CARE COMPASS NETWORK

Title: 9 Guidelines for 30 Day Care Transitions
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Clinical Guideline # CGC-CG-01

Purpose: The purpose of these guidelines is to provide some level of consistency across those organizations within the Care Compass Network participating in project *2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions*. Based on outcomes from similar programs within the region, it is believed by the Care Compass Network 2.b.iv project planning committee that inclusion of these guidelines in program implementation will promote optimal project outcomes.

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1. Support Community Referrals

1.1 Purpose/ Description:

Provide and coordinate services that support patients to develop, meet, and maintain self-management care goals. In essence, empower patients and their caregivers to understand how best to access appropriate care and to be their own advocate.

1.2 Guidelines:

- Evaluate any existing relationships with community organizations.
- Assist patients in accessing healthcare services with optimal efficiency.
- As indicated, refer patients to additional care providers that will complement their self-management goals and assist patient/caregiver to schedule appointments/complete relevant application forms. For example (but not exclusively):
    - Primary/specialty care provider
    - Long term home care
    - Palliative care
    - Hospice
    - Diabetes consultation
    - Smoking cessation
    - Weight loss programs
- As indicated, refer patients to additional community-based programming that will complement their self-management goals and assist them to schedule appointments/complete relevant application forms. For example (but not exclusively):
    - County/Office for the Aging
    - Prescription support programming
    - Family and children's services
    - WIC (Women, Infants and Children)
    - Housing support

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2. Create Virtual Support Groups/RMS Panel

2.1 Purpose/Description:

The RMS Panel could give good insight on beneficiaries' and providers' understanding of Care Transition program, willingness to have a Care Transition Coach come to the home and benefits expected from the Care Transition Program.

2.2 Guidelines:

- ✓ Community Resource Guide
- ✓ Where to Refer – most appropriate based on
  - Diagnosis
  - Other
- ✓ Assess Patient Resource
- ✓ Process to follow

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3. Create Warm Hand Offs/Minimize Hand Offs

3.1 Purpose/Description:

In order to optimize care coordination and encourage patient engagement as patients move among providers, sites of care, and levels of care, hand offs should be minimized. Hand offs refer to the transfer of patient care from one care team member to the next and need to be collaborative and thorough in order to optimize patient outcomes (and prevent patient harm).

In "warm hand offs" a care team member directly introduces the patient to the next in efforts to establish an initial face-to-face contact between the patient and the caregiver while conferring the trust and rapport the patient has already developed with the previous care team member.

3.2 Guidelines:

- Review patient history and discharge plan of care prior to meeting them
- Whenever possible, and with the patient consent, involve the patient's family and/or caregivers in discussions surrounding the plan of care.
- Facilitate introductions of new care team members
- When communicating to care team members be thorough and direct, ask yourself, "what do I know that others need to know in order to provide optimal care/coaching to this patient?"

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4. Encourage Family/Caregiver Involvement

4.1 Purpose/Description:

Patient families and/or caregivers are important members of the patients extended care team. In support of optimal care coordination, patient family members and/or caregivers should be included in all aspects of the care transitions process – with the patient's consent. Successful engagement of families/caregivers can lead to enhanced engagement of the patient and inclusion of the entire care team in the hospital discharge planning process promotes patient outcomes and patient safety.

4.2 Guidelines:

<u>During the hospital stay:</u>

- If applicable, identify members for the patients extended care team and include them in care planning conversations and all aspects of the DSRIP care transitions program:
    - Medication self-management
    - Overall plan of care including any follow up appointments and the importance of keeping them
    - Recognition of signs/symptoms of worsening disease and how best to respond including who to contact in the event of problems
    - How to maximize use of the personal health record
- Listen to and honor the family/caregiver preferences and concerns - clarify and confirm your understanding.
- Ensure that patient preferences, goals, and experiences are communicated to provider and all members of the patient's care team

<u>During the home visit/follow-up phone calls:</u>

- Continually assess patient care needs and make referrals to community resources as indicated
- Engage family/caregivers in medication management
- Reinforce how to recognize signs/symptoms of worsening disease and how best to respond including who to contact in the event of problems
- Work with family/caregivers to coordinate the overall plan of care including any follow up appointments

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5. Promote Health Literacy

5.1 Purpose/Statement:

Health literacy refers to one's ability to obtain, process, and understand basic health information and services needed to make appropriate health decision. For whatever reason, many patients lack health literacy or a true understanding of their medical condition and therefore are somewhat incapable of making the best decisions about their own care and treatment.

5.2 Guidelines:

- Review patient's full history prior to meeting with them
- Assess patient (and family/caregiver where applicable) level of understanding – consider any religious and/or cultural barriers to understanding
    - Tailor approach based on assessment
- Connect patients to available community resources (see 1. Support Community Navigation)
- Provide education tools and resources that are appropriate for the patient's level of health literacy

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6. Maximize Care Team Collaboration

6.1 Purpose/Description:

Successful care transitions require a collaborative approach among care providers – nurses, physicians, social workers, and community based services. Coordinating care effectively is a complex activity, particularly in the context of coordinating services offered outside the hospital. Care team members should work collaboratively to maximize patient engagement and minimize avoidable readmissions.

6.2 Guidelines:

- Create clarity around roles and responsibilities to minimize confusion and promote patient engagement.
- Maintain continuity and familiarity – warm hand offs
- Where possible, develop a plan of care/discharge plan within 24 hours of admission
- Participate and assist in coordinating the discharge or transfer process
- Work with discharge planner to set an expected date of discharge within 48 hours of admission
- Review plan of care/discharge plan daily
- Involve patients and caregivers in care plan development
- Utilize LACE Assessment or similar tool to determine level of care coordination needed upon discharge.
- Link primary care/community services and other community based organizations
- Ensure that patients' preferences, goals, and experiences are communicated to providers

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7. Meet Patients Physically Where They Are

7.1 Purpose/Description:

Patient engagement begins upon first introduction. Early engagement may positively impact patient's likelihood to participate.

7.2 Guidelines:

- Patients who meet program criteria will be identified within 24 hours of admission to the hospital by Care Transitions contracted care provider.
- Contracted providers review will introduce Care Transitions to the patient during their inpatient stay.
    - Inform patient on Care Transitions process/goals, role of community health provider
    - Introduce the Patient Personal Health Record
    - Obtain consent from patient to have Care Transition Coach follow up post discharge
    - Coordinate and collaborate with the hospital staff involved in patient discharge, including making all appropriate documentation entries
- Once discharged, patients will receive a home visit at their community location within 72 hours of discharge
    - Establish Date, Time and Location
    - Employ Motivational Interviewing
    - Coordinate with Family/Caregivers
- Follow-up telephone calls to the patient will be made in approximately 7 day increments during the 30 day post discharge period

8. Outreach and Engagement

8.1 Purpose/Description:

Early engagement and outreach provides greater opportunity to establish rapport with patients, organize and plan services, and to work closely with the interdisciplinary team to develop a comprehensive transition of care plan to ensure program success.

8.2 Guidelines:

- Identify patients qualifying for Care Transitions programming
- Engage with indicated services/providers currently working with patient
- Understand the discharge plan developed by the hospital
- Meet with patient (family or caregivers) prior to discharge
    - Educate them on Care Transitions process/goals, role of community health provider
- Introduce the Patient Personal Health Record
- Schedule home visit within 3 business days after discharge

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9. Provide Incentives

9.1 Purpose/Description

To incentivize Medicaid members to better manage and take greater responsibility for their care, incentives may be offered to members as part of/during the care transition period.

9.2 Guidelines:

- ✓ When
  - Frequency
  - What Determines
  - Type
- ✓ Consistent with Medicaid Regulation
- ✓ Consistent Across PPS (Performing Provider System)

Date	Revision Log	Updated By
2/19/16	Initial Draft	D. Sculley

These Guidelines shall be reviewed periodically and updated consistent with the requirements established by the Board of Directors, Care Compass Network's senior management, Federal and State law(s) and regulations, and applicable accrediting and review organizations.