

Care Transition Coach

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CARE TRANSITIONS PROGRAMS

A PASSION FOR BETTER MEDICINE.™



What is Care Transitions

- Bridging Care from a hospital setting to Home
- Care Transitions is a program that helps clients to take a more active role in Their health care.
- Clients receive tools and skills that are supported by a Transition Coach who follows clients across settings for the first 4 weeks after leaving the hospital and focuses on Medicine self management , managing doctor follow ups and understanding of red flags that point to a drop in health.

Why Care Transitions

- The Affordable Care Act has several provisions regarding improving Care Transitions and Care Coordination and Reducing Readmissions.
- The most relevant are the provisions to encourage improved performance on 30 day readmission rates for 3 conditions . MI, heart failure and Pneumonia by assessing a payment penalty for hospitals with higher than expected readmission rates.
- The list of conditions and the magnitude of penalty will increase in subsequent years.
- The key elements of the Care Transition Intervention is Low Cost , Low intensity and adaption to other settings.

Benefits of Care Transitions

The evidence based research has shown that Care Transitions Intervention has significantly reduced 30 day Readmits while the coach is involved and also has shown a significant reduction with 90-180 day readmits with sustained effects of coaching. This is a nationwide program and has been adopted by over 500 care organizations.

The Program is centered around 4 pillars

COACH

- Build and reinforce patient and caregiver confidence to play an active role with their health care team.
- Promote communication and self management skills
- Promote patient engagement with healthcare decisions and choices.
- The Care Transitions Coach is different from other services such as home health .The Coach does not provide hands on skilled services.
- The Coach works with the patient and family to help them be better prepared to take care of their health conditions and help them get their needs met during care transitions.

Coach

The Program includes:

- Hospital Visit- Introduces the program and Coach to the Patient
- Home visit – Reviews Medications with client. Coaches client to resolve medication discrepancies and coaches clients to fill out a personal health record with listings of all medications and supplements. Review Red flags and how to respond to the flags. Review Personal goal and provide the support and tools to reach their goal. Provide role modeling and support to self manage making follow up appointments with Physicians.
- 3 Follow up phone calls to provide the resources and tools to support the client to self manage their health conditions.

CTI PILLAR 1 MEDICATION REVIEW

- COACH
- Home visit - Patient identifies all medications
- Patient demonstrates their “system” for taking meds
- Coach compares Patients medicine “system “ to discharge instructions
- Patient is coached to resolve differences.

Patient is more aware of medications and reason for taking meds.

Patient is in control of resolutions to med discrepancies.

CTI Pillar 2 Personal Health Record

- Paper tool completed by the Patient. Lists all medications taken including supplements and vitamins.
- Personal Goal set by the patient .
- Questions for the Physicians .
- Organizes all Medications and personal history in one book.
- Goal to work towards
- Questions written in the book to ask the doctor to remind them of their concerns.

CTI PILLAR 3

Red Flags

- Review Red Flags and coaching the patient to be aware of symptoms becoming worse.
- Who to call if there are red flags.
- Coach patient how to monitor and manage their disease.

Pillar 4

- Follow up appointments after discharge.
- Coach and role model how to make appointments and what to say.

Doing for the Patient puts the Patient in the back seat

Coaching the Patient puts the Patient in the Driver's Seat

Educating the Patient puts the Patient in the passenger's seat



Fiscal Year 2013

Health Coach							
Referrals	Admissions	Refused or Inappropriate	Admission Conversion Rate	Readmissions w/in 30 days	% Readmitted	Refusals / Inappropriate Readmitted	% of Refusals Readmitted
9	4	5	44%	1	25%	1	20%
25	9	16	36%	2	22%	5	31%
31	16	15	52%	2	13%	7	47%
17	10	7	59%	1	10%	0	0%
29	24	5	83%	1	4%	1	20%
26	20	6	77%	3	15%	3	50%
20	16	4	80%	5	31%	0	0%
25	18	7	72%	6	33%	0	0%
39	29	10	74%	4	14%	4	40%
25	15	10	60%	3	20%	5	50%
31	25	6	81%	5	20%	0	0%
27	17	10	63%	2	12%	2	20%
304	203	101	67%	35	17%	28	28%

Questions



Cedar Crest



17th Street



Muhlenberg



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