



Best Practice: Transitional Care Coordination

Medical Social Worker Track



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Medical Social Worker Track

This best practice intervention package track is designed to educate social workers 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 Medical Social Worker 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 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 Social Workers”	Page 63	10 minutes
<input type="checkbox"/>	Read “Care Transitions: Joe’s Story”	Page 64	5 minutes
<input type="checkbox"/>	Listen to Transitional Care Coordination: Personal Health Record for MSW & Home Health Aide podcast	Page 65	20 minutes
<input type="checkbox"/>	Review the Personal Health Record then complete your own PHR	Page 66	15 minutes
<input type="checkbox"/>	Complete the social worker post-test	See link below	10 minutes
	Total time for completion		60 minutes



Transitional Care Coordination Key Points for Social Workers

BUILDING UPON THE BASICS

Definition:

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 health care providers to help the patient take control of his or her own health care issues and to help with communication across settings (hospital, nursing home, home health, physician office, home).



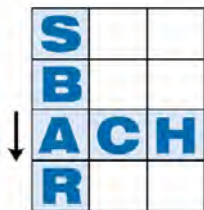
Acute Care Hospitalization Connection:

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).

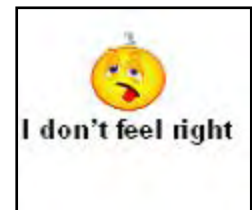
What can “I” do to support transitional care coordination? Build upon the Basics!



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



- Ask your patients to locate their emergency care plan during each visit.
- Communicate with other interdisciplinary team members to ensure smooth patient transitions from one discipline to the other.



Note: For more information about any of these previous topics see the MSW tracks on www.homehealthquality.org

Care Transitions: Joe's Story

Joe is a 72 year-old retired farmer. He lives with his wife in a modest rural home. His wife takes responsibility for managing Joe's diet and medications. Joe recently experienced his first bout of heart failure for which he was hospitalized. He has a history of COPD and osteoarthritis. He was actively followed by home health for physical therapy prior to this hospitalization. The following depicts optimal **care transition activities** that should occur during **handovers** between health care practitioners and settings. Note the focus on the four pillars of care transitions:

1. **Assistance with medication self-management**
2. **Patient-centered health record owned and maintained by the patient**
3. **Timely informed primary care physician (PCP)/specialist follow-up**
4. **Knowledge of red flags indicative of worsening condition and instructions on how to respond**

Handover: Home to Hospital

- Joe takes his personal health record with him to hospital
- Home medications are reconciled on admission to hospital

Hospital Prepares for Discharge to Home

- Wife is identified as primary caregiver/learner
- Patient-friendly discharge instructions are provided specific to diet, medication, daily weights, when to see PCP, cardiologist and reasons to seek medical help, including numbers to call
- Personal health record is updated by patient with coaching from hospital discharging clinician as needed



Handover: Hospital to Home Health

- Referral to home health services includes Joe's condition, functional status, medical history and all medications and instructions provided
- Medications are reconciled on admission to home health
- Admitting home health clinician reviews personal health record and hospital discharge instructions with Joe and his wife
- A patient emergency care plan is collaboratively established with information on when to call agency or seek emergency care
- Home health clinician ensures that Joe or his wife schedules and keeps follow-up appointments
- Home health clinician updates PCP on Joe's status, including self-management goals

Handover: Home Health to Physician

- Wife prepares list of questions and concerns to discuss at physician appointments with coaching by home health nurse as needed
- Joe takes personal health record to PCP and cardiologist visits
- Joe updates personal health record with coaching by physician office staff as needed





Transitional Care Coordination Multi-Media Activity

Podcast*

Transitional Care Coordination Clinician Podcast Instructions:

Title	Description	Link
Transitional Care Coordination: Personal Health Record for MSW & Home Health Aide	<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 included also. 	<p>The podcast link is located at http://www.homehealthquality.org/hh/ha/interventionpackages/tcc.aspx</p>

*A podcast is a digital media file, for use on a 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

Personal Health Record

The Personal Health Record (PHR) is a tool that was featured on the **Transitional Care Coordination: Personal Health Record for MSW & Home Health Aide** podcast. The PHR assists the patient take control of his or her own health care issues and with communicating across settings. To obtain a better understanding of the PHR and its application, you can complete this sample PHR (starting 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.



Medical Social Worker Post-test Transitional Care Coordination



Clinician Name _____

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. Home care can support transitional care coordination by the following actions **except**:
 - A. Developing and maintaining an emergency care plan with the patient/caregiver
 - B. Reconciling medications
 - C. Encouraging physician follow-up appointments
 - D. Coordinating nursing and social worker visits to provide one service on a given day
 - E. Initiating/educating on a Personal Health Record
3. 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
4. Medical social workers can assist patient/caregiver with the patient's Personal Health Record (PHR) by all of the following **except**:
 - A. Assist patient/caregiver in completing the PHR
 - B. Remind patient/caregiver to keep PHR current with medications and physician appointments
 - C. Encourage patient/caregiver to write questions to physicians in the PHR
 - D. Remind patient/caregiver to take PHR to physician office appointments
 - E. Order appropriate laboratory studies

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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 on page 30.