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Care Transitions at Stanford Coordinated Care

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Avoid Readmissions through Collaboration (ARC)

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Objectives

- Define care transitions and where they occur
- Identify Coleman's 4 elements of care transitions
- Describe steps of care transitions related to hospitalization
- Illustrate an example of a care transitions intervention

Primary Reasons for Hospital Readmission

- Lack of timely, coordinated connection with Primary Care Provider
- Medication management problems
- Not knowing when to seek help
- Lack of follow up on tests and treatments

Care Transitions

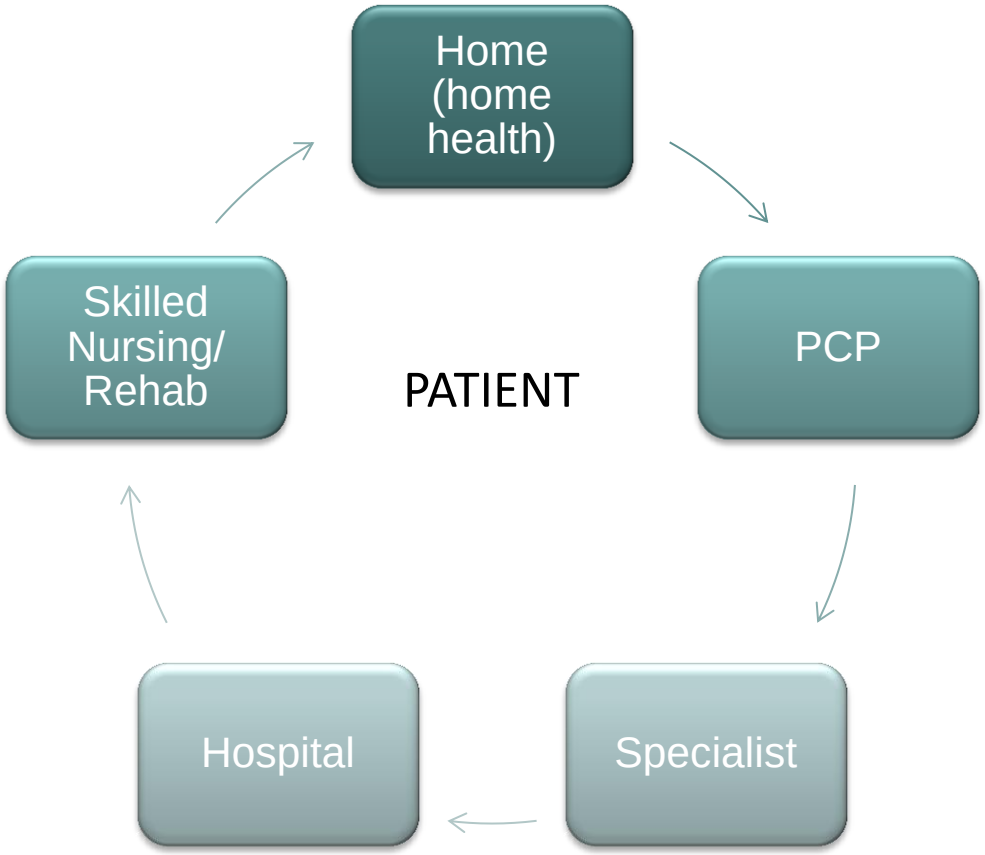
Movement patients make between healthcare providers and settings as their condition and care needs change

http://www.caretransitions.org/definitions.asp

Care Transitions Goals

- Empower patients to be partners
- Reduce re-admissions
- Reduce long lengths of stay
- Improve patient satisfaction
- Bridge the Hospitalist – PCP gap

Where do Care Transitions Occur?



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The Coleman Model

Four Pillars

1. Medication Self-management
2. Dynamic Personal Health Record
3. Disease Management Education
4. Follow-Up Appointments
5. Community Resources

Eric Coleman, MD
Arch. Int. Med 2006

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Personal Health Record

Personal Information

Family Caregiver Information

Name: _____

Relation to Patient: _____

Phone #: _____

Alternate Phone #: _____

In what ways do your caregivers help you manage your conditions?

_____

_____

Advance Directive / Living Will:

☐ NO ☐ YES Where can this be found?

_____

Health Care Provider Information

Primary Care Dr.: _____

Phone #: _____

Pharmacy: _____

Other Providers: _____

Questions for other Providers:

Pharmacist

Case Manager

Other (list name, specialty, organization)

Questions for my Primary Care Doctor:

My Health Conditions:

1. _____
   - Red Flags: _____
   - Action Steps: _____
2. _____
   - Red Flags: _____
   - Action Steps: _____
3. _____
   - Red Flags: _____
   - Action Steps: _____
4. _____
   - Red Flags: _____
   - Action Steps: _____
5. _____
   - Red Flags: _____
   - Action Steps: _____

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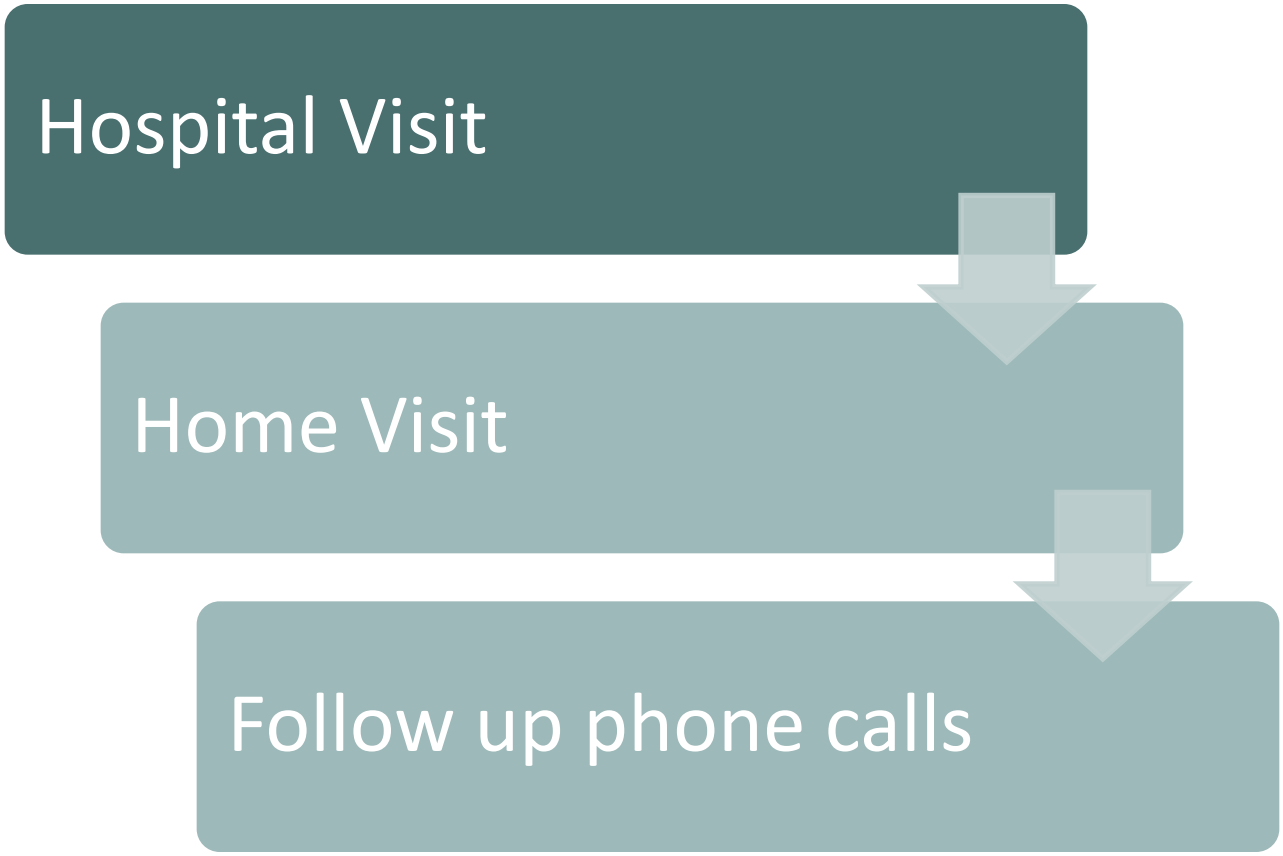
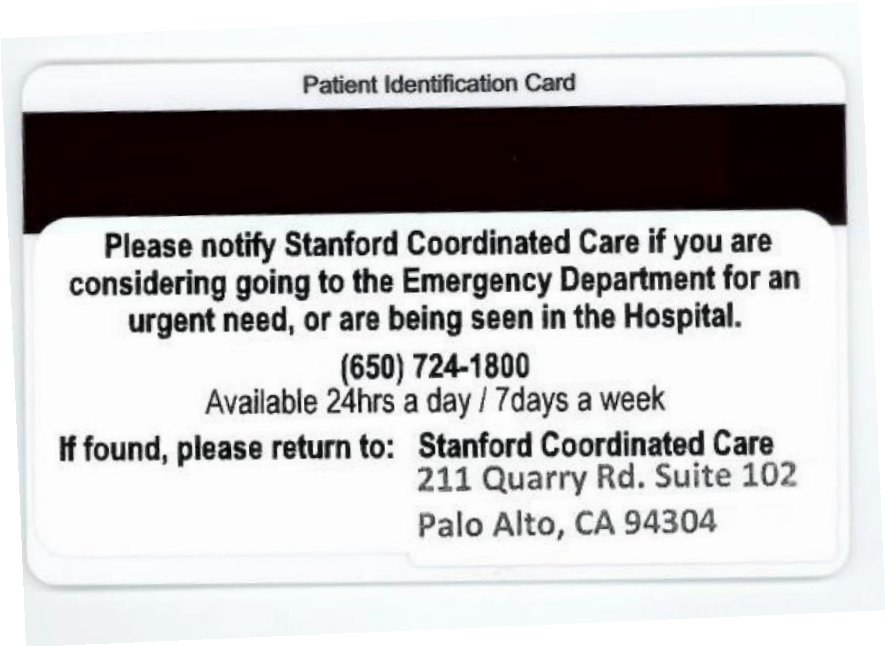
Care Transitions Intervention



Stanford Coordinated Care Patient ID card



Welcome to Stanford Coordinated Care (SCC) Primary Care Plus Clinic

Below you will find a list of benefits provided to you through SCC Primary Care Plus Clinic.

- Prompt access to your care team Monday through Friday during business hours; with 24/7 direct access to your primary care physician Monday through Sunday, by calling 650.724.1800.
- Same day and next day clinic appointment for urgent needs.
- Pharmacist review of your medications
- In-office labs available for your convenience.
- Behavioral Health & Physical Therapy clinicians on-site, as well as a Clinical Nurse Specialist. (With no Co-pay's or additional cost to you).
- Your physician will take calls after business hours at night and/or over the weekends for serious issues that cannot wait until the next business day. If you find yourself in a situation considering whether or not you need to go to the emergency room or urgent care, please contact our clinic at 650.724.1800 to speak with your SCC primary care physician before going directly to the emergency room, unless you cannot safely wait a few minutes to speak to us. In a major emergency please call 911.
- If you are admitted to the hospital, please be sure to contact your care team at 650.724.1800 as soon as possible or at least within 24-hours of admission, so that we may be of assistance to you.

"We've Got Your Back!"

The Hospital Visit

- CNS identifies hospitalized patient
- CNS initiates coaching activities in hospital
  - Personal health record
  - Discharge preparation checklist
- CNS sets up expectation for home visit following discharge

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The Home Visit

- CNS performs medication reconciliation
- CNS ensures follow up appointments made
- CNS reviews red flags
- CNS completes home survey

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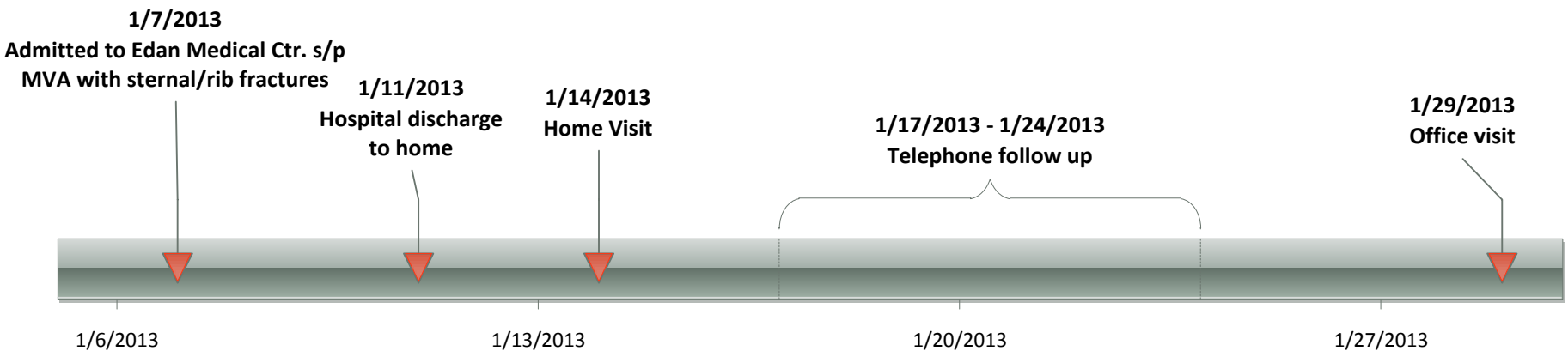
Follow up telephone call

- CNS answers remaining med questions
- CNS reminds patient to share dynamic health record across visits
- CNS provides advocacy in getting follow up appointments
- CNS reviews red flags and self-management

Case Study



- During hospitalization
  - Care coordinator contacted inpatient nurse by phone
  - Licensed Clinical Social Worker (LCSW) contacted case manager/discharge planner by phone
- Home visit done by care coordinator and physician's assistant (PA) student
- Telephone follow up by LCSW and care coordinator

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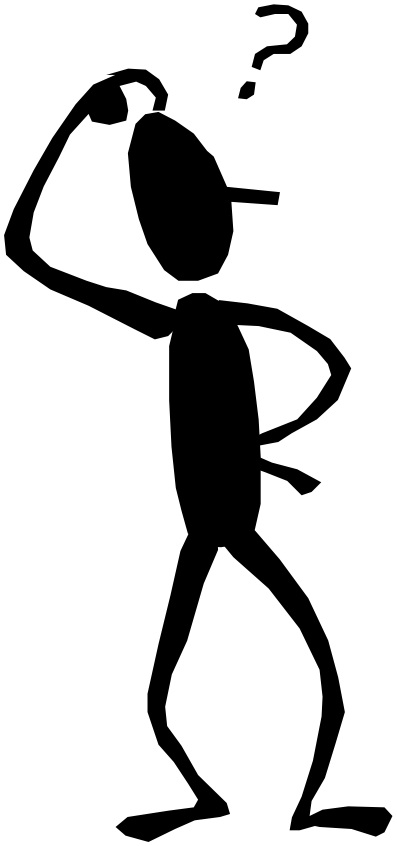
Questions?



References

- The Care Transition Program: http://www.caretransitions.org/definitions.asp
- Coleman, E. A., Parry, C., Chalmers, S., & Min, S. (2006). The care transitions intervention: Results of a randomized controlled trial. *Archives of Internal Medicine, 166,* 1822-1828.