Care Coordination and Transition Management
Facilitating Safe and Seamless Transitions between Health Care Settings

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Purpose
This session is designed to illustrate the RN’s critical role in assisting, facilitating and enabling patients to transition seamlessly between health care settings. The complexity of health care demands that nurses demonstrate knowledge, skills and attitude to drive quality and safety outcomes.

Objectives
• Identify and describe evidence based dimensions of care coordination-transition management.

• Examine the relationship between leadership competencies and care coordination-transition management competencies.

• Illustrate the impact care coordination-transition management has on patient and health system outcomes.

Advocate Good Samaritan Hospital

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Care Coordination

"Function that helps ensure that the patient’s needs and preferences for health services and information sharing across people, functions, and sites that are met over time.”

Deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services.

Transitional Care

Broad range of time - limited services designed to:

• ensure health care continuity
• avoid preventable poor outcomes among at risk populations
• promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another

(Naylor, Aiken, Kurtzman, OBIs, and Hirschmanet, 2011)

Transitional Care Requirements

• Comprehensive care plan
• Availability of well-trained practitioners
• Information about the patient's goals, preferences, and clinical status.
• Includes:
  – Logistical arrangements
  – Education of the patient and family
  – Coordination among the health professionals involved in the transition

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Transition Issues Dramatically Impact Patient Care

The need is critical...
- Complex, vulnerable patients: chronic illness, multiple comorbidities, and social complexities
- Complex health care systems
  - Shorter length of stay
  - Requires cross-setting communication
- Financial
  - Patient costs (specialists, diagnostics, medications, reduced benefits)
  - Health system costs (reimbursement, readmission penalties)

Inpatient HCAHPS Care Transition Questions
- During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
- During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
- When I left the hospital, I had a good understanding of the things I was responsible for in managing my health?

American Nurses Association

Legislation/National Support for CCTM
- CMS
- NQF
- AHRQ
- IHI Triple Aim
- Affordable Care Act
- IOM Future of Nursing Report
- National Transitions of Care Coalition (NTOCC)

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American Nurses Association
- ANA Scope and Standards of Practice
- ANA Position statement on Care Coordination and Registered nurse Essential Role (2012a)
  "Patient-centered care coordination is a core professional standard and competency for all registered nursing practice..."
- ANA White paper: The Value of Nursing Care Coordination (2012b)
- ANA Framework for Measuring Nurses’ Contribution to Care Coordination (2013)
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**ANA Scope and Standards of Practice**

- **STANDARD 5. IMPLEMENTATION**
  - The registered nurse implements the identified plan.
  - **STANDARD 5A. COORDINATION OF CARE**
    - The registered nurse coordinates delivery.
  - **STANDARD 5B. HEALTH TEACHING AND HEALTH PROMOTION**
    - The registered nurse employs strategies to promote health and a safe environment.
  - **STANDARD 5C. CONSULTATION**
    - The graduate-level prepared specialty nurse or advanced practice registered nurse provides consultation to influence the identified plan, enhance the abilities of others, and affect change.

**Care Coordination-Transition Management Model (CCTM)**

- **2011 CCTM Model Development**
  - Dr. Sheila Hass and Dr. Beth Ann Swan
- **Vision**
  - Standardize work of ambulatory, acute, subacute and home care providers related to CCTM
- **Dimensions and KSA’s (Knowledge, Skills and Attitudes)**
- **Recommended CMS reimbursement for RN-CCTM**

**CCTM Core Curriculum**

**Models for Transitions of Care**

**Hospital to Home Transition Models**
- Better Outcomes for Optimizing Safe Transitions (BOOST)
- Society for Hospital Medicine - 2008, 2014
- Transitional Care Model (Naylor)
- Care Transitions Intervention (Coleman)
- Project Re-Engineered Discharge (RED)
- SMART Discharge Protocol (R4)
- Bridge Program
- Enhanced Discharge Planning Program

**Practice-based Care Coordination Models that include Care Transitions Elements**
- Guided Care
- Care Management Plus
- IMPACT (Depression, Diabetes)
- MCCD: Best practice sites (CMS)
- Massachusetts General Care Management Program
- Geriatric Resources for Assessment and Care of Elders (GRACE)

**Other Initiatives**
- INTERACT
- State Action on Avoidable Re-hospitalization (STAAR)

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Project Boost

- **Goal:**
  - High-risk patient identification, application of risk-specific interventions
  - Reduce 30 day readmission rates for general medicine patients
  - Reduce length of stay
  - Improve patient satisfaction scores
  - Improve information flow between inpatient and outpatient providers
  - Improve patient and family preparation for discharge

BOOST Tools

- TARGET (8P Risk Assessment)
- Risk Specific Interventions
- Universal checklist
- GAP

http://www.hospitalmedicine.org/Webs/Quality_Innovation/Mentored_Implementation/Project_BOOST/Project_BOOST.aspx

Patient PASS: A transition record

Project RED (Re-Engineered Discharge)

- RED Toolkit developed by Agency for Healthcare Research and Quality (AHRQ) working with Boston University Medical Center:
  - Delayed transfer of discharge summary
  - Unknown test results
  - Lack of follow-up
  - Medication reconciliation and adverse events
- Consists of 12 actions to ensure smooth and effective transition at discharge

Project RED (Re-Engineered Discharge)

1. Language assistance
2. Follow-up appointments
3. Plan for pending tests/labs
4. Arrange post-discharge services/equipment
5. Discharge medication reconciliation and procurement
6. Reconcile the discharge plan with national guidelines (CHF, Stroke)
7. Teach written discharge plan patient can understand
8. Educate pt. on diagnosis/meds
9. Review problem management
10. Assess patient's understanding of discharge plan
11. Facilitate DC summary to next care provider
12. Discharge call back reinforcing plan

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**INTERACT™**

**Background:**
- Supported by CMS. Used by many nursing homes across the country.
- Current quality improvement project supported by a grant from the Commonwealth Fund, will involve a total of 30 nursing homes in 3 states.

**Goal:**
- Improve identification, evaluation, and communication about changes in resident status.
- Reduce frequency of transfers to the acute hospital.

**Tools**

- Acute Care Transfer Document checklist
- SBAR Communication Form and Progress Note
- Hospital to Post Acute Care

**Care Paths**

- Educational/decision support tools:
  - Acute Mental Status Change
  - Fever
  - GI Symptoms – nausea, vomiting, diarrhea
  - Shortness of Breath
  - Symptoms of CHF
  - Symptoms of Lower Respiratory Illness
  - Symptoms of UTI

**Common Characteristics of all Models of CCTM**

- Identify at risk patient – skills or services
- Patient/family engagement, goal identification and education (lifestyle, medications, symptom management)
- Comprehensive care plan- short and long term

**Organizational Support Required for Effective CCTM**

- Organizational priority
- Risk stratification process
- Comprehensive needs assessment and patient centered plan of care
- Timely communication between providers
- Facilitation of access to follow-up care

**Leadership competencies**

- Organizational Support
- Patient/Family Needs
- CCTM Competencies

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**AMSN Leadership Competencies**

- Clinical knowledge and expertise
  - including population health and chronic disease management
- Emotional Intelligence
- Communication Skills
- Coordination Skills
  - Providers, insurance, community resources
- Collaboration Skills

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**CCTM Competencies**

1. Advocacy
2. Education and Engagement of Patients and Families
3. Coaching and Counseling of Patients and Families
4. Patient-centered Care Planning
5. Support for Self-management
6. Nursing Process

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**CCTM Competencies**

7. Teamwork and Collaboration
8. Cross Setting Communications and Care Transitions
10. CCTM Between Acute Care and Ambulatory Care
11. Informatics Nursing Practice
12. Telehealth Nursing Practice

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**CCTM/Leadership Competencies**

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**CCTM/Leadership Competencies**

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Additional Specialized Skills

- Chronic Disease Assessment/Care Planning
- Health Insurance/Benefits
- Community Resources
- Research and Evaluation Skills

Advocacy

Patient and Population level

- Identifying barriers: financial, transportation, psychosocial, health literacy
- Understanding link between health and poverty, homelessness, mental illness, aging and frailty, intellectual and developmental disabilities
- Care addresses unique needs of these groups

Professional

- Policy development affecting health care delivery and design

Education and Engagement of Patients and Families

- Assess readiness, knowledge and abilities
- Methods
  - "Universal precautions" approach
  - Active listening
  - Teach back
  - Ask me three
- Prioritization: Survival, ease, resources

**Bring This Plan to ALL Appointments**

Oscar Sanchez
Discharge Date: August 1, 2012

TRY TO QUIT SMOKING: Call Jon Doe at (555) 555-3344 at ABC Medical Center.


### Medicines

<table>
<thead>
<tr>
<th>Time of Day</th>
<th>Medication</th>
<th>Amount</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning</td>
<td>Blood Pressure Procida X Nilepine</td>
<td>90 mg</td>
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<tr>
<td>Morning</td>
<td>Hydrochlorothiazide</td>
<td>25 mg</td>
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<tr>
<td>Morning</td>
<td>Clonidine HC</td>
<td>0.1 mg</td>
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<tr>
<td>Morning</td>
<td>Lipitor Atorvastatin Calcium</td>
<td>20 mg</td>
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</tr>
<tr>
<td>Morning</td>
<td>Protonix Pantoprazole Sodium</td>
<td>40 mg</td>
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</tr>
<tr>
<td>Morning</td>
<td>Aspirin EC</td>
<td>325 mg</td>
<td>1 pill</td>
</tr>
</tbody>
</table>

**Bring this Plan to ALL Appointments**

Oscar Sanchez

What is my main medical problem?

Chest Pain

When are my appointments?

- Wednesday, August 8 at 11:30 a.m.
- Thursday, August 16 at 3:20 p.m.
- Wednesday, September 12 at 9:00 a.m.

For a Followup appointment For your arthritis To check your heart

Office Phone: (555) 555-5555 Office Phone: (555) 555-6666

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Coaching and counseling of patients and families

Nursing Process/Patient Centered Care Planning

Comprehensive Assessment
- Physical
- Psychosocial
- Functional
- MiniCog
- Get up and Go Test

Patient Self Management Skills Common to all Chronic Conditions
- Stress reduction
- Interactions with health care providers
- Obtaining needed information
- Adapting to work
- Managing relations
- Managing emotions

Teamwork and Collaboration- MUST HAVES
- Break down barriers (handoffs, schedules, technology, communication styles)
- Use structured communication methods
  - Huddles, SBAR
  - Routine Case reviews, conferences
  - EMR standards
  - Virtual communication methods- telehealth, paging systems, Skype
- Difficult Conversations

Population Health Management
- Incorporates preventative, wellness and chronic care needs

Telehealth
- Utilizing telephone, fax, email, internet, video monitoring and interactive video for information exchange

Informatics Nursing Practice
- Integration of nursing science, computer science and information science
CCTM between acute and ambulatory care

Factors influencing poor transitions:
- Ineffective communication and care coordination
- Lack of follow-up care
- Insufficient patient/caregiver education
- Non-adherence to the plan of care
- Unavailability of resources

Patient variables affecting transitions

Neurological
- Decision making ability/surrogate – guardian needed
- Language barrier/health literacy
- Short and long term functional deficits
- Power of Attorney for HealthCare

Respiratory
- Oxygen requirement
- CPAP/BIPAP/Ventilator
- Tracheostomy/Suction
- Chest tube/pleurX catheter
- COPD diagnosis

Cardiac
- Anticoagulant therapy
- Vascular Access Device
- Life vest
- CHF diagnosis

GI/Nutrition
- Dialysis
- Foley/straight cath/drain

Renal/Urological
- Dialysis
- Foley/straight cath/drain

Patient variables affecting transitions

Musculoskeletal
- Weight bearing status/endurance
- Cast, brace
- Assistive device

Integumentary
- Wound care/dressings
- Support Surface

Psychosocial/Emotional
- Goals of care unclear
- End of life decisions – need for POLST
- Homeless/living in group home
- Addictions/Psychiatric diagnosis
- Transportation
- Lack of support

Patient Variables Affecting Transitions

Funding/Payer/Regulatory/Plan of Care Consideration

- Medications – cost and schedule
- [NOA, vancomycin, ABX, narcotics] adherence
- Observation vs inpatient/life care contracts
- DME/home care needs/preferred provider face to face
- Lack of insurance/underinsured
- Undocumented
- Out of network
### Real Patients - Real Challenges - #1

- 56 year old male with progressive neurological disease
- Able to perform ADL’s, mobile, alert and oriented
- Lives 250 miles from hospital
- Elective tracheostomy for airway protection
- Discharge needs:
  - Education, psychomotor skills
  - DME, home care and supplies
  - Follow-up

### Real Patients - Real Challenges - #1

<table>
<thead>
<tr>
<th>CCTM Competencies</th>
<th>Leadership competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education/Coaching/</td>
<td>Clinical Knowledge</td>
</tr>
<tr>
<td>Care planning</td>
<td>Emotional Intelligence</td>
</tr>
<tr>
<td>Nursing Process</td>
<td>Communication</td>
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<td>Cross Setting</td>
<td>Coordination</td>
</tr>
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<td>Communication</td>
<td>Collaboration</td>
</tr>
<tr>
<td>Advocacy</td>
<td></td>
</tr>
</tbody>
</table>

### Real Patients - Real Challenges - #2

- 42 year old female, non English speaking, Medicaid
- Admitted with pelvic abscess and needs IV antibiotics for 2 weeks after discharge
- No family transportation available
- Going home with PICC line
- Coordinated with ID to get 1x day antibiotic, arranged for care at outpatient infusion center, Medicaid covered transportation to/from infusion center

### Real Patients - Real Challenges - #3

- 45 year old on his 3rd admission for alcohol detox- on BP meds
- No insurance
- Chemical dependency nurse already has relationship with patient from previous admissions
- Patient finally agrees to go to 30 day treatment program after hospitalization
- Bedside RN facilitates all consultants signing off to coordinate with day treatment program has bed

### Real Patients - Real Challenges - #3

- Bedside RN ensures prescriptions written for patients medications and 30 day complimentary supply arranged at hospital’s preferred pharmacy
- Cab “voucher” given with one stop at drive through pharmacy to obtain meds since treatment program does not provide

### Real Patients - Real Challenges - #4

- 82 year old married male suffered CVA- lengthy hospitalization (30 days) due to complications but discharged to acute rehab. Wife visited daily and had same PCP as patient.
- Wife told PCP she was having abdominal pain- saw PCP in office- CT scan done- suspicious for pancreatic mass.
- While husband in rehab, wife hospitalized, rapidly declined
- Care manager coordinated with rehab to have husband visit wife while still aware- ambulance, portable oxygen, rehab facility staff accompany

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Impact of patient engagement of health outcomes

- Improved outcomes when patients:
  - Self manage symptoms and problems
  - Engage in activities that maintain function and reduce decline
  - Are involved in treatment and diagnostic choices
  - Collaborate with providers and the team
  - Select providers/organizations that demonstrate quality

Consequences of Ineffective Transitions

- Wrong treatment/unnecessary testing
- Delay in diagnosis/care
- Severe adverse events
- Medication errors-omission
- Patient complaints
- Not honoring patient treatment preferences
- Increased healthcare costs
- Increased length of stay

Critical role of Frontline RN

- Patient history- provides basis for at risk patient
- Goals and plan- short and long term
- Consult services and disciplines to advance plan of care
- Monitor that services and disciplines have been identified, arranged and delivered
- Assist patient/family to identify questions

New initiatives

- Post Acute Networks- NP and protocols for common conditions in rehab settings to prevent readmissions
- Precertification for DME/Home care/Rehab prior to planned surgeries with known needs at discharge
- Adult patient care protocol
- EMR Enhancements
- Medicare contracted DME provider by zip code

Adult patient care protocol

...
Example of Letter of Medical Necessity for authorization for Trach and Suction Supplies

Measuring success

- Avoidable ED visits
- Avoidable re-hospitalizations
- Elimination of unnecessary medications
- Patient experience data- HCAHPS
- Effectiveness of program includes many data points:
  - clinical indicators
  - patient satisfaction
  - financial data
  - research study data (RCT, quasi-experimental studies)

Questions

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Thank you!

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