

Best Practice Intervention Package: Transitional Care Coordination



BUILDING UPON THE BASICS

Theme for final three Best Practice
Intervention Packages:

- December: Patient Self-Management
- January: Disease Management
- **February: Transitional Care Coordination**

BUILDING UPON THE BASICS

Purpose of Patient Self-Management,
Disease Management and
Transitional Care Coordination:

- Advance to a higher level of care
- Improve patient outcomes
- Improve patient satisfaction
- Reduce avoidable hospitalizations

Objectives

After viewing this WebEx, the learner will
be able to:

- Define Transitional Care Coordination
- Identify tools/resources available in this Best Practice Intervention Package (BPIP)
- Recognize components of the Best Practice Intervention Package that will be of value to your agency

Transitional Care Coordination

Utilizing the following best practices can help
design an effective care transitions program

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 Goes Both Ways

Sending ↔ Receiving

Care Transitions

Refers to the **patients moving** between health care practitioners and settings **as their condition and care needs change** during the course of a chronic or acute illness (Care Transitions Program, University of Colorado).

<http://www.caretransitions.org>

The Care
Transitions
ProgramSM

Care Coordination

- Targets the chronically ill who are at risk for elevated health care and provides services that fill the gaps in our traditional, reactive system
- Combines the elements to keep the chronically ill and elderly as healthy as possible and to reduce the use of costly services such as the emergency room and inpatient hospitalization (Meckes, 2005)

Transitional 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).

Transitional Care Coordination

- Poses challenges that distinguish it from other types of care
- Transitional care encompasses both the **sending and receiving aspects** of the transfer and is essential for those with complex care needs (AGS, 2006)

Sending ↔ Receiving



Transitional Care Coordination Handoffs/Handovers

Care transitions = **handovers** in care

- Significant patient safety issue
- Information often acquired and transmitted without determining comprehension
- Should imply transfer of patient information as well as professional responsibility to both deliver the information and assure it is understood.



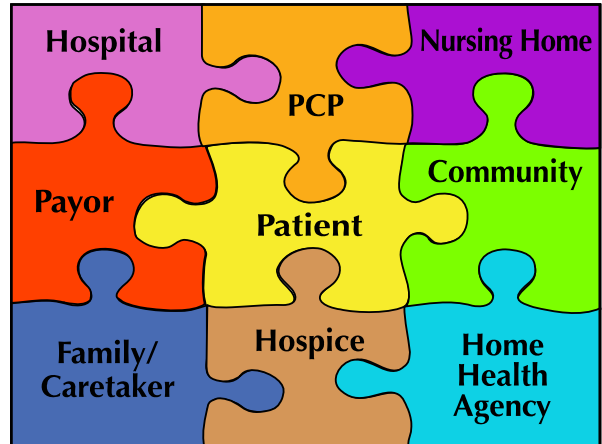
Transitional Care Coordination Handovers

The role of handovers is to:

- Exchange vital information
- Share impressions of patient status
- Exchange information and assume or pass on responsibility
- Support patient safety

Transitional Care Coordination Handovers

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

The Four Pillars of Care Transition Activities

<p>1. Medication Self-Management</p> <p>Goal: Patient is knowledgeable about medications and has a medication management system.</p> <p>Home Health Activities:</p> <ul style="list-style-type: none"> Discuss importance of understanding medications and having a system in place. Reconcile medication regimen after any hand-off, liberty and correct any discrepancies. Assist with medication simplification to support a manageable regimen. <p>Follow-Up: Assess any remaining medication questions.</p>	<p>2. Patient-Centered Record</p> <p>Goal: Patient understands and utilizes a personal health record (PHR) to facilitate communication and ensure continuity of care planned across settings. The patient manages the PHR.</p> <p>Home Health Activities:</p> <ul style="list-style-type: none"> Explain PHR and its components. Review and update PHR after any hand-off. Encourage patient to update and share the PHR with primary care practitioners (PCP) and in specialists at follow-up visits. <p>Follow-Up: Discuss outcome of visits with PCP and/or specialists.</p>	<p>3. Physician Follow-Up</p> <p>Goal: Patient schedules and completes follow-up visit with PCP specialist and is empowered to be an active participant in these interactions.</p> <p>Home Health Activities:</p> <ul style="list-style-type: none"> 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. <p>Follow-Up: Provide advice on getting prompt appointments, if necessary.</p>	<p>4. Red Flags</p> <p>Goal: Patient is knowledgeable about indicators that their condition is worsening and how to respond.</p> <p>Home Health Activities:</p> <ul style="list-style-type: none"> Collaboratively develop an emergency care plan (ECP). Discuss signs and symptoms of impending changes in health status. Reinforce when to call and when. <p>Follow-Up: Update and review ECP with every patient contact.</p>
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Adapted from <http://www.caretransitions.org>

Four Pillars

Patient Centered Record (PHR) + Patient/Caregiver Coaching (self-management support)


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 handoffs to and from the home health community.

The ACH Connection


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



Resources

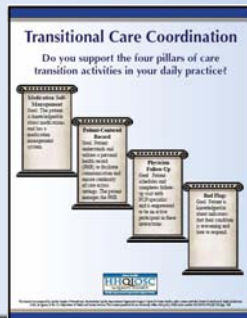


Remember to take this record with you to all of your medical appointments and hospitalizations



Poster

- Poster
- Connection Pages



Leadership Track

- Agency assessment
- Action items
- Action plan

BUILDING UPON THE BASICS

Nursing and Therapy Tracks

- Transitional Care Coordination: Key Points for Clinicians
- The Four Pillars of Care Transition Activities
- Care Transitions: Joe's Story
- Podcast
- Examples of Excellence
- Post-test with Free CNEs for RNs or Certificate for LPN and Therapists

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Medical Social Worker Track

- Transitional Care Coordination: Key Points for Social Workers
- Care Transitions: Joe's Story
- Podcast
- Personal Health Record (including completion of own PHR)
- Examples of Excellence
- Post-test



BUILDING UPON THE BASICS

Home Health Aide Track

- Transitional Care Coordination: Key Points for Home Health Aides
- Podcast
- Personal Health Record (including completion of own PHR)
- Post-test



BUILDING UPON THE BASICS



Home Health Quality Improvement
National Campaign

"Piecing the Puzzle Together... to Reduce Avoidable Hospitalizations."



This is the final BPIP Educational WebEx for the HHQI National Campaign.

Congratulations on your commitment to the HHQI National Campaign!!

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