The Role of Home Care in Care Transitions

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Massachusetts Care Transitions Seminar
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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

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## Re-Hospitalization Rates

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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/
“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


www.caretransitions.org

www.qualitynet.org/

www-transitionalcare.info