Community Care
OF NORTH CAROLINA

CCNC TRANSITIONAL CARE PROCESS

OVERVIEW	There is increasing national awareness of medical errors and quality deficiencies that occur across care settings. The Joint Commission on Accreditation of Healthcare Organizations' increased focus on medication reconciliation and discharge planning, and the National Quality Forum's examination of performance measures for post-hospitalization care coordination are examples of efforts to improve the care transitions process. The Institute of Medicine is advocating pay for performance approaches to incentivize improved care coordination across settings and strategies to determine how best to incorporate the patient and caregiver into efforts to improve their quality of care. The recent IOM Chasm report advocates health care models that are patient-centered and collaborative and coordinate care across provider settings.	
PURPOSE	Transitional care utilizes structured interventions to ensure coordination and continuity of health care as patients transfer between different locations or different levels of care. Transitional care is based on a comprehensive plan of care and a patient's goals, preferences, and clinical status. It includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition.	
TARGET POPULATION	Networks receive inpatient data from participating hospitals. At a minimum, patients who meet CCNC priority criteria, have a targeted chronic disease, or in the clinical judgment of the Care Manager would be appropriate candidates for intensive Care Management services are the focus of outreach efforts. It is anticipated that these patients would require care across multiple settings.	
PROGRAM COMPONENTS	1	Standardized Care Management process provided by a professional trained to perform critical activities that empower the patient/caregiver with self-management skills
	2	Initiation and Maintenance of a Self-Management Notebook when appropriate and/or Patient/CG education which includes Knowledge of Red Flags that may indicate a worsening condition and when to call the Primary Care Provider.
	3	Emphasis on follow-up care with the Primary Care Provider and Specialist(s) and to facilitate communication between service providers, the patient, and the caregiver.
	4	Emphasis on medication self-management and compliance through educating the pt/cg about medicines and ensuring that a medication management system is in place.
RECOMMENDED TIME FRAME	Four-week program initiated during inpatient admission with:	
	❖	1 or more CM contacts prior to discharge
	❖	CM contact **within 72 hours / 3 business days** following discharge. **Optimally, a home visit will occur, but face to face contact is required as a minimum. The primary goal of this contact is for MEDICATION RECONCILIATION.**
	❖	3 or more follow-up phone calls/contacts
ROLE OF THE CARE MANAGER	**The primary role of the Case Manager is to:**	
	❖	facilitate interdisciplinary collaboration across transitions
	❖	encourage the patient and caregiver to play a central and active role in the formation and execution of the plan of care
	❖	promote self-management skills and facilitate communication between the patient/caregiver, primary care provider, and other service providers
	❖	promote medication compliance through consultation with network pharmacist, patient and/or caregiver education, and by ensuring that a medication management system is in place

CCNC TRANSITIONAL CARE MODEL

Care Managers should use this model to guide the basic sequence and content of transitional interventions

Stage of Intervention	Medication Self-Management	Patient Centered Record (Self-Management Notebook-SMN)	Follow-Up	Red Flags
Goal	Patient and/or Caregiver (CG) are knowledgeable about medications and have a medication management system in place	Patient and/or CG maintain a Self-Management Notebook (SMN) to facilitate communication and ensure continuity across providers and settings	Patient and/or CG schedules and completes follow-up visit with the PCP/Specialist	Patient/CG is knowledgeable about symptoms that indicate their conditions are getting worse and what to do when this occurs
Hospital Contact	Discuss importance of medication adherence and understanding changes to the medication regimen prior to hospital discharge	Explain that CM will encourage the patient to implement a Self-Management Notebook (SMN) after discharge, and that the CM will assist the patient in getting the notebook started	Encourage patient/CG to make PCP follow-up appointment as soon as discharge date is known	Discuss symptoms that indicate Red Flags in their health status or that they are experiencing a possible drug reaction
Home or Face-to-Face Visit	Reconcile pre- and post- hospital medication lists	Review Discharge Summary and explain the purpose of the SMN	Emphasize the importance of the follow-up visit	Assess through patient interview for presence of symptoms that would indicate exacerbation
	Obtain network pharmacist consult	Assist patient in filling out appropriate sections of notebook	Assist patient/CG in making a list of questions to discuss with the PCP at follow-up visit	Discuss symptoms and side effects of medications
	Identify and correct discrepancies based on input from pharmacist and the PCP	Review and update SMN with any subsequent visits		Review Red Flags that would indicate the need to call the PCP or obtain emergent care
Follow-Up Calls / Contact	Provide ongoing education related to medications, assess for side effects, monitor compliance, and encourage patient to report problems to PCP	Encourage the patient to take the SMN to all medical appointments and share with the provider	Provide advocacy in getting the patient a follow-up appointment, and if necessary, agree to attend visit with the patient	Reinforce when the PCP should be called

Parry C, Coleman EA, Smith JD, Frank JC, Kramer AM. **The Care Transitions Intervention: A Patient-Centered Approach to Facilitating Effective Transfers Between Sites of Geriatric Care.** Home Health Services Quarterly. 2003;22(3):1-18.

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CCNC TRANSITIONAL CARE MODEL: INTERVENTIONS

The tables below outline CCNC **MINIMUM** guidelines for transitional interventions.

HOSPITAL CONTACT

Medication Management	Self-Management Notebook	Medical Care Follow-Up	Red Flags	Other
Discuss Medication Management system currently in home and any barriers to patient taking medications as prescribed	Explain that CM will encourage patient to use a Self-Management Notebook after discharge	Advise on making follow-up appointment with PCP or Specialist	Discuss self-management concepts and assess readiness to change	Discuss post-hospital care options
				Talk to patient about support at home
				Ask about DME already in home

HOME or FACE-TO-FACE CONTACT

Medication Management	Self-Management Notebook	Medical Care Follow-Up	Red Flags	Other
Compare pre-hospital medications with medications on hospital or SNF discharge list	Document correct medication regimen	Ensure that follow-up appointments are made	Review Discharge Instructions	Discuss pt's personal goals and possible steps for achieving
Identify medications that were prescribed but not obtained	Identify medications needing refill		Provide education about any new conditions then review old conditions where treatments/meds have changed or pt/cg express a need	
Identify medication discrepancies	Reinforce need for patient to bring SMN to all future health care encounters and to show it to service providers	Identify problems that require immediate PCP or specialist visit		Ensure DME is delivered
Consult network pharmacist for additional evaluation				Assess adequacy of support system, need for ongoing case management, and prepare pt/cg to interact with any ordered home care services.
Facilitate pharmacist and PCP med reconciliation efforts		Develop questions with pt/cg for PCP/Specialist	Discuss red flag symptoms to monitor, what to do if they occur, and when the PCP should be called	
Identify barriers to obtaining meds and compliance issues		Attend f/u visit with patient as needed		
Follow-up with pt/cg to ensure their understanding of any med changes implemented by the PCP		Clarify whether pt will need f/u tests and provide teaching if needed		Connect patient to necessary community resources

FOLLOW-UP PHONE CALLS / CONTACTS

Medication Management	Self-Management Notebook	Medical Care Follow-Up	Red Flags	Other
Review adequacy of medication management system	Update Self Management Notebook as needed	Remind pt about scheduled f/u visits	Review and teach self-management of conditions	Review patient goals and progress made toward reaching them
Assess medication compliance	Reinforce need for patient to bring SMN to all future health care encounters and to show it to service providers	Identify problems that require immediate PCP or specialist visit	Assess pt condition and report to PCP as indicated	Ensure that DME supplies are being delivered as needed
Answer questions / review meds				
Identify meds needing refills/barriers to refill		Provide teaching about f/u tests	Review when to call PCP	Connect patient to community resources PRN

Initial:03/08; rev 04/08 Reference: "Users Manual: THE CARE TRANSITIONS INTERVENTION: IMPROVING TRANSITIONS ACROSS SITES OF CARE (C) 2007 CARE TRANSITIONS PROGRAM, DENVER COLORADO, WWW.CARETRANSITIONS.ORG"

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