



COORDINATING CARE USING TRANSITIONAL STRATEGIES

Navigating the “Black Hole”

*Lecia Snell-Kinen, MSN, APRN-CSN, CCTN
Vice President, Transplant and Cardiac Services*

BioScrip

Disclosures

Faculty Disclosure

As a sponsor accredited by the ACCME, the ACPE and the ANCC to provide continuing education for the healthcare team, OptumHealth Education requires the disclosure of all relevant financial relationships a faculty member has with any commercial interest. The faculty reported the following:

- Ms. Snell is an employee of BioScrip.

Reviewer Disclosures

To ensure fair balance and avoid bias, the content for this activity has been reviewed by an independent medical expert with no relevant financial relationships and has been approved by OptumHealth Education.



Objectives

- Examine the costs of readmissions
- Describe risk factors for readmissions
- Examine transition strategies to reduce readmissions and improve patient outcomes

Case Presentation

JF is a 62 year old male with Stage D heart failure secondary to viral cardiomyopathy. He was referred for heart transplant evaluation. He was hospitalized and initiated on inotrope therapy as a potential bridge to VAD.

Other comorbidities include HTN, CAD with h/o MI and diabetes. He is recently widowed and has 3 children that are supportive of his health care needs. His home is about 50 miles from the transplant center.

Case Presentation

The Discharge

- He was discharged to home yesterday on continuous IV milrinone. The decision to discharge him was made on rounds at 1:30 pm. His daughter can take him home at 5:00 pm
- **JF is stable on his current dose of milrinone; his Na and K levels are not stabilized; discharge orders include daily lab draws with changes made accordingly on an outpatient basis**
- A follow up MD appointment is made for one week later

Discharge instructions

METHOD		DESTINATION		<input checked="" type="checkbox"/> General	<input type="checkbox"/> Diabetic diet
<input checked="" type="checkbox"/> Wheelchair	<input type="checkbox"/> Cart	<input checked="" type="checkbox"/> Home	<input type="checkbox"/> Home health care	<input type="checkbox"/> 2,000 mg sodium/low fat/low cholesterol	<input type="checkbox"/> Other <i>low fat/low cholesterol</i>
<input type="checkbox"/> Walk	<input type="checkbox"/> No restrictions	<input type="checkbox"/> Food/Drug interaction			
Options: <i>Push/pull</i>		Options: <i>Push/pull</i>		<input checked="" type="checkbox"/> Restrictions: <i>avoid heavy lifting</i>	
Options: <i>Drive car</i>		Options: <i>Drive car</i>		<input checked="" type="checkbox"/> Restrictions: <i>no driving</i>	
Options: <i>Other</i>		Options: <i>Other</i>		<input type="checkbox"/> Other	
When restrictions are lifted, exercise 30 minutes/day.					
CONSULT YOUR PHYSICIAN IF:			SPECIAL INSTRUCTIONS OR TREATMENTS		
nos more severe. 101°F. less, increases, or becomes foul smelling. ig. <i>low back</i> slon. st pain or shortness of breath. is, overnight 15 lbs. in one week. the swelling in legs/ankles/belly.			HF - Weigh yourself first thing every morning. Stop smoking. Limit alcohol intake. <i>Surgeon's instructions - avoid alcohol</i> <i>stay to take hygiene tabs every morning and</i> <i>Corzear 100 mg in evening</i> <i>Deprotein 200mg daily</i> <i>Chyburide 30mg</i>		
SCHEDULE	ACTION/USE	COMMENTS	ASSISTING SERVICES		
<i>100 mg</i>	<input type="checkbox"/> PO	<i>100 mg</i>	For home nursing care and equipment, you may contact Memorial Home Care at (674) 273-2273.		
<i>200 mg</i>	<input type="checkbox"/> PO	<i>200 mg</i>	For your convenience, medications are available at Memorial Family Pharmacy; their phone number is (674) 647-7176.		
<i>100 mg</i>	<input type="checkbox"/> PO	<i>100 mg</i>			
<i>100 mg</i>	<input type="checkbox"/> PO	<i>100 mg</i>			
<i>100 mg</i>	<input type="checkbox"/> PO	<i>100 mg</i>			
<i>100 mg</i>	<input type="checkbox"/> PO	<i>100 mg</i>			
IP You are scheduled to see:					
Date	<i>2/27/10</i>	Phone	<i>237-1340</i>		
Date		Phone	<i>237-1340</i>		
SIGNATURES					
I understand the above instructions, and all of my medications and... been returned to me.					
Date	<i>2/27/10</i>	Nurse Signature	<i>[Signature]</i>		
Physician Signature (Optional)		Date			
ORIGINAL - Patient COPY - Medical Record					
INSTRUCTIONS <i>[Handwritten notes]</i>					



Case Study

Home Visit

- The home care nurse is visiting him today to assess his status and continue teaching on medications, self-care monitoring/care needs, and inotrope management.
- The home care nurse does not have a copy of the discharge summary. She is unaware of his baseline BP, weight, and pulse. She is unaware of what parameters should be called to the physician. She is also unaware of the plan of care related to transplant.
- She does not know when JF is scheduled to be seen again by the MD

Case Presentation

The nurse calls the office nursing coordinator and asks for information. The nurse coordinator from yesterday is off on vacation today.

The daughter tells the nurse that she thinks they are planning to do some type of surgery before his transplant. But she states “We received so much information over the past few weeks, I really don’t know what is happening. We go back to the transplant center next week.”

Case Presentation

- On the next home visit 2 days later, the patient tells the nurse that he feels more short of breath, but it still “isn’t as bad as it used to be”.
- His weight is up 3 lbs since the last visit. His pulse and BP are slightly elevated as well. The nurse does not know this as she does not have his baseline data.
- The nurse continues teaching the patient about his medications and inotrope management. She changes the dressing on his PICC line.
- The nurse tells him that she will call tomorrow to check on him.

Case Presentation

The Readmission

JF never receives the follow up call from the home nurse because he was readmitted to the hospital with c/o SOB and pitting edema in his extremities after calling “911” during the night.

It was determined that JF was not taking the right dose of diuretics due to poor medication reconciliation. His lab was not drawn as ordered; there was no follow-up and adjustments regarding his electrolytes

Potentially Preventable Hospitalizations

- Are prevalent, costly, burdensome for patients and families and frustrating for health care providers
- No one provider can “just work harder”
- Problem is exacerbated by highly fragmented delivery system in which providers act in isolation and patients become responsible for their own care coordination
- Most payment systems reward maximizing units of care delivery rather than quality of care over time

Hospitalizations and Readmissions

- 19.6 % of nearly 12 million Medicare discharged from the hospital were re-hospitalized within 30 days¹
 - 34% within 90 days
- Medicare heart failure readmissions = 24% within 30 days
- Readmission rates are considered a reflection of quality of care
 - Incomplete treatment
 - Poor care of underlying problem
 - Poor coordination of discharge services²
- Significant costs both financially and to patient outcomes

Jencks, et al., NEJM, 2009, 360: 1418-1428¹

Goldfield NI, et al. Health Care Financing Review. 2008; 30(1):75-91²

Financial Costs

- Up to a 3% cut to all DRGs for readmissions over the expected rate
- Up to 1% in fiscal year 2013, 2% in FY 2014 and not to exceed 3% in FY 2015 and beyond
- Initially: AMI, pneumonia and heart failure
- Expands to COPD, CABG, PTCA and other vascular conditions in 2015
- 10 year savings = \$ 71 billion
- The proposed prospective payment system began Oct. 2012 (FY 2013)

Costs of Readmissions

- Hospital re-admissions for the 19.6 percent of Medicare patients, who must be readmitted within 30 days of their original release, cost the U.S. health care system approximately \$15 billion a year

Systemic Costs of Poor Transitions



NATIONAL TRANSITIONS OF CARE COALITION

Improved Transitions of Patient Care Yield Tangible Savings;
<http://www.ntocc.org/Portals/0/PDF/Resources/TangibleSavings.pdf>

Costs to Patient Outcomes

- Medication errors harm an estimated 1.5 million people each year in the U.S., costing the nation at least \$3.5 billion annually
- An estimated 66 percent of medication errors occur during transitions: upon admission, transfer or discharge of a patient

Systemic Costs of Poor Transitions

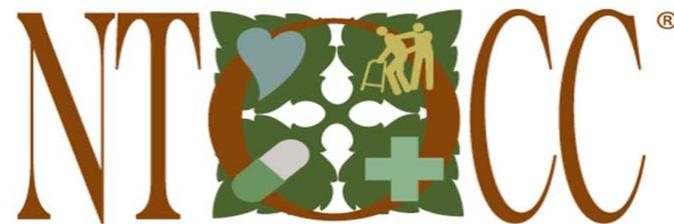


Improved Transitions of Patient Care Yield Tangible Savings;
<http://www.ntocc.org/Portals/0/PDF/Resources/TangibleSavings.pdf>

Costs to Patient Outcomes

- Decline in functional capacity
- Nosocomial Infection
- Adverse event
- Decreased quality of life
- In hospital - mortality

Systemic Costs of Poor Transitions



NATIONAL TRANSITIONS OF CARE COALITION

Improved Transitions of Patient Care Yield Tangible Savings;
<http://www.ntocc.org/Portals/0/PDF/Resources/TangibleSavings.pdf>

The Problem

- Hospital discharges are not standardized
- Current structure relies on behavior of individuals
- At Discharge: ¹
 - 63% unable to state the purpose of their meds
 - 58% unable to state their diagnosis
- 41% of inpatients discharged with a pending test result ²
 - 37% actionable and 13% urgent
 - 2/3 of physicians unaware of results

¹Patients' Understanding of Their Treatment Plans and Diagnosis at Discharge. Amgad N. Makaryus, MD, Eli A. Friedman, MD. Mayo Clinic Proceedings. August 2005; 80(8):991-994.

²Annals of Internal Medicine. 2005; 143(2):121-8.

- *“Readmissions are not primarily about people being rehospitalized because of mistakes made in the hospital. Readmissions are about making transitions effectively. Taking care of people with ongoing problems or chronic illnesses and frailty. Transitions of care not done well...evidence suggests they wind up back in the hospital.”*

Stephen Jencks, M.D., former senior clinical adviser to CMS

Efforts to Reduce Readmission Rates

- Project Boost (Better Outcomes for Older Adults through Safe Transitions): Society of Hospital Medicine
 - Significant decrease in readmissions in centers that utilized¹
- The Transitional Care Model (TCM): University of Pennsylvania
 - Demonstrated significant reductions in cost
 - \$3000/patient at 24 weeks²
 - \$5000/patient at 1 year³

¹Improved Transitions of Patient Care Yield Tangible Savings;

<http://www.ntocc.org/Portals/0/PDF/Resources/TangibleSavings.pdf>

²Naylor, et al. (1999) Comprehensive discharge planning and home follow-up hospitalized elders: a randomized clinical trial. JAMA, 281, 613-620

³Naylor, et al. (2004). Transitional care of older adults hospitalized with Heart failure. Journal of American Geriatric Society, 52, 675-684

Efforts to Reduce Readmission Rates

- The Guided Care Model: John Hopkins
 - 24% fewer days in hospital
 - 37% fewer skilled nursing facility days
 - 15% fewer emergency department visits
 - 29% home health care episodes
 - Net savings (per Guided Care Nurse) \$1,364 (Leff et al. 2009)
- Project Re-Engineered Discharge (RED): Boston University Medical Center
 - 30% reduced rate of hospital utilization at 30 days
 - 34% reduction in costs/patient
- Home Based Primary Care (HBPC): US Department of Veterans
 - 63% decrease in hospital spending
 - 24% reduction in 30-day readmissions (Stone and Hoffman, 2009)

Efforts to Reduce Readmission Rates

- Geriatric Resources for Assessment and Care of Elders (GRACE): Indiana University
 - \$1,432/patient¹
- Rush University Medical Center's Enhanced Discharge Planning Program (EDPP)
 - Decreases in readmission rates up to 180 days
 - Mortality rates reduced
 - \$1,293/patient²

¹Counsell, et al.(2007). Geriatric care management for low-income seniors: a Randomized trial. JAMA, 289(22), 2623-2633)

²Rush University Medical Center ((2011). Older adult programs, enhance discharge planning programs.

Transitional Care Defined

- The movement of patients between Health Care Providers as their condition and care needs change
- Transitions of Care are a set of actions designed to ensure coordination and continuity produce measurable outcomes:
 - Accountable provider at all points of care transitions
 - A provider who serves as a central coordinator across all settings of care and who has the capacity to send and receive information when patients are transitioning between care sites.
 - Standardized Tools available to all providers involved in the care of the individual
 - Integrated technology system that is interoperable to both patients and providers
- Ensures that patient needs and preferences and information sharing across people, functions and sites are met over time.

Challenges to Successful Transitions

- Decreased length of stay (LOS), continuing therapy after discharge
- Aging population – greater complexity, many co-morbidities
- Many care venues, many providers, poor communication
- Relies on the behavior of individuals
- Practice defined by location (i.e hospitalist, PCP)
- Current Fee for Service does not reimburse care coordination

CMS Transitional Care Physician Initiative

- Effective January 1, 2013 Physicians can begin to receive payment from Medicare for providing transitional care management services.
- Medicare will cover transitional care management services included in 2 new CPT codes:
99495 and 99496.
- These codes allow physicians to efficiently report time spent discussing patient care plans, connecting patients to community services, transitioning patient from inpatient setting with emphasis on coordinating services to prevent readmissions to the hospital.
- Both codes require a physician must have and document some form of medical discussion with patient and or caregiver, not necessarily in person about care transitions within 2 days of discharge from a facility. An additional face to face visit must occur within two weeks.
 - Code (99495) Moderate Complexity = \$169.99
 - Code (99496) High Complexity= \$231.36

CMS Transitional Care Payment Initiative

Who is eligible to receive TCM Services:

- Beneficiaries discharged from inpatient acute care hospital; rehabilitation hospitals; post acute Skilled Nursing Facility; Long Term Acute Care Facility.
- Facility does not include patients discharged to a SNF or to a community mental health center

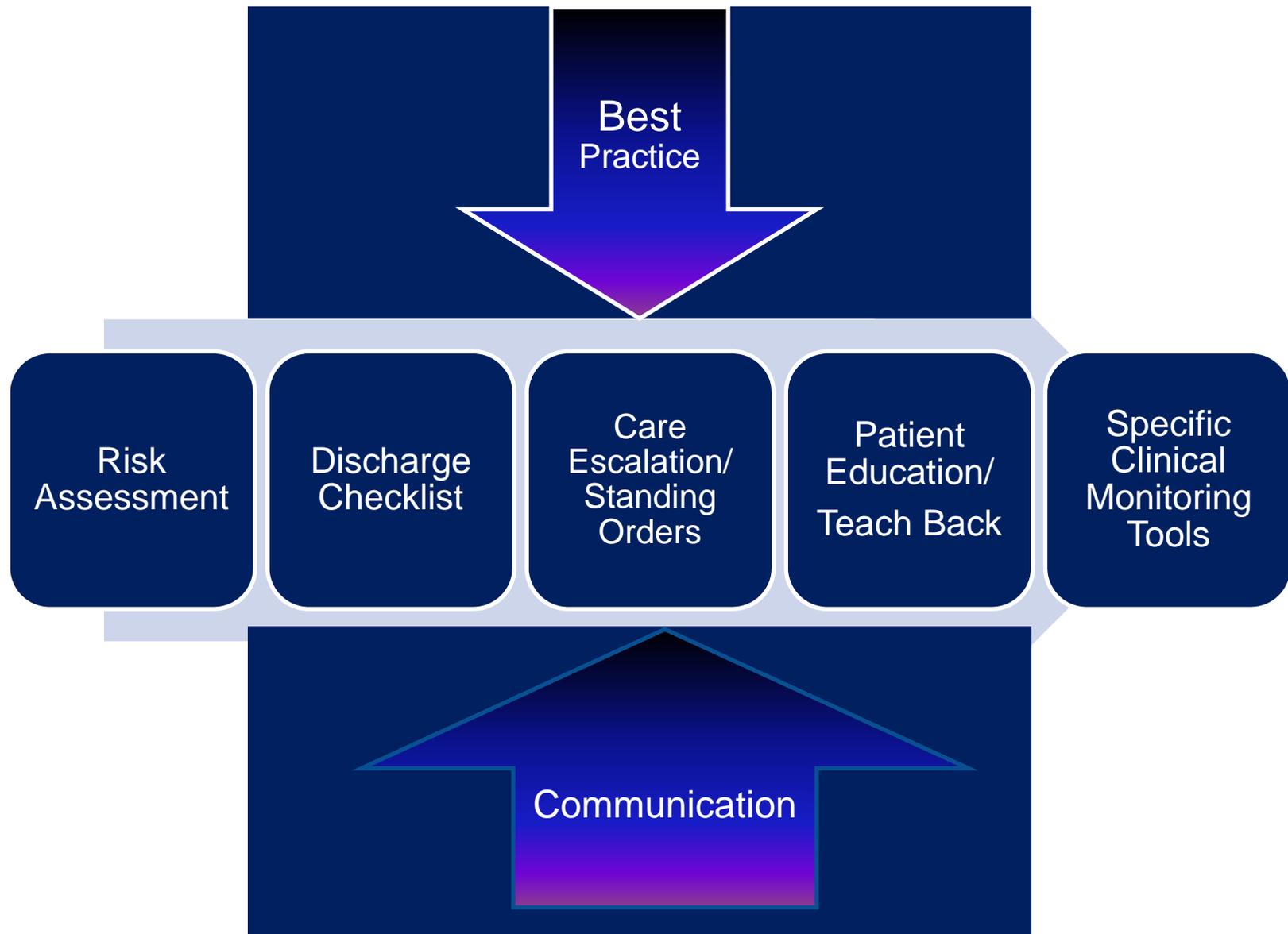
What are required elements for TCM:

- Communication with patient or caregiver within 2 business days of facility discharge.
- Communication may be by direct contact, phone or electronic means.
- Must include capacity for prompt interactive communication addressing patients status and needs beyond scheduling follow up care. within 2 business days of facility discharge.
- Communication may be performed by clinical staff under the supervision of the physician or other qualified professional (**Transitional Care Coordinator**)
- Date of communication must be documented.
- Face to face visit within 7 days of discharge for patients of high complexity
- Face to Face visit within 14 days of discharge for patients of moderate complexity
- Medication Reconciliation and management performed no later than date of face to face visit.

CMS Transitional Care Payment Initiative

- This payment does not apply to patients discharged to a SNF
- Physician can bill for only 1 unit per patient per month
- Physician cannot bill for both TCM and CPO for the same patient in the same 30 day period.
- This program currently only applies to beneficiaries associated with payment from CMS.
- It is projected that commercial payors will follow CMS lead by paying for TCM services.

Standardizing the Discharge Transition



Communicate, Communicate, Communicate



**Targeting Patients (Risk), Face to Face Evaluation,
Close Interaction, Patient self-management strategies,
Standardization (tools and monitoring)**

- 
- Motivational Interviewing
 - Teach Back

TRANSITIONAL CARE

Risk Assessment

Project Boost: The 8 Ps

- Problem Meds/Polypharmacy
 - Insulin, warfarin, digoxin, ASA
- Psychological (depression, other mental illness)
- Principle diagnosis (heart failure, diabetes, COPD, AMI)
- Physical limitations
- Poor health literacy (can't teach back)
- Poor social support/lack of caregiver
- Prior hospitalizations (last 12 months) and length of current stay
- Palliative care needs (pain, symptom management)
- The “Snell” 9th P: Early post-acute referral

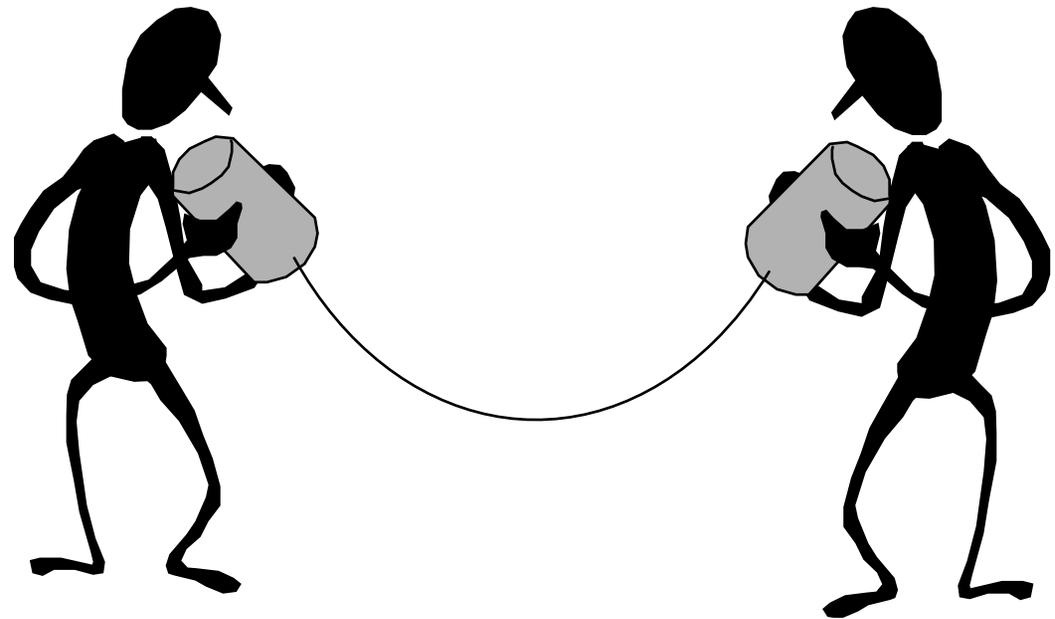


So there's risk....now what?

Mitigate the risks



Standardize Communication



Key Questions

- What risk factors can we mitigate or minimize?
- What is patient's goal of returning home?
- What is the patient's/family's biggest concern about discharge?
- Did we address potential interventions that can be done to prevent the patient from calling 911 or going to the ED?
 - Did we educate the patient about this plan?
- Disease specific

BOOST Interventions: Problem Medications/Polypharmacy

- Medication specific education using Teach Back provided to patient and caregiver
- Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin)
- Specific strategies for managing adverse drug events reviewed with patient/caregiver
- Eliminate unnecessary medications
- Simplify regimen
- Follow-up phone call at 72 hours to assess adherence and complications



BOOST Intervention: Psychological

- Assessment of need for psychiatric aftercare if not in place
- Communication with aftercare providers, highlighting this issue if new
- Involvement/awareness of support network insured

BOOST Intervention: Diagnosis

- Review of national discharge guidelines, where available
- Disease specific education using Teach Back with patient/caregiver
- Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms
- Discuss goals of care and chronic illness model discussed with patient/caregiver

BOOST Intervention: Physical Limitations

- Engage family/caregivers to ensure ability to assist
- Assessment of home services to address limitations
- Follow up phone call within 72 hours to assess with adherence

BOOST INTERVENTION: Poor Health Literacy

- Committed caregiver involved in planning/administration of all general and risk specific interventions
- Aftercare plan education using Teach Back provided to patient and caregiver
- Link to community resources for additional patient/caregiver support
- Follow-up phone call within 72 hours to assess adherence and complications



BOOST INTERVENTION: Poor Social Support

- Follow-up phone call at 72 hours to assess condition, adherence and complications
- Follow-up appointment with aftercare medical provider within 7 days
- Involvement of home care providers of services with clear communications of discharge plan to those providers
- Engage a transition coach

BOOST INTERVENTION: Prior Hospitalization

- Review reasons for re-hospitalization in context of prior hospitalization
- Follow-up phone call at 72 hours to assess condition, adherence and complications
- Follow-up appointment with aftercare medical provider within 7 days

BOOST INTERVENTION: Palliative Care

- Assess need for palliative care services
- Identify goals of care and therapeutic options
- Communicate prognosis with patient/family/caregiver
- Assess and address bothersome symptoms
- Identify services or benefits available to patients based on advanced disease status
- Discuss with patient/family/caregiver role of palliative care services and benefits and services available



Care Transition Bundle

7 Essential Intervention Categories (NTOCC)

- Medication Management
- Transition Planning
- Patient Family Engagement/Education
- Information Transfer
- Follow-Up Care
- Healthcare Provider Engagement
- Share Accountability across Providers and Organizations

<http://www.ntocc.org/Portals/0/PDF/Compendium/SevenEssentialElements.pdf>

Care Transition Bundle: Medication Management

- Ensure the safe use of medications by patients and their families based on plans of care
 - Assess patient's medication intake
 - Medication review including herbals and OTC, allergies, and drug interactions
 - Identify problem medications
 - Identify polypharmacy
 - Adherence and medications schedules
 - Patient and family education about medications
 - Teach back method to establish understanding of medication plan
 - Explain medication action
 - Review each medication's purpose and side effects
 - Develop and implement a plan for medication management
 - Med reconciliation
 - Assess patient plan to determine realistic
 - Determine patient's ability to obtain medications

Care Transition Bundle: Transition Planning

- A formal process that facilitates the safe transition of patients from one level of care to another and/or to another provider
 - Clearly identified practitioner (or team) to facilitate the patient's transition plan
 - Transitional care nurse (RN) or Advance practice nurse
 - Assess patient's post-care needs
 - Management of patient's transition needs
 - Hospital and home assessment to ensure safe transition
 - Coaching and support regarding healthy lifestyle and regimen
 - Self-care management skills with return demonstrations/teach back
 - Consider literacy level
 - Use of standardized transition planning tools
 - Checklists
 - Electronic transfer of info among providers

Care Transition Bundle: Transition Planning

- Completion of a standardized transition summary
 - Expedited transmissions
 - Discharge summary
 - Written instructions for patients

- Care escalation planning
 - What will patient do
 - What can be done prior to ED, hospitalization, or 911 called

Care Transition Bundle: Patient and Family Engagement and Education

- Patients and families are knowledgeable about condition and plan of care
 - Signs and symptoms of exacerbation
 - Who to call/when
- Handoff communication
- Develop self-care management skills

- Use of patient preferred learning style and literacy level
- Use of patient appropriate tools (MAP)
- Assure patient has working equipment to do self-monitoring

Care Transition Bundle: Information Transfer

- Share pertinent information with patient, family, and other healthcare providers in a timely manner
 - Implement clearly defined communication models
 - Formal communication tools (standardized)
 - Clearly identified practitioner providing transition communication

Care Transition Bundle: Follow-Up Care

- Confirm primary care and specialist FU
 - Within 48 hours post-acute care
- Make appointments and follow-up testing prior to discharge
- Clearly defined healthcare provider to call with problems (24/7)
- RN follow-up call by next business day to monitor condition
 - Reinforce of discharge plan and key symptoms
- Frequent follow-up to detect subtle changes in patient status or impending problems

Care Transition Bundle: Healthcare Provider Engagement

- Clearly identify patient's primary healthcare provider
- Use nationally recognized practice guidelines
 - Reconcile the transition plan with national guidelines
 - Implement evidence-based tools
- Hub of case management activities

Care Transition Bundle: Share Accountability

- Clear and timely communication of the patient's care plan
- Ensuring a responsible health care provider at all times
- Assuming responsibility for transition of care
- Monitoring and managing outcomes of transition program
 - Performance improvement

STANDARDIZING TRANSITION



Discharge
Checklist

Transition Checklist

Standardized Transition Checklist

- Disease specific
- Identify responsible provider to complete
- Part of medical record
- Medication teaching done using teach back method
- Medication reconciliation
- Patient has prescriptions and ability to get filled
- Care escalation plan
- Assure patient has FU appt.
- Contact information for post-acute care providers
- Referrals in community made
- Transportation arrangements
- Written discharge instructions that are written at patient literacy level and legible

Reconciliation of Medication List

Independent medication reconciliation by transition liaison

- Patients carry a complete, **accurate** list of their medications (purpose, dose, typical side effects) – brown bag!!!
- Discrepancies between new orders and prior meds are identified and explained to the patient and caregiver (in writing)
- Reconciliation of med lists occur throughout hospitalization especially upon a transfer and as close to discharge as possible
- Consider implementation of an electronic system

STANDARDIZING TRANSITION



Care
Escalation
Plan/Standing
Orders

Care Escalation Plan/
Standing Orders

Standing Orders/Care Escalation

This document is to be used by the home care nurse as an assessment guide only to assure all aspects of patient therapy and care are addressed during a home health visit or telephone assessment. The nurse should document against all of the following each home care visit and each telephone assessment with the patient / caregiver. The following are the parameters set for:

Patient name: _____ DOB: _____

Acceptable Parameters per Dr. _____

(Report variances in parameters to both pharmacy and physician)

Baseline Data Date: _____

Weight: _____ pounds in _____ hours **Baseline Weight** _____ pounds

B/P: _____ - _____ systolic; _____ - _____ diastolic; **Baseline** _____ / _____

Pulse: < _____ or > _____ **Baseline** _____

Temperature: Report temperature > _____ ° F

ICD Yes No Date Placed _____

PICC Line

Date Placed: _____ External Length: _____ Catheter Length: _____

Standing Orders/Care Escalation

- **Example: Home Inotropes**
 - **Standing orders for**
 - **Alteplase (cath-flo)**
 - **Peripheral IV placement**
 - **IV diuretics**
 - **PRN Nursing visits**
 - **Two pumps available in the home at all times**
 - **Battery changes with every bag change**

STANDARDIZING TRANSITION



Patient
Education/
Teach
Back

Patient Education/
Engagement

STANDARDIZING TRANSITION

Specific
Clinical
Monitoring

Specific Clinical Monitoring

Heart Failure Clinical Assessment Tool

RXE - HF Refill Assessment_4-1-2012

Date / Time: 12:00 PM Category: General Review

General Review

1. Referring Institution: (for data collection specific to an organization)

2. Primary Payer Name: (for data collection specific to a payer)

3. Other data collection group (e.g. physician, referral source, etc)

4. Spoke to?

5. Relationship to patient? Patient (self) Spouse/domestic partner Family member Other caregiver Home health nurse

6. Verify address for this delivery and update delivery ticket if applicable (enter changes below):

7. For the first delivery of the month, ask the patient if their insurance has changed. No changes Yes - notify intake/reimbursement dept.

8. Have there been any changes to your medications? Yes (update med profile in CPR+ & notify RPh) No (no action required)

9. How are you taking your medication (verify proper use of meds provided by BioScrip)?

10. Infusion pumps (check all that apply) Are the pumps working properly? Pumps are working correctly Pump(s) not working correctly - add comments below Pumps are rotated with bag changes Pumps not rotated, reminded patient
** Remind patient to rotate between the pumps provided with each bag change.

11. Have any doses been missed? Yes No

12. If yes, briefly describe missed doses:

13. Heparin flush count?

14. Saline flush count?

17. Patient's current weight in Lbs?

18. How does the present weight compare to the last weight? (Make sure patient is weighing at same time each day and on same scale?) Increased by 5 or more pounds About the same (within 5 pounds) Decreased by 5 or more pounds Not sure / can't remember

Chest pain Increased abdominal size (girth) Skin retains a dimple after pressing on it Short of breath when sitting in a chair Short of breath with minimal movement Short of breath with moderate movement Short of breath while lying down flat Must sleep sitting up Must be propped up on pillows to sleep No problem

19. Have you had any of the following symptoms? (RPh/RN to followup with patient as appropriate) N/A No problems Redness Soreness

20. Have there been any problems with the IV catheter? Swelling Pain Drainage Bad smell Difficulty flushing Other: see comments

21. Do you have either of the following? (If patient answers yes, notify RPh/RN) No problem Fever >100 degrees Pain not controlled by medication

22. If patient has a fever how long have they had it?

23. Was there a recent ER visit? Yes, due to this condition/therapy Yes, not due to this condition/therapy No

24. If yes, specify date and reason for visit?

25. Have you been hospitalized recently? (Since last assessment) Yes, due to this condition/therapy Yes, not due to this condition/therapy No

26. If yes, why were you hospitalized and for how long (provide specific dates)



How would the case study change if there was a transitional care initiative?

Case Presentation

JF is a 62 year old male with Stage D heart failure secondary to viral cardiomyopathy. He was referred for heart transplant evaluation. He was hospitalized and initiated on inotrope therapy as a potential bridge to VAD.

Other comorbidities include HTN, CAD with h/o MI and diabetes. He is recently widowed and has 3 children that are supportive of his health care needs. His home is about 50 miles from the transplant center.

Case Presentation

The Discharge

- He was discharged to home yesterday on continuous IV milrinone. Home providers were notified at the start of therapy as the CM knew the plan was to discharge on inotropes. When the Team rounded at 1:30 pm, all services were ready for discharge
- **JF is stable on his current dose of milrinone; his Na and K levels are not stabilized; discharge orders include daily lab draws with changes made accordingly on an outpatient basis**

Case Study

Home Visit

- The home care nurse is visiting him today to assess his status and continue teaching on medications, self-care monitoring/care needs, and inotrope management
- The home care nurse has a copy of the discharge summary. Discharge orders include baseline BP, weight, and pulse and parameters that should be called to the physician. She understands that decisions are being made about bridging to transplant and that electrolytes need to be followed closely

Case Presentation

- She knows that JF has an appointment next week. She confirms with him and his daughter that JF will be able to get to this appointment
- A call is made to the NP following the visit with all the information. No new orders are received

Case Presentation

- On the next home visit 2 days later, the patient tells the nurse that he feels more short of breath, but it still “isn’t as bad as it used to be”.
- His weight is up 3 lbs since the last visit. His pulse and BP are slightly elevated as well.
- The nurse knows this is a change from his baseline and meets criteria for a call to the physician team.
- She also discusses his medication regimen and ability to take his medications as prescribed

Case Presentation

The Readmission

- It is determined that JF was confused about the dose of diuretics to be taken. He was taking his pre-admission dose
- Additional teaching is provided regarding low sodium diet
- A single dose of diuretics is prescribed to be given in the home with FU labs the next day; standing orders are given for further management
- The nurse notifies the pharmacist of the changes in the plan

Other Resources Utilized

BOOST: Better Outcomes for Older adults through Safe Transitions. Retrieved 5/26/14 from <http://www.hospitalmedicine.org/Boost>

Facts about hand-off communications, 2010. Joint Commission Center for Transforming Healthcare accessed online on 11/18/2011 at http://www.centerfortransforminghealthcare.org/projects/about_handoff_communication

Facts about speak up initiatives, 2002. Joint Commission accessed online on 2/13/2011 at http://www.jointcommission.org/GeneralPublic/Speak+Up/about_speakup.htm

Other Resources Utilized

Health Leaders Media Retrieved 02/28/2011

<http://www.healthleadersmedia.com>

National Quality Forum. Retrieved 02/26/11 from

http://www.qualityforum.org/projects/care_coordination.aspx

Social Work Leadership Initiative. Retrieved 02/26/11 from

<http://www.socialworkleadership.org/nsw/care/carecoordination.php>

Patient Protection and Affordable Care Act of 2010. Retrieved 02/26/11 from

<http://www.kff.org/healthreform/upload/8061.pdf>

Institute for Healthcare Improvement

<http://www.ihl.org>

<http://www.jointcommission.org/toc.aspx>