



Best Practice: Transitional Care Coordination

Home Health Aide Track



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Home Health Aide Track

This best practice intervention package track is designed to educate home health aides in transitional care coordination as it relates to their daily practice and in supporting the goal of reducing avoidable hospitalizations.

Objectives

After completing the activities included in the Home Health Aide Track of this **Best Practice Intervention Package–Transitional Care Coordination** the learner will be able to:

1. Describe transitional care coordination and the role of home health
2. Describe how previous Home Health Quality Improvement Best Practice Intervention Packages support optimal transitional care coordination
3. Recognize the relationship with more active participation of patient and caregiver and reduction of avoidable acute care hospitalization
4. Identify clinical practices that promote effective care transitions

Complete the following activities:

	Activity	Location	Estimated Time
<input type="checkbox"/>	Read “Transitional Care Coordination: Key Points for Home Health Aides”	Page 79	5 minutes
<input type="checkbox"/>	Listen to Transitional Care Coordination: Personal Health Record for MSW & Home Health Aide podcast (audio recording) and use the discussion questions for group interaction	Page 80	25 minutes
<input type="checkbox"/>	Review the Personal Health Record then complete your own PHR	Page 81	20 minutes
<input type="checkbox"/>	Complete the home health aide post-test and give to your clinical manager	Page 90	10 minutes
	Total time for completion		60 minutes



BUILDING UPON THE BASICS

Transitional Care Coordination: Key Points for Home Health Aides

Definitions:

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

Personal Health Record: A tool prepared by the patient with assistance from healthcare providers to help the patient take control of his or her own health care issues and to help with communicating across settings (hospital, nursing home, home health, physician office, home).

Acute Care Hospitalization Connection:

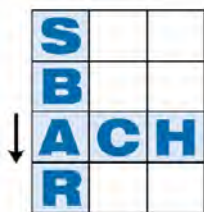
Care transition interventions designed to encourage patients and their caregivers to assume a more active role during care transitions suggests reduction in avoidable rehospitalization rates (Coleman, et al., 2006).



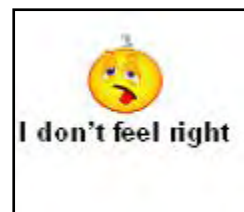
What can “I” do to support transitional care coordination?



- Be aware of factors that may affect the patient taking his or her medications correctly.
- Review patients’ personal health record and encourage them to keep it up to date.
- Remind patients of the need to follow with their physician appointments.
- Use SBAR to communicate patient concerns to the team.



- Ask your patients to locate their emergency care plan during each visit.
- Review the patient home health aide care plan to see if the plan is complete and that you understand your assignments. Communicate any questions to your manager.



Note: For more information about any of these previous topics see the Home Health Aide Tracks on www.homehealthquality.org



Transitional Care Coordination Multi-Media Activity Podcast*

Transitional Care Coordination Podcast Instructions:

Title	Description	Link
Transitional Care Coordination: Personal Health Record for MSW & Home Health Aides	<ul style="list-style-type: none">• This 20-minute audio recording discusses Transitional Care Coordination and the role of home care.• A discussion of the Personal Health Record and previous Best Practice Packages is also included.	The podcast link is located at http://www.homehealthquality.org/hh/hha/interventionpackages/tcc.aspx

*A podcast is a digital media file, often an audio recording, placed on by the Internet and made available to the listener on their home computer or personal digital recording device for convenience.

There are several ways to listen to the podcast:

- Visit the link above and listen directly through the Web site
- Download the podcast by right clicking on the audio file and selecting "Save Target As ..." This will save the file to your hard drive. Once you have saved the file, you can listen to it on your computer or can save the audio file to a CD or MP3 player.

Discussion Topics

1. During one of your patient visits, it is determined between the patient and the office nurse that the patient needs sent to the emergency department (a transition in care).
 - Who would you notify?
 - What information would you need to provide?
 - What would you suggest that the patient/family take with them to the emergency department?
2. Your patient has now returned home from the hospital (a transition in care).
 - What information would you need to know to provide quality care?
 - Where would you find that information?
 - o Where would you go or whom would you call to get information you do not have?
3. Look at the sample Personal Health Record and discuss what home health aides can do to encourage patients to use the record and tips for patients to remember to take it with them to the physician's office, hospital or any other health provider.



Personal Health Record

The Personal Health Record (PHR) is a tool that is featured on the **Transitional Care Coordination: Personal Health Record for MSW & Home Health Aide** podcast. A PHR helps the patient take control of his or her own health care issues and assists with communication across settings.

To obtain a better understanding of the PHR and its application, you can complete this sample PHR (beginning on the next page) for yourself. You can use the PHR as you cross care settings, visit physician offices, etc.

Your Personal Health Record

*Remember to take this
record with you to all of your
medical appointments and
hospitalizations*



The Personal Health Record of:

_____ DOB: __/__/__

Personal Information

Address: _____

Home Phone: _____

Alternate Phone: _____

Caregiver Information

Name: _____

Home Phone: _____

Alternate Phone: _____

Relationship: _____

Health Care Providers

Physician: _____ Ph: _____

Specialist: _____ Ph: _____

Specialist: _____ Ph: _____

Home Care Provider(s)

ALWAYS take insurance cards with you!

Advance Directives

Advance Directives? Yes No

Do Not Resuscitate Comfort Care

Health Care Proxy

Name of Proxy: _____

Medical History

- Arthritis
- Abnormal Heart Rhythm
- Cancer
- Diabetes
- Hardening of the Arteries
- Heart Disease
- Heart Failure
- High Blood Pressure
- Hip Fracture/Replacement
- Lung Disease
- Medical/Surgical Back Conditions
- Pacemaker Serial # _____
- Pneumonia
- Stroke

Other Diagnoses: _____

Hospital/Facility Discharge Checklist

Before I leave the care facility, the following tasks should be completed:

- I have been involved in decisions about what will take place after I leave the facility.
- I understand where I am going after I leave this facility and what will happen to me once I arrive.
 - Discharge to other facility
 - Discharge to a home health agency
 - Discharge home to care of self/family
- I have the name and phone number of a person I should contact if a problem arises during my transfer.
- I understand what my medications are, how to obtain them, and how to take them.
- I understand the potential side effects of my medications and whom I should call if I experience them.
- I understand what symptoms I need to watch out for and whom to call should I notice them.
- I understand how to keep my health problems from becoming worse.
- My doctor or nurse has answered my most important questions prior to leaving the facility.
- My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.



Home Health Aide Transitional Care Coordination Post-Test



Clinician _____ Date _____

Directions: Choose the ONE BEST response to the following questions. Circle your answer that identifies the ONE BEST response.

1. Transitional care coordination is a set of actions to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location.
 - A. True
 - B. False
2. Personal health records should include the following information:
 - A. Caregiver(s) name and phone number
 - B. Physician(s) name and phone number
 - C. Advance Directives
 - D. Current medications and allergies
 - E. All of the above
3. Home health aides can assist patient/caregiver with their Personal Health Record (PHR) by:
 - A. Reminding patient/caregiver to keep PHR current with medications and physician appointments
 - B. Reminding patient/caregiver to write questions to physicians in the PHR
 - C. Reminding patient/caregiver to take PHR to physician office appointments
 - D. All of the above
4. The following are examples of what a patient/caregiver could write in the "Notes" section of their Personal Care Record:
 - A. "Tell the doctor about the fall I had on February 1st."
 - B. "Ask the doctor about my blood work results from last week."
 - C. "Tell the doctor I need refills on my Lasix and Prilosec."
 - D. "Ask the homecare nurse to explain my diet again."
 - E. All of the above
5. Transitional care includes the handover between a variety of settings including hospitals, home, skilled or rehabilitation facilities, physician offices, hospice and community.
 - A. True
 - B. False

Answers to Post-test are located in the Leadership Section page 30.