



Care Transitions: From Hospital to Home

Michael Halling & Care Transitions Team

TRANSITION PROGRAM PURPOSE

- Assist patients/clients as they transition from the acute care setting back to their homes
- Improve continuity of care while empowering patients to be their own healthcare advocates.
- Reduce avoidable hospital readmissions
- Dually Beneficial
 - Patient Centered- Ownership of own Health Care
 - Reduces health care costs by reducing readmissions.

SWIRCA & More's Care Transitions

- Inspired by Dr. Eric Coleman's Care Transitions Program® with focus on the "The 4 pillars"
 - Medication Management
 - Red Flags
 - Medical Follow-up
 - Personal Health Record

Read More about Dr. Coleman's model at www.caretransitions.org
- Hospital Buy-in
 - Had roundtable discussions with key figures from each hospital present.
 - Established formal partnerships w/ St. Mary's Medical Center, Deaconess Hospital, and Deaconess Gateway Hospital.
 - Did not happen over-night

SWIRCA's Care Transitions Timeline

- July 2012--Started w/ 1 Coach at St. Mary's Hospital
- November 2012---2nd Coach added and expanded Care Transitions to Deaconess Hospital—Main Campus
- May 2013--Care Transitions extended to Deaconess Gateway and Deaconess Heart Hospital
- July 2013--Awarded Cardinal Health Foundation Grant to hire 3rd Coach.
- August 2013-- 3rd Coach Identified
- January 2014-- Health Care Excel (Medicare QIO) highlights SWIRCA & More and community partners in a report to CMS.
- July 2014-- SWIRCA & More receives an Award of Excellence from Health Care Excel (Medicare QIO) for "Integrating Care for Populations and Communities."

The Intervention Process

- 1 Hospital Visit (Ideally)
- 2 Home Visits
 - 1st home visit within 48 hours of discharge
 - 2nd home visit within 5-7 days of 1st home visit
- 3 Follow-up phone calls
 - 1st—Seven days after last home visit
 - 2nd—30 Day Follow-up
 - 3rd—60 Day Follow-up
- Will transfer to an on-going case manager if there are additional needs

HOW DO WE ASSIST THE PATIENT?

- Encourage the use of a personal health record
- Medication self-management
- Encourage patient follow-up with primary physician
- Reinforce patient knowledge of red flags
- Assist with access to community resources.

CRITERIA FOR REFERRALS

- Patient lives in Posey, Gibson, Vanderburgh or Warrick. We hope to expand to Spencer and Perry later.
- Being discharged without home health
- Has a diagnosis of heart failure, COPD, renal failure or pneumonia.
- Exclusion criteria: under 18 years of age, homeless, dementia without a caregiver, admission based solely on mental health or substance abuse.

FIRST STEPS FOR AN INTERVENTION

- Referrals are sent to SWIRCA
 - Have formal partnerships with St. Mary's Medical Center, Deaconess Hospital-Main, and Deaconess Gateway Hospital
- Hospital visit: (Ideally)
 - Introduce Self
 - Explain the purpose and benefits of the program
 - Reinforce that there is **NO COST** to the patient
 - Get informed consent signed
 - Reinforce importance of discharge instructions
 - Ensure that home address and contact information are correct.
 - Schedule a home visit, ideally within 24-48 hours, either in person at the hospital or by phone after discharge.

INITIAL HOME VISIT

- Complete patient proficiency scale.
 - Provides qualified statistics for intervention success down the road.
- Discuss warning signs/Red Flags (discharge paperwork)
- Introduce patient to Personal Health Record
- Medication Self Management.
 - Medication Reconciliation (including making sure new scripts were filled)
 - A medication discrepancy communication form is used to document any issues or concerns with the medications, and, when necessary, fax it to the doctor or pharmacist for clarification.
 - Coach patients on how to resolve these issues on their own in the future, such as calling the doctor or pharmacist.

INITIAL HOME VISIT CONTINUED

- Resource linkage as needed. For example, does the client have money to get medications filled? Is assistance needed in the home?
- Primary care physician follow-up appointment.
 - Review discharge paperwork to locate primary physician appointment and review with patient.
 - If no appointment, coach will assist client in making an appointment with the physician.
 - Coach will ensure the patient has transportation and try to arrange transportation if needed.
- Work with client establish his/her own health goal. This should help with patient compliance.

PATIENT PROFICIENCY SCALE

Directions: For each statement, rate patient's level of performance using the following guide:

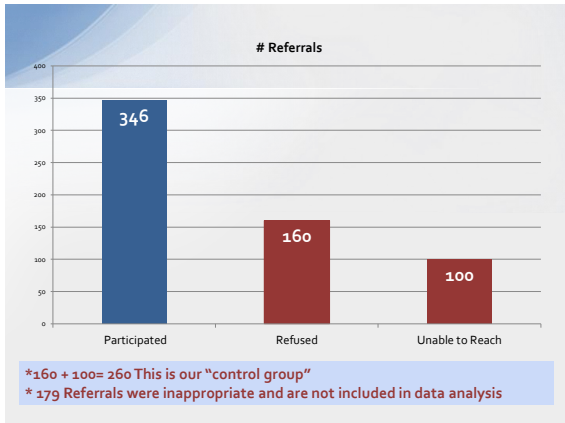
1	2	3	4
1 2 3 4 Patient lacks knowledge and understanding in this area, or is unable to complete this task	1 2 3 4 Patient has a small amount of knowledge and understanding in this area, or is able to complete this task with moderate assistance	1 2 3 4 Patient has a good deal of knowledge and understanding in this area, but could still benefit from coaching or assistance	1 2 3 4 Patient is proficient in this area, or is independent in completing this task
Medication Management	Red Flags	Medical Care Follow Up	Personal Health Record
1 2 3 4 Demonstrates effective use of Medication Management System (pill organizer, med dispenser, etc.)	1 2 3 4 Demonstrates understanding of Red Flags, or warning signs that condition may be worsening	1 2 3 4 Can schedule and follow through on appointment(s)	1 2 3 4 Understands the purpose of PHR and the importance of updating PHR
1 2 3 4 For each medication, understands the purpose, when and how to take, and possible side effects.	1 2 3 4 Reacts appropriately to Red Flags per education given (or understands how to react appropriately)	1 2 3 4 Writes a list of questions for PCP and/or Specialist and brings to appointment	1 2 3 4 Is able and willing to bring PHR to every health encounter
1 2 3 4 Demonstrates ability to accurately update medication list.			
1 2 3 4 Is able and willing to confirm medication list with PCP and/or Specialist			
Sum: /16	Sum: /8	Sum: /8	Sum: /8
Total Score: /40			

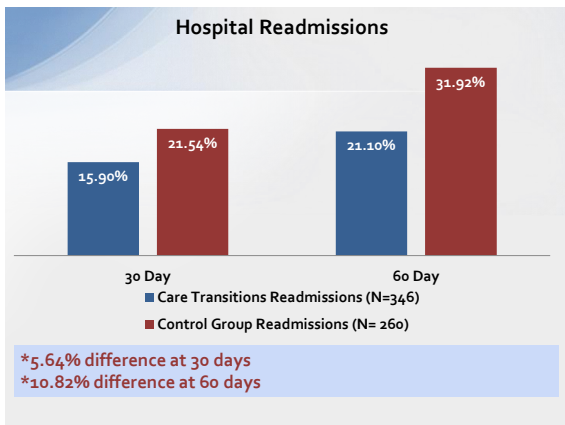
MEDICATION DISCREPANCY COMMUNICATION FORM

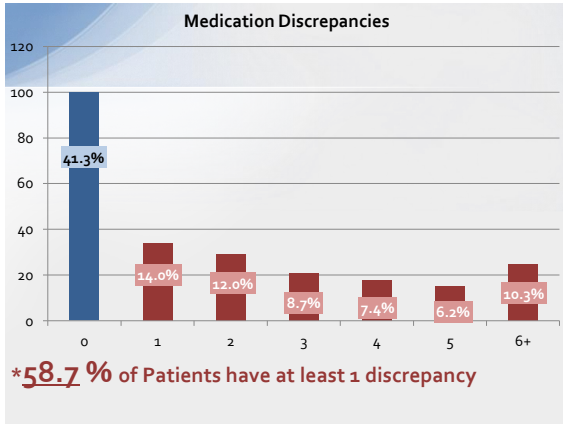
- The medication discrepancy communication form is designed to facilitate reconciliation of medication regimens across settings and prescribers. It is designed for use by a social worker to identify possible medication discrepancies based on observations and patient reports.

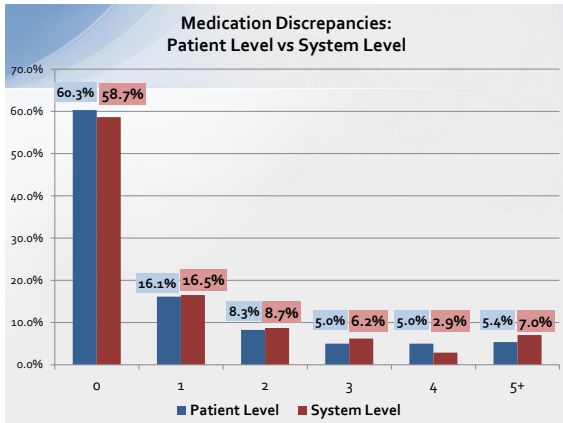
FOLLOW UP PHONE CALLS

- We will follow up with client over the 60 days to review further needs, physician followups, medication compliance, hospitalizations and review the progress towards goals and reinforce usage of the personal health record.
- Patient Proficiency Scale Post-Tests completed at 30 day and 60 day follow-up calls.
- Referrals made to on-going Case Management if need is identified.









CARE TRANSITION vs. CASE MANAGEMENT

Care Transitions

- See patient immediately following discharge
- Short term intervention
- Specific goals: reduce readmit, improve transition of care, 4 pillars of care.
- Improve transfer of information between settings as needed.
- Specific diagnosis at this time.

Case Management

- Patient not seen as quickly unless it is an emergency situation.
- CM is usually a long term need.
- No diagnosis or age exclusion.
- Patient/client must have a need for services or assistance to remain in the community setting. CM will assist with resource linkage

THINGS TO REMEMBER...

- There is **NO COST** to the patients
- Coaches do **NOT** interfere with patient care
- Coaches do **NOT** practice medicine or direct patient care
- Coaches **DO** empower patients with their health care
- Coaches are trained professionals
- Coaches can assist patients with transitions across various health care settings
- Coaches can assist patients who are at high risk for re-admissions

CHALLENGES

- Patients understanding and acceptance of this new program. Once discharge is discussed the focus for the patient is on leaving the hospital. Many patients refuse the program if they have family supports.
- Seeing the patients before they leave the hospital increases the likelihood they will understand and accept the program.
- Finding the patients once they return to the community. Many times the patient ends up going home with family members, etc and we are unable to locate them.

Contacting the ADRC

Office Hours:
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8:00 am – 4:30 pm

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QUESTIONS?
