTA, & SLP): Apply for a certificate of attendance for completing the therapist track activities. **Complete evaluation/post-test online at:** **http://www.zoomerang.com/survey.zgi?p=WEB227DSPBLX2K**

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 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.

This material based on the Four Pillars of CTA developed by the University of Colorado Health Sciences Center, is adapted for home health by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization for Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number 8SOW-PA-HHQ07.715 App. 12/07.

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.
- Make every effort to reconcile medications from hospital to home. Assess for the need to obtain an order for nursing to manage and monitor medication regimen.
- Ensure that patients follow up with their physician appointments.

- Help patients/caregivers prepare for physician appointments by preparing questions and concerns in advance.
- Utilize the SBAR method to improve communication.
- Review the patients' personal health records and encourage them to keep it up- to- date.

- Communicate 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 therapy tracks on www.homehealthquality.org

Several key tools are available to assist with care transitions that were developed by Dr. Eric Coleman's Care Transition 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**
:: *Italicized text suggests patient's perspective and/or intended meaning*

Patient Level

- ☐ Adverse Drug Reaction or side effects
- ☐ Intolerance
- ☐ Didn't fill prescription
- ☐ Didn't need prescription
- ☐ Money/financial barriers
- ☐ Intentional non-adherence *"I was told to take this but I choose not to."*
- ☐ Non-intentional non-adherence (ie:Knowledge deficit) *"I don't understand how to take this medication."*
- ☐ Performance deficit *"Maybe someone showed me, but I can't demonstrate to you that I can."*

System Level

- ☐ Prescribed with known allergies/intolerances
- ☐ Conflicting information from different informational sources. *For example, discharge instructions indicate one thing and pill bottle says another.*
- ☐ Confusion between brand & generic names
- ☐ Discharge instructions incomplete/inaccurate/illegible. *Either the patient cannot make out the hand- writing or the information is not written in lay terms.*
- ☐ Duplication. *Taking multiple drugs with the same action without any rationale.*
- ☐ Incorrect dosage
- ☐ Incorrect quantity
- ☐ Incorrect label
- ☐ Cognitive impairment not recognized
- ☐ No caregiver/need for assistance not recognized
- ☐ Sight/dexterity 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.

Your Personal Health Record

***Remember** to take this record with you to all of your medical appointments and hospitalizations*

Home Health
HHQIOSC
QUALITY INSIGHTS
Quality Improvement Organization Support Center

This material prepared by Dr. Eric Coleman, UCHSC, HCPR, and funded by the John A. Hartford Foundation and the Robert Wood Johnson Foundation, is provided by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number 8SOW-PA-HHQ07.714. App. 12/07.

To better manage my health and medications, I will:

- Take this Personal Health Record with me to ALL doctor visits and future hospitalizations and in the event of evacuation.
- Call my doctor if I have questions about my medications or if I want to change how I take my medications.
- Tell my doctors about ALL medications I am taking, including over-the-counter drugs, vitamins and herbal formulas.
- Update my Medication Record with any changes to my medications.
- Know why I am taking each of my medications.
- Know how much, when and for how long I am to take each medication.
- Know possible medication side effects to watch out for and what to do if I notice any.

Recent Test Results

Date	Wt	BP	HR	BS	Lab Result

Wt = Weight BP = Blood Pressure HR = Heart Rate BS = Blood Sugar

The Personal Health Record of:

______________________________DOB: __/__/__

Personal Information

Address:__________________________________

____

Home Phone: ______________________________

Alternate Phone: ___________________________

Caregiver Information

Name:____________________________________

Home Phone:_______________________________

Alternate Phone:____________________________

Relationship:_______________________________

Health Care Providers

Physician:___________________Ph:___________

Specialist:__________________Ph:___________

Specialist:__________________Ph: ___________

Home Care Provider(s)

____

____

ALWAYS take insurance cards with you!

Advance Directives

Advance Directives? Yes ☐ No ☐

Do Not Resuscitate ☐ Comfort Care ☐

Health Care Proxy ☐

Name of Proxy: ______________________________

Medical History

- ☐ Arthritis
- ☐ Abnormal Heart Rhythm
- ☐ Cancer
- ☐ Diabetes
- ☐ Hardening of the Arteries
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Hip Fracture/Replacement
- ☐ Lung Disease
- ☐ Medical/Surgical Back Conditions
- ☐ Pacemaker Serial #_____________
- ☐ Pneumonia
- ☐ Stroke

Other Diagnoses: __________________________

____

Recent Test Results

Date	Wt	BP	HR	BS	Lab Result

Wt = Weight BP = Blood Pressure HR = Heart Rate BS = Blood Sugar

Immunizations

Immunization	Date Received
Flu Shot (every year)	
Flu Shot (every year)	
Flu Shot (every year)	
Pneumonia	
Tetanus	

Medications

y:________________________________

Phone Number: ________________________

Allergies:_____________________________

____

Medicines I Take

Name	Dose	When	Date Stopped

Medicines I Take

Name	Dose	When	Date Stopped

Medicines I Take

Name	Dose	When	Date Stopped

Doctor Visits

Date	Doctor	Reason

Hospitalization Information

Admitted: ___/___/___ Discharged: ___/___/____

Hospital: ____
Reason: ____

Admitted: ___/___/___ Discharged: ___/___/____

Hospital: ____
Reason: ____

Admitted: ___/___/___ Discharged: ___/___/____

Hospital: ____
Reason: ____

Admitted: ___/___/___ Discharged: ___/___/____

Hospital: ____
Reason: ____

Admitted: ___/___/___ Discharged: ___/___/____

Hospital: ____
Reason: ____

Medicines I Take

Name	Dose	When	Date Stopped

Notes:

Hospital/Facility Discharge Checklist

Before I leave the care facility, the following tasks should be completed:

- ☐ I have been involved in decisions about what will take place after I leave the facility.
- ☐ I understand where I am going after I leave this facility and what will happen to me once I arrive.
  - Discharge to other facility
  - Discharge to a home health agency
  - Discharge home to care of self/family
- ☐ I have the name and phone number of a person I should contact if a problem arises during my transfer.
- ☐ I understand what my medications are, how to obtain them, and how to take them.
- ☐ I understand the potential side effects of my medications and whom I should call if I experience them.
- ☐ I understand what symptoms I need to watch out for and whom to call should I notice them.
- ☐ I understand how to keep my health problems from becoming worse.
- ☐ My doctor or nurse has answered my most important questions prior to leaving the facility.
- ☐ My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- ☐ If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

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

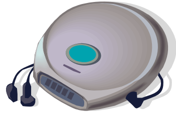
- Wife is identified as primary caregiver/learner
- Patient-friendly discharge instructions are provided specific to diet, medication, daily weights, when to see PCP, cardiologist and reasons to seek medical help, including numbers to call
- Personal health record is updated by patient with coaching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

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.

This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number 8SOW-PA-HHQ08.735 App. 1/08.

Therapy Post-test
Transitional Care Coordination

Clinician Name________________________________ Date__________________

All therapists, including OTAs and PTAs, can apply for a certificate of attendance to use towards continuing education for 1.2 continuing education hours by following the directions on page 48.

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.

Best Practice: Transitional Care Coordination

Medical Social Worker Track

This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number: 8SOW-PA-HHQ07.468 App. 1/2008

Medical Social Worker Track

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

Objectives

After completing the activities included in the Medical Social Worker 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:

	Activity	Location	Estimated Time
❑	**Read "Transitional Care Coordination: Key Points for Social Workers"**	**Page 63**	**10 minutes**
❑	**Read "Care Transitions: Joe's Story"**	**Page 64**	**5 minutes**
❑	**Listen to Transitional Care Coordination: Personal Health Record for MSW & Home Health Aide podcast**	**Page 65**	**20 minutes**
❑	**Review the Personal Health Record then complete your own PHR**	**Page 66**	**15 minutes**
❑	**Complete the social worker post-test**	**See link below**	**10 minutes**
	Total time for completion		**60 minutes**

Transitional Care Coordination
Key Points for Social Workers

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).

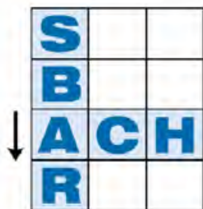
Personal Health Record: A tool prepared by the patient with assistance from health care providers to help the patient take control of his or her own health care issues and to help with communication across settings (hospital, nursing home, home health, physician office, home).

Acute Care Hospitalization Connection:

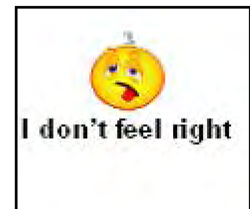
Care transition interventions designed to encourage patients and their caregivers to assume a more active role during care transitions suggests reduction in avoidable rehospitalization rates (Coleman, et al., 2006).

What can "I" do to support transitional care coordination? Build upon the Basics!

- Be aware of factors that may affect the patient taking his or her medications correctly.
- Review patients' personal health records and encourage them to keep it up to date.



- Remind patients of the need to follow up with their physician appointments.
- Use the SBAR method to communicate patient concerns to the team.



- Ask your patients to locate their emergency care plan during each visit.
- Communicate 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 MSW tracks on www.homehealthquality.org

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

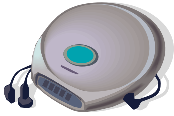
- Wife is identified as primary caregiver/learner
- Patient-friendly discharge instructions are provided specific to diet, medication, daily weights, when to see PCP, cardiologist and reasons to seek medical help, including numbers to call
- Personal health record is updated by patient with coaching 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: Personal Health Record for MSW & Home Health Aide	• This 20-minute audio recording discusses Transitional Care Coordination and the role of home care. • A discussion of the Personal Health Record and previous Best Practice Packages is included also.	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.

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- 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

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Personal Health Record

The Personal Health Record (PHR) is a tool that was featured on the **Transitional Care Coordination: Personal Health Record for MSW & Home Health Aide** podcast. The PHR assists the patient take control of his or her own health care issues and with communicating across settings. To obtain a better understanding of the PHR and its application, you can complete this sample PHR (starting on the next page) for yourself. You can use the PHR as you cross care settings, visit physician offices, etc.

Your Personal Health Record

***Remember** to take this record with you to all of your medical appointments and hospitalizations*

This material prepared by Dr. Eric Coleman, UCHSC, HCPR, and funded by the John A. Hartford Foundation and the Robert Wood Johnson Foundation, is provided by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization Support Center for Home Health, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number 8SOW-PA-HHQ07.714. App. 12/07.

The Personal Health Record of:

______________________________DOB: __/__/__

Personal Information

Address:____

____

Home Phone: ________________________________

Alternate Phone: ______________________________

Caregiver Information

Name:______________________________________

Home Phone:________________________________

Alternate Phone:______________________________

Relationship:_________________________________

Health Care Providers

Physician:____________________Ph:___________

Specialist:____________________Ph:___________

Specialist:____________________Ph: ___________

Home Care Provider(s)

____

____

ALWAYS take insurance cards with you!

Advance Directives

Advance Directives? Yes ☐ No ☐

Do Not Resusitate ☐ Comfort Care ☐

Health Care Proxy ☐

Name of Proxy: ______________________________

Medical History

- ☐ Arthritis
- ☐ Abnormal Heart Rhythm
- ☐ Cancer
- ☐ Diabetes
- ☐ Hardening of the Arteries
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Hip Fracture/Replacement
- ☐ Lung Disease
- ☐ Medical/Surgical Back Conditions
- ☐ Pacemaker Serial #______________
- ☐ Pneumonia
- ☐ Stroke

Other Diagnoses: __________________________

____

To better manage my health and medications, I will:

- Take this Personal Health Record with me to ALL doctor visits and future hospitalizations and in the event of evacuation.
- Call my doctor if I have questions about my medications or if I want to change how I take my medications.
- Tell my doctors about ALL medications I am taking, including over-the-counter drugs, vitamins and herbal formulas.
- Update my Medication Record with any changes to my medications.
- Know why I am taking each of my medications.
- Know how much, when and for how long I am to take each medication.
- Know possible medication side effects to watch out for and what to do if I notice any.

Recent Test Results

Date	Wt	BP	HR	BS	Lab Result

Wt = Weight BP = Blood Pressure HR = Heart Rate BS = Blood Sugar

Recent Test Results

Date	Wt	BP	HR	BS	Lab Result

Wt = Weight   BP = Blood Pressure   HR = Heart Rate   BS = Blood Sugar

Immunizations

Immunization	Date Received
Flu Shot (every year)	
Flu Shot (every year)	
Flu Shot (every year)	
Pneumonia	
Tetanus	

Medications

y:_________________________________

Phone Number: _________________________________

Allergies:_________________________________

____

Medicines I Take

Name	Dose	When	Date Stopped

Medicines I Take

Name	Dose	When	Date Stopped

Medicines I Take

Name	Dose	When	Date Stopped

Medicines I Take

Name	Dose	When	Date Stopped

Notes:

Doctor Visits

Date	Doctor	Reason

Hospitalization Information

Admitted: ___/___/___ Discharged: ___/___/____

Hospital: ____
Reason: ____

Admitted: ___/___/___ Discharged: ___/___/____

Hospital: ____
Reason: ____

Admitted: ___/___/___ Discharged: ___/___/____

Hospital: ____
Reason: ____

Admitted: ___/___/___ Discharged: ___/___/____

Hospital: ____
Reason: ____

Admitted: ___/___/___ Discharged: ___/___/____

Hospital: ____
Reason: ____

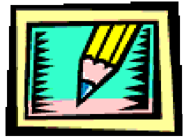
Hospital/Facility Discharge Checklist

Before I leave the care facility, the following tasks should be completed:

- ☐ I have been involved in decisions about what will take place after I leave the facility.
- ☐ I understand where I am going after I leave this facility and what will happen to me once I arrive.
  - Discharge to other facility
  - Discharge to a home health agency
  - Discharge home to care of self/family
- ☐ I have the name and phone number of a person I should contact if a problem arises during my transfer.
- ☐ I understand what my medications are, how to obtain them, and how to take them.
- ☐ I understand the potential side effects of my medications and whom I should call if I experience them.

- ☐ I understand what symptoms I need to watch out for and whom to call should I notice them.
- ☐ I understand how to keep my health problems from becoming worse.
- ☐ My doctor or nurse has answered my most important questions prior to leaving the facility.
- ☐ My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- ☐ If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

Medical Social Worker
Post-test
Transitional Care Coordination



Clinician Name________________________________ Date__________________

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 social worker visits to provide one service on a given day
   E. Initiating/educating on a Personal Health Record

3. Personal health records should include the following information:
   A. Caregiver(s) name and phone number
   B. Physician(s) name and phone number
   C. Advance Directives
   D. Current medications and allergies
   E. All of the above

4. Medical social workers can assist patient/caregiver with the patient's Personal Health Record (PHR) by all of the following **except:**
   A. Assist patient/caregiver in completing the PHR
   B. Remind patient/caregiver to keep PHR current with medications and physician appointments
   C. Encourage patient/caregiver to write questions to physicians in the PHR
   D. Remind patient/caregiver to take PHR to physician office appointments
   E. Order appropriate laboratory studies

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 on page 30.

Best Practice: Transitional Care Coordination

Home Health Aide Track

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Home Health Aide Track

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

Objectives

After completing the activities included in the Home Health Aide 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 avoidable acute care hospitalization
4. Identify clinical practices that promote effective care transitions

Complete the following activities:

	Activity	Location	Estimated Time
❑	**Read "Transitional Care Coordination: Key Points for Home Health Aides"**	**Page 79**	**5 minutes**
❑	**Listen to Transitional Care Coordination: Personal Health Record for MSW & Home Health Aide podcast (audio recording) and use the discussion questions for group interaction**	**Page 80**	**25 minutes**
❑	**Review the Personal Health Record then complete your own PHR**	**Page 81**	**20 minutes**
❑	**Complete the home health aide post-test and give to your clinical manager**	**Page 90**	**10 minutes**
	Total time for completion		**60 minutes**

Transitional Care Coordination: Key Points for Home Health Aides

Definitions:

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).

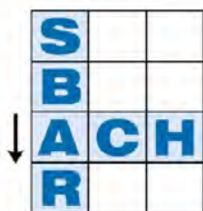
Personal Health Record: A tool prepared by the patient with assistance from healthcare providers to help the patient take control of his or her own health care issues and to help with communicating across settings (hospital, nursing home, home health, physician office, home).

Acute Care Hospitalization Connection:

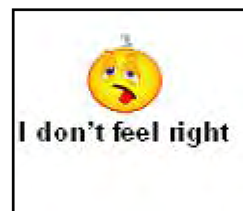
Care transition interventions designed to encourage patients and their caregivers to assume a more active role during care transitions suggests reduction in avoidable rehospitalization rates (Coleman, et al., 2006).

What can "I" do to support transitional care coordination?

- Be aware of factors that may affect the patient taking his or her medications correctly.
- Review patients' personal health record and encourage them to keep it up to date.

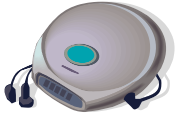


- Remind patients of the need to follow with their physician appointments.
- Use SBAR to communicate patient concerns to the team.



- Ask your patients to locate their emergency care plan during each visit.
- Review the patient home health aide care plan to see if the plan is complete and that you understand your assignments. Communicate any questions to your manager.

Note: For more information about any of these previous topics see the Home Health Aide Tracks on www.homehealthquality.org



Transitional Care Coordination Multi-Media Activity Podcast*

Transitional Care Coordination Podcast Instructions:

Title	Description	Link
Transitional Care Coordination: Personal Health Record for MSW & Home Health Aides	• This 20-minute audio recording discusses Transitional Care Coordination and the role of home care. • A discussion of the Personal Health Record and previous Best Practice Packages is also included.	The podcast link is located at **http://www.homehealthquality.org/hh/hha/interventionpackages/tcc.aspx**

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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.

Discussion Topics

1. During one of your patient visits, it is determined between the patient and the office nurse that the patient needs sent to the emergency department (a transition in care).
   - Who would you notify?
   - What information would you need to provide?
   - What would you suggest that the patient/family take with them to the emergency department?
2. Your patient has now returned home from the hospital (a transition in care).
   - What information would you need to know to provide quality care?
   - Where would you find that information?
     - Where would you go or whom would you call to get information you do not have?
3. Look at the sample Personal Health Record and discuss what home health aides can do to encourage patients to use the record and tips for patients to remember to take it with them to the physician's office, hospital or any other health provider.

Personal Health Record

The Personal Health Record (PHR) is a tool that is featured on the **Transitional Care Coordination: Personal Health Record for MSW & Home Health Aide** podcast. A PHR helps the patient take control of his or her own health care issues and assists with communication across settings.

To obtain a better understanding of the PHR and its application, you can complete this sample PHR (beginning on the next page) for yourself. You can use the PHR as you cross care settings, visit physician offices, etc.

Your Personal Health Record

***Remember** to take this record with you to all of your medical appointments and hospitalizations*

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The Personal Health Record of:

______________________________DOB: __/__/__

Personal Information

Address:______________________________________

____

Home Phone: _________________________________

Alternate Phone: ______________________________

Caregiver Information

Name:____

Home Phone:__________________________________

Alternate Phone:_______________________________

Relationship:__________________________________

Health Care Providers

Physician:_____________________Ph:_____________

Specialist:_____________________Ph:_____________

Specialist:_____________________Ph: _____________

Home Care Provider(s)

____

____

ALWAYS take insurance cards with you!

Advance Directives

Advance Directives? Yes ☐ No ☐

Do Not Resusitate ☐ Comfort Care ☐

Health Care Proxy ☐

Name of Proxy: ________________________________

Medical History

- ☐ Arthritis
- ☐ Abnormal Heart Rhythm
- ☐ Cancer
- ☐ Diabetes
- ☐ Hardening of the Arteries
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Hip Fracture/Replacement
- ☐ Lung Disease
- ☐ Medical/Surgical Back Conditions
- ☐ Pacemaker Serial #______________
- ☐ Pneumonia
- ☐ Stroke

Other Diagnoses: ___________________________

____

To better manage my health and medications, I will:

- Take this Personal Health Record with me to ALL doctor visits and future hospitalizations and in the event of evacuation.
- Call my doctor if I have questions about my medications or if I want to change how I take my medications.
- Tell my doctors about ALL medications I am taking, including over-the-counter drugs, vitamins and herbal formulas.
- Update my Medication Record with any changes to my medications.
- Know why I am taking each of my medications.
- Know how much, when and for how long I am to take each medication.
- Know possible medication side effects to watch out for and what to do if I notice any.

Recent Test Results

Date	Wt	BP	HR	BS	Lab Result

Wt = Weight BP = Blood Pressure HR = Heart Rate BS = Blood Sugar

Recent Test Results

Date	Wt	BP	HR	BS	Lab Result

Wt = Weight BP = Blood Pressure HR = Heart Rate BS = Blood Sugar

Immunizations

Immunization	Date Received
Flu Shot (every year)	
Flu Shot (every year)	
Flu Shot (every year)	
Pneumonia	
Tetanus	

Medications

y:__________________________________

Phone Number: ____________________________

Allergies:__________________________________

____

Medicines I Take

Name	Dose	When	Date Stopped

Medicines I Take

Name	Dose	When	Date Stopped

Medicines I Take

Name	Dose	When	Date Stopped

Medicines I Take

Name	Dose	When	Date Stopped

Notes:

Doctor Visits

Date	Doctor	Reason

Hospitalization Information

Admitted: ___/___/___ Discharged: ___/___/____

Hospital: ____
Reason: ____

Admitted: ___/___/___ Discharged: ___/___/____

Hospital: ____
Reason: ____

Admitted: ___/___/___ Discharged: ___/___/____

Hospital: ____
Reason: ____

Admitted: ___/___/___ Discharged: ___/___/____

Hospital: ____
Reason: ____

Admitted: ___/___/___ Discharged: ___/___/____

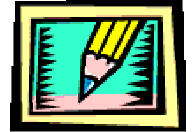
Hospital: ____
Reason: ____

Hospital/Facility Discharge Checklist

Before I leave the care facility, the following tasks should be completed:

- ☐ I have been involved in decisions about what will take place after I leave the facility.
- ☐ I understand where I am going after I leave this facility and what will happen to me once I arrive.
  - Discharge to other facility
  - Discharge to a home health agency
  - Discharge home to care of self/family
- ☐ I have the name and phone number of a person I should contact if a problem arises during my transfer.
- ☐ I understand what my medications are, how to obtain them, and how to take them.
- ☐ I understand the potential side effects of my medications and whom I should call if I experience them.
- ☐ I understand what symptoms I need to watch out for and whom to call should I notice them.
- ☐ I understand how to keep my health problems from becoming worse.
- ☐ My doctor or nurse has answered my most important questions prior to leaving the facility.
- ☐ My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- ☐ If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

Home Health Aide Transitional Care Coordination Post-Test



Clinician_________________________________ Date_________________________

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. Personal health records should include the following information:
   A. Caregiver(s) name and phone number
   B. Physician(s) name and phone number
   C. Advance Directives
   D. Current medications and allergies
   E. All of the above

3. Home health aides can assist patient/caregiver with their Personal Health Record (PHR) by:
   A. Reminding patient/caregiver to keep PHR current with medications and physician appointments
   B. Reminding patient/caregiver to write questions to physicians in the PHR
   C. Reminding patient/caregiver to take PHR to physician office appointments
   D. All of the above

4. The following are examples of what a patient/caregiver could write in the "Notes" section of their Personal Care Record:
   A. "Tell the doctor about the fall I had on February 1st."
   B. "Ask the doctor about my blood work results from last week."
   C. "Tell the doctor I need refills on my Lasix and Prilosec."
   D. "Ask the homecare nurse to explain my diet again."
   E. All of the above

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.