The Role of Home Care in Care Transitions

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Masspro Collaborative Project

- 5 home care agencies
- 4 meetings over one year from Sept. 2007 – June 2008
- Monthly conference calls
- Site visits
- Guest speakers

Mission

The mission of the Care Transitions Collaborative is to improve the communication of information

as the patient moves from an inpatient setting to home care.

Goal

- Enhance the clarity of discharge information so as to improve care processes and empower the patient to take an active role in health management.
- Decrease the acute care hospitalization with participants in the Care Transitions Project.

Why Improve Care Across Settings?

- Improve patient outcomes.
- Decrease acute care re-hospitalization.
- Improve communications.
- Improve patient satisfaction.
- Facilitate medication reconciliation.
- Assists in meeting regulatory requirements.
  - Joint Commission National Patient Safety Goals.

The "Business Case"

- What's in it for me? (WII FM).
- The hospital perspective.
- The patient perspective.
- The home care 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.

Care Transitions Activities

	1	2	3	4
Coach	√	√	√	√
Medication self-management.	√	√	√	√
Patient centered record.	√	√	√	√
Physician follow-up appointment.	√	√	√	√
Education red flags.	√	√	√	√
Phone calls to pt.s	√	√	√	√

Re-Hospitalization Rates

	1	2	3	4	Total
# of patients enrolled	8	5	6	10	29
# of patients re-hospitalized	2	1	1	3	7 **24%**

The agencies 9 months later

- “Coach” position was eliminated.
- Had difficulty maintaining program.
- Will be participating with the recipient of Schwartz Center grant.
- Has formed a bond with local medical center to continue the project.

CMS 9th SOW

- Project to continue through summer of 2011 (3 year contract).
- Goal: eliminate fragmentation of care and reduce unnecessary hospital readmissions.
- Involve hospitals, skilled nursing facilities and home health.

14 States in the 9th SOW Project

What's next on the horizon?

- Hospital and community system-wide interventions.
- Interventions that target specific diseases or conditions.
- Interventions that target specific reasons for readmission.

www.cfmc.org/caretransitions/

Quote

"Home healthcare is the component of the healthcare industry best positioned to bridge gaps in care between hospitals and home, especially for high-risk groups such as older adults coping with multiple health problems."

(Naylor, 2006. p. 48)

References

- Naylor, M. (2006). Transitional care: A critical dimension of the home healthcare quality agenda. *Journal for Healthcare Quality. 28*(1). 48-53.
- www.caretransitions.org
- www.qualitynet.org/
- www.transitionalcare.info