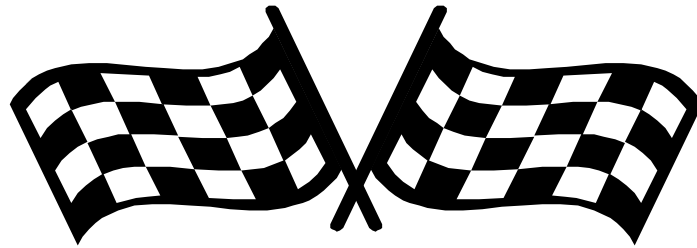


# Home Health Quality Improvement National Campaign



## Best Practice Intervention Fast Track Package Transitional Care Coordination



# Transitional Care Coordination

## Definition:

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

## Transitional Care Coordination Goes Both Ways



## Key Points:

- **Primary Goal:** To provide patients with tools and support that promote knowledge and self-management of their transitions as they move from one setting to another
- **ACH Connection:** Care transition interventions designed to encourage patients and their caregivers to assume a more active role during care transitions may reduce re-hospitalization rates.
- **Care transitions are not optional.** Handoffs between healthcare settings and providers occur daily. **Transitional care coordination is a choice.**
- **A Personal Health Record (PHR)** facilitates communication and ensures continuity of care planning across providers and setting. The patient or caregiver manages the PHR.
- **Role of home health:** Home healthcare is uniquely positioned to improve transitional care and outcomes for the growing population of older adults with continuous complex needs (Naylor, 2006).
- **Build Upon the Basics:** By building upon the basic best practices for decreasing hospitalization, home health agencies can overcome many of the challenges to improving the quality of transitional care coordination.
- **Four Pillars:** The care transitions intervention has been built on four pillars of Care Transition Activities (see tool, next page)

# 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.

