

## West County Health Centers, Inc. Clinical Protocol

<b>Clinical Protocol:</b>	<b>Transition Care</b>	<b>Category:</b>
<b>Staff Role:</b>	<b>RN</b>	<b>Page: 1</b>

**Protocol Summary:**

- **Assist with successful transition for patients recently discharged from inpatient hospital or skilled-nursing facility.**
- **Minimize hospital re-admission through proactive RN Care Management, and communication, and coordination.**

Care team RN Care Manager will contact the patient within 48 hours of discharge from a hospital or skilled nursing facility or as soon as notice is received of transition.

Patients will see their PCP within one week of discharge. This is to include all newborns and post-partum women (contacted by OB RN case managers).

Care Team RN Care Manager to conduct RN Transition visit (timeframe expectation: within 48 hours of discharge if possible).

*Note: Visit can be at home or in office but home visit is preferable to understand potential barriers or risk factors that would be more readily apparent when interacting in the home environment.*

Initial Transition Care Visit to be guided by intake bubble sheet and follow the Coleman Model “Four Pillars” assessment.

1. **Medication:** reconciliation of medications for patient and within eCW; medication education including type, reason, administration, and refill management; coaching around self-management of medication; motivational interviewing around medication adherence.
2. **Personal Health record:** update eCW on inpatient events or changes; written summary for patient/care giver of active health history; introduction to health portal.
3. **Medical Follow-up:** Assist with management of primary care and specialty care follow-up appointments; review care team support and plan for communication; ensure needed radiology and laboratory appointments are planned; education about agenda setting for medical appointments.
4. **Risk reduction:** Education and management plan for symptoms concerning for worsening disease (red flags); self-management assessment guided by *Patient Activation Measure tool*.

Additional management: DME arrangement; comfort care including pain management and bowel care; ADL assessment, assessment of adequate food, housing, and transportation; home health referral; IHSS referral.

Communication with Care Team and other health partners (home health, specialty care, care givers, etc.) as indicated to coordinate and optimize care transition.

Follow up visit by phone or in office and closely managed for the first 30 days after discharge.

Documentation of transition care visits will be made in a progress note or telephone encounter virtual visit utilizing the RN Transition of Care template or the bubble sheet will be scanned into the patient chart.

<b>Effective Date:</b>	<b>Revision Date:</b>
<b>Supervisor Approval:</b> _____ <span style="display: block; text-align: center; font-size: small;"><i>Initial</i></span>	<b>Medical Director Approval:</b> _____ <span style="display: block; text-align: center; font-size: small;"><i>Initial</i></span>

