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A Patient-Centered Transitional Care Case Management Program

Taking Case Management to the Streets and Beyond

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ABSTRACT

Background: In 2011, the Hunter Holmes McGuire Veterans Administration Medical Center (VAMC) in Richmond, VA, had a cumulative readmission rate and emergency department (ED) revisits for discharged Veterans of 1 in 5. In 2012, a transitional care program (TCP) was implemented to improve care coordination and outcomes among Veterans, with an emphasis on geriatric patients with chronic disease. This TCP was created with an interdisciplinary approach using intensive case management interventions, with a goal of reducing Veteran ED and hospital revisits by 30%.

Purpose of Research: To examine the impact of the McGuire VAMC TCP on Veteran ED and hospital utilization and costs.

Primary Practice Setting: Veterans being discharged to home following an inpatient admission, ED visit, and/or short rehab stay.

Methodology and Sample: The primary means of identifying patients for the program is through daily screening of the previous 24-hour admission and ED report, which the inpatient nurse practitioner performs. She completes an extensive review of each Veteran's electronic medical record to determine the number of ED visits and inpatient admissions at the VAMC and in the community. Initial criteria for consideration in the program included the following: more than two hospital admissions and/or ED visits in the past 90 days or at high risk for readmission based on a Care Assessment Need score of greater than 95. Two hundred Veterans participated in the program in fiscal year (FY) 2013, with 146 participating in FY 2014. A retrospective chart review of Veterans participating in the TCP in FYs 2013 and 2014 was conducted, with a focus on number of admissions and ED visits 90 days prior to admission to the TCP and 90 days following TCP admission. Average admission and ED costs for this VA were calculated to determine cost savings from pre- to post-90 days of admission and ED visits.

Results: Veterans who obtained TCP services in FYs 2013 and 2014 experienced a 67% decrease in hospital admissions and a 61% decrease in ED visits in the 90 days following participation in this program compared with the 90 days prior to participation. This produced an estimated net savings of $3,823,673 in medical center costs. In addition, registered nurse case managers (RN CMs) noted improved patient compliance and satisfaction with care and the licensed clinical social worker noted reduced caregiver burden.

Implications for Case Management Practice: The results of this program demonstrate how using an interdisciplinary approach to develop patient-centered transition plans of care through intensive case management interventions improves resource utilization with substantial financial savings. This program represents a feasible option for other VAMCs as well as civilian hospitals seeking to provide cost-effective transitional care to patients upon discharge and prevent untimely readmissions. With an RN CM at the hub of patient care, this program successfully demonstrates the value of smooth care transitions.

Key words: *emergency department visit and admission reduction, high-risk elderly, intensive case management, transitional care*

On average, 19.6% of Medicare fee-for-service beneficiaries who have been discharged from the hospital were readmitted within 30 days and 34% were readmitted within 90 days. According to Medicare Payment Advisory Commission (MedPAC), hospital readmissions within 30 days accounted for $15 billion of Medicare spending (National Transitions of Care Coalition [NTOCC], 2010). Although transition problems can occur as patients move between inpatient settings skilled nursing facilities, primary and specialty care offices, community health centers, rehabilitation facilities, home health agencies, hospice, and their homes, the

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risk is particularly high when patients leave the hospital to receive care in another setting or home (Jing, Young, & Williams, 2014).

Research has identified several gaps in care behind failed care transitions. Per Naylor and Keating (2008), factors that contribute to gaps in care during critical transitions include poor communication, incomplete transfer of information, inadequate education of patients and family caregivers, limited access to essential services, and absence of single point person to ensure continuity of care. Language and health literacy issues as well as cultural differences exacerbate the problem.

Lattimer, Sminkey, Skinner, and Serbin (2013) describe transition points as the weakest links in the chain of care, leading to inefficiency, fragmentation, and poor outcomes. There are health as well as economic costs associated with poor transitions in care. Such failures create serious patient safety, quality of care, and health outcome concerns. Furthermore, they place significant financial burdens on patients and the U.S. health care system as a whole. All of these variables contribute to patient and family caregivers' dissatisfaction (NTOCC, 2010).

So, what is transitional care? Transitional care is defined as a broad range of time-limited services designed to ensure health care continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another (Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011).

Veterans Administration Medical Centers (VAMCs) across the nation have tackled health care's weakest link with the aim of improving care transitions. The Hunter Holmes McGuire VAMC has developed a multidimensional approach to improving care transitions, with options that not only address Veterans' needs but also address distance from the facility. The transitional care program (TCP) was developed for Veterans with multiple emergency department (ED) visits and hospital admissions for the same or similar diagnoses in a 90-day period. By focusing on medication and treatment adherence, this program has reached its goal of decreasing, and in some cases eliminating, additional ED visits or hospital readmissions by this population. This article provides a detailed outline of the Hunter Holmes McGuire VAMCs TCP's clinical protocols, feasibility, and assessment of its impact on 90-day rehospitalization and ED utilization as well as cost savings. Evidence is provided that this TCP may be a practical and effective transitional care option for other VAMCs, as well as civilian hospitals, that serve urban as well as rural patients.

Description of Industry Trends

Rigorous studies in hospital settings in the Department of Veteran Affairs health care system as well as in the civilian sector demonstrate that TCPs that provide in-home visits or telephonic follow-up, with focused support during the immediate post-hospital period, can improve patient safety and reduce hospitalizations. The NTOCC encourages health institutions, providers, and caregivers to utilize best practice models when designing TCPs. Since the Affordable Care Act of 2010 was introduced, a variety of evidenced-based transition care models have been established to improve patient outcomes and reduce costs. These care models include the following: Project BOOST (Better Outcomes for Older Adults Through Safe Transitions-Society of Hospital Medicine); Project Red (Re-engineered Discharge-Boston University Medical Center); the STARR (State Action on Avoidable Re-hospitalizations) initiative (Center for Innovative Health Strategies); the Care Transitions Intervention (Coleman); Transitional Care Model (TCM, Naylor), the Bridge Model (adaption of the Enhanced Discharge Planning Program, EDPP, Illinois Transitional Care Consortium); the Grace (Geriatric Resources for Assessment and Care of Elders) Model (Indiana University School of Medicine, Counsell); INTERACT (Interventions to Reduce Acute Care Transfer tools (Centers for Medicare & Medicaid Services); Guided Care (Boult); Hospital to Home Program (Forsyth Medical Center, Winston Salem, NC); and Coordinated-Transitional Care (C-TraC) Program (Department of Veterans Affairs).

The Hunter Holmes McGuire VAMC TCP takes the approach that "it takes a village" to manage Veterans with multiple chronic illnesses who are at high risk for readmission to the hospital or ED. TCP developers utilized components from some of the above-listed best practices to build this program. The TCP has a multidisciplinary team that is staffed by advanced practice nurses as described in Naylor's TCM, which includes the components of screening, engaging patient and caregiver, managing symptoms, educating/promoting self-management, collaborating, ensuring continuity, coordinating care, and maintaining relationship. The TCP described in this article

utilizes registered nurse case managers (RN CMs) who provide either home visits or telephone calls as in the VA's C-TraC program (Kind et al., 2012) with the Veteran and/or Veteran's caregiver.

This TCP team includes a licensed clinical social worker (LCSW) who assists with accessing Veterans benefits and community resources as well as providing caregiver support. As pointed out by Watkins, Hall, and Krig (2012), although there are many well-designed and successful TCPs, there may be a lack of focus on seniors with a combination of complex social and medical needs. Without transportation to the doctor or grocery store, many frail older adults who leave the hospital are unable to properly care for themselves when they return home. The results from this Hospital to Home Program emphasize the importance of social worker involvement to assist in connecting patients to community supports and to work with patients and families to address unexpected needs. A social worker is also trained to address the denial of need expressed by some patients and families.

The World Health Organization states that medication and treatment adherence issues are the primary reasons for readmissions and ED visits (CMSA, 2012). This supports the integration into this TCP of the NTOCC (2010) recommendation of standardizing medication reconciliation through electronic health records and expanding the role for pharmacists as well as standardizing the patient's personal medicine list. Medication adherence is also advocated by Crotty, Rowett, Spurling, Giles, and Phillips (2004), who demonstrated that use of a pharmacist transition coordinator improved aspects of inappropriate use of medications across health sectors, specifically hospital to long-term care.

Description of Program

The Hunter Holmes McGuire VAMC TCP is currently staffed with a physician medical director who provides program oversight; two nurse practitioners (NPs), one inpatient and one outpatient; a clinical pharmacist (PharmD) who covers inpatient and outpatient areas; two RN CMs; and an LCSW. When this program was initiated, Veterans with two ED visits and/or two inpatient admissions within a 90-day period were identified by the inpatient NP or PharmD utilizing a screening process. If the Veteran met this basic criteria as well as additional criteria described in the Sample section of this article, a consult was placed to the outpatient NP and the Veteran was subsequently contacted either while inpatient or within 3 to 5 days of discharge. This criterion was expanded to include Veterans who meet high-risk Care Assessment Need (CAN) score criteria. The CAN score is a risk stratification tool used to identify patients at highest risk for hospital admission and/or death for focused care management. It is based on statistical prediction models of Veterans enrolled in primary care, using patient characteristics and health care use information. The CAN score is expressed as a percentile ranging from 0, which is the lowest risk, to 99, which is the highest risk (Fihn & Box, 2013).

The TCP is currently funded through the Office of Rural Health; therefore, there is a focus on meeting needs of rural Veterans in addition to those who fall within a set 50-mile radius of the hospital for RN CM or LCSW home visits. Veterans living outside the 50-mile radius or who decline home visits are offered telephone clinic. Additional key program features include collaborating with the inpatient team to reduce errors in the discharge planning process; inpatient PharmD completing medication review prior to discharge; fast tracking to key VA and/or non-VA-contracted resources such as Skilled Home Health (HH), Home Health Homemaker or Aide, Home-Based Primary Care (HBPC), and Care Coordination Home Telehealth; providing prompt in-home RN CM visit postdischarge and collaborating with Veteran's primary care team throughout the 29-day program.

The inpatient NP and/or PharmD screen Veterans who meet program criteria and identify potential problems and educational deficits that may increase risk for readmission. They collaborate with the inpatient medicine team to reduce errors in the discharge planning process as well as place an electronic consult for TCP services. The PharmD attempts to complete an intensive medication reconciliation and education of the Veteran and family prior to discharge in order to help prevent medication errors at home.

The results of this program demonstrate how using an interdisciplinary approach to develop patient-centered transition plans of care through intensive case management interventions improves resource utilization with substantial financial savings. This program represents a feasible option for other VAMCs as well as civilian hospitals seeking to provide cost-effective transitional care to patients upon discharge and prevent untimely readmissions. With an RN CM at the hub of patient care, this program successfully demonstrates the value of smooth care transitions.

Some consults are made on the basis of chart review when the inpatient NP and/or PharmD are unable to see the Veteran prior to discharge.

Some Veterans will transition to nursing homes (NH), either in the VA or in the community, for short-term rehabilitation following their hospitalizations. In these cases, these Veterans are tracked on the TCP log (Appendix A). The TCP LCSW makes contact with the NH to obtain a discharge date. The day prior to the Veteran's NH discharge, the TCP PharmD will contact the NH to obtain a list of discharge medications. She forwards this information to the TCP RN CM, who then makes contact with the Veteran or caregiver to schedule a home visit. If the Veteran is outside the 50-mile home visit radius, he or she will be scheduled for the telephone clinic.

The LCSW receives the consult, adds the Veteran's name as well as pertinent information to the tracking log, and assigns the Veteran to one of the RN CMs. If the Veteran is still hospitalized, the RN CM makes an attempt to visit the Veteran on the inpatient unit. If the Veteran has been discharged, the RN CM contacts the Veteran by phone to offer services and schedule an initial home visit as soon as possible postdischarge. Home visits require a written consent form be signed by the Veteran. If a Veteran declines home visits, the RN CM offers him or her the phone clinic. The PharmD or one of the RN CMs calls the Veteran who accepts telephone clinic follow-up once a week for 29 days.

For Veterans who accept home services, the RN CM makes either weekly home visits or telephone calls postdischarge once a week for 29 days. Most Veterans receive at least two home visits and two telephone calls during the 29-day period. The RN CM performs an initial assessment that includes a safety evaluation, an extensive medication review, and physical assessment. Abnormalities and discrepancies are reported to TCP team members as well as the Veterans' primary care provider (PCP) and care manager. The RN CM also provides education and written information on disease management. The RN CM collaborates with and/or coordinates services with the Veteran's PCP and care manager as well as non-VA providers such as HH agencies. Contact is maintained with the Veteran's PCP and care manager through the VAMC's electronic patient record, instant messaging, and/or phone calls. At the end of the 29-day program, the Veteran returns to his or her PCP or is admitted to the HBPC program, depending on Veteran preference and needs assessment. To ensure continuity of care as the Veteran transitions from the TCP to primary care or HBPC, the RN CM provides a copy of the Veteran's current plan of care.

The PharmD and RN CM collaborate to provide the Veteran with an accurate discharge medication (pill box fill) chart (Appendix B), adjusting the print size to accommodate Veterans with low vision. The RN CM may also offer the Veteran a patient log (Appendix C) as a tool to self-monitor vital signs, weight, blood glucose levels, and/or O_2 saturation. The RN CM collaborates with the Veteran and family or caregiver to develop an initial plan of care that is provided to the Veteran on the assessment visit followed by updates on subsequent visits (Appendix D). As part of the initial assessment, the RN CM not only discusses the health care teams' goals for the Veteran but also assesses the Veteran's personal goals and incorporates them onto the plan of care. Many times, these goals focus on the Veteran's desire to remain independent, at home and out of the hospital.

In addition to tracking and managing TCP consults, the LCSW completes a psychosocial assessment; assists Veterans in applying for VA benefits; links Veterans to community resources; and assesses caregiver stress levels, as well as providing counseling and/or community resources. The outpatient NP is available to collaborate with RN CMs and LCSW during home visits, as needed, advising them over the phone on urgent concerns such as elevated blood pressure or blood glucose levels as well as signs or symptoms of congested heart failure. This NP also reviews medications on the basis of the RN CMs assessment, makes adjustments as indicated, calls Veterans to clarify any questions/issues/symptoms, and advises them on the basis of the current assessment. This NP is available to order medications renewals if the RN CM has difficulty accessing Veterans' PCP and will consult with the PCP on the current plan of care as indicated. The outpatient NP takes the lead for data collection assisted by the RN CMs. The RN CMs record Veterans pre- and post-90-day admissions and ED visits (if they receive this information) on the spreadsheet for Veterans enrolled into the TCP and assist the outpatient NP in chart reviews as needed. A chart with TCP interventions by the team member is provided in Appendix E.

Methods

Design

Excel spreadsheets were developed and used to track information on Veterans who accepted TCP services, as well as those who did not accept services (Appendix F). A retrospective review of medical records for Veterans who accepted TCP services was conducted for fiscal years (FYs) 2013 and 2014, with a focus on number of admissions and ED visits 90 days prior to admission to the TCP and 90 days following TCP admission for same diagnosis. A TCP outcomes chart (Appendix G) was developed to track and record the following items each month during the FY: total number of patients enrolled, number

of hospitalizations 90 days prior to TCP enrollment, number of hospitalizations 90 days post-TCP enrollment, number ED visits 90 days prior to TCP enrollment, and number of ED visits 90 days post-TCP enrollment. The costs of a 4.45-day admission length of stay and ED visits were calculated as detailed in the Measures section below.

Setting

The Richmond, VA Hunter Holmes McGuire VAMC is a 399-bed facility offering primary, secondary, and tertiary health care in medicine, surgery, neurology, rehabilitation medicine, intermediate care, acute and sustaining spinal cord injury, skilled NH care, and palliative care and is located in Central Virginia. The TCP is for Veterans making inpatient to outpatient transitions from the VA, community hospital, or ED to home. Some Veterans will transition to NHs either in the VAMC or community for short-term rehabilitation following their hospitalizations prior to TCP follow-up.

Sample

Veterans with more than two hospital admissions and/or ED visits in the past 90 days or at high risk for readmission based on a CAN score of greater than 95 were identified for TCP. Additional screening criteria included admission diagnosis of acute exacerbation of chronic disease (e.g., chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, or hypertension); vague admission diagnosis, that is, not specific to a disease process (e.g., falls, generalized weakness, or failure to thrive); and/or poor social support system (e.g., lives alone and/or absence of caregiver). Exclusion criteria included Veterans who were active substance abusers, had a primary mental health diagnosis, were homeless, and/or with a spinal cord injury. Veterans with spinal cord injury receive transition services through another VAMC program. Veterans who met the aforementioned inclusion criteria as well as lived with in a 50-mile radius of the VAMC were offered services and, if they accepted, were enrolled in the TCP for home visits. Veterans living outside the VAMC 50-mile radius, or who declined home visits, were offered telephone calls and, if they accepted, were enrolled in the TCP telephone clinic. In FY 2013, 200 Veterans participated in the program, with 146 participating in 2014. There was only one RN CM assigned to the program for the first 6 months of 2014, which contributed to the drop in number of participants.

Measures

Numerators included number of hospital admissions 90 days post-TCP enrollment and number of ED visits 90 days post-TCP enrollment. Denominators included number of hospital admissions 90 days prior to TCP enrollment and number of ED visits 90 days prior to TCP enrollment. Admission cost calculation was based on $2,539 (average cost per day for 4.45-day length of stay for a general medical acute admission at the Richmond, VA, VAMC), which totals $11,298.55 for cost per admission (DiMeoSpeights, 2014). ED cost calculation is based on average U.S. ED visit cost of $2,168 (Abrams, 2013).

Demographics

Of the 200 Veterans participating in FY 2013, 198 were male and two were female, ranging in age from 54 to 93 years. Of the 146 Veterans participating in FY 2014, 143 were male and three were female, ranging in age from 47 to 92 years. A majority of the Veterans in the program were at least 65 years old. Most of the participants suffered from chronic illnesses to include but not limited to chronic obstructive pulmonary disease, congestive heart failure, diabetes mellitus, and/or hypertension and were receiving eight or more medications.

Program Outcomes

Pre-TCP enrollment ED 90-day visit totals for FY 2013 were 212 and 244 for FY 2014 for a total of 456. Post-TCP enrollment ED 90-day visit totals for FY 2013 were 66 and 113 for FY 2014 for a total of 179. This is a difference of 277 ED visits, which is a 61% decrease (see Figure 1). Pre-TCP 90-day enrollment hospital admissions for FY 2013 were 309 and 266 for FY 2014 for a total of 575. Post-TCP 90-day enrollment hospital admissions for FY 2013 and FY 2014 were 96 each year for a total of 192. This is a difference of 383 hospital admissions, which is a 67% decrease (see Figure 2). The total cost savings

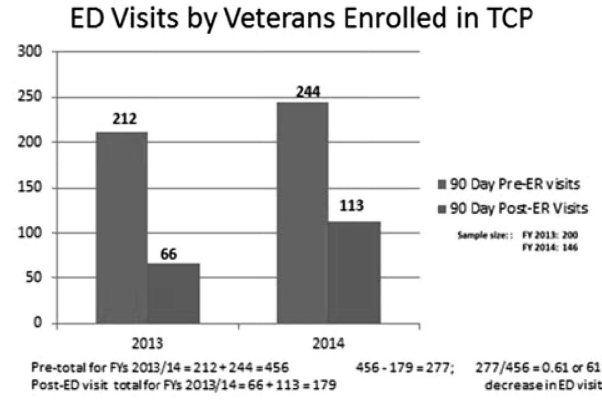

FIGURE 1
ED visits by Veterans enrolled in the TCP. ED/ER = emergency department; TCP = transitional care program.

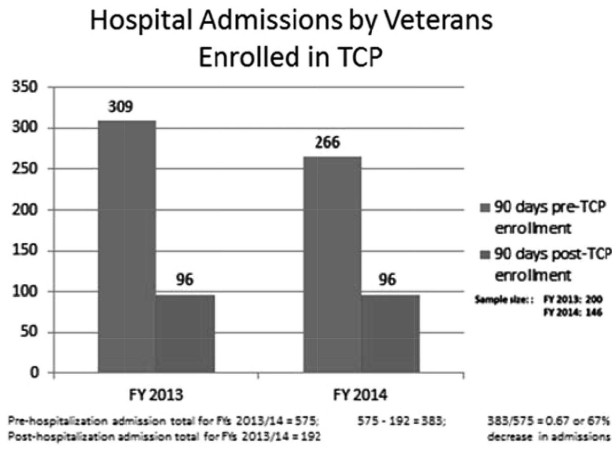

FIGURE 2
Hospital admissions by Veterans enrolled in the TCP.
FY = fiscal year; TCP = transitional care program.

from avoided ED visits and hospital admissions for FY 2013 were $2,193,820 and $1,629,835 for FY 2014. The total estimated medical center program cost savings equaled $3,823,673 (see Table 1). Cost determination for admissions and ED visits is explained in the "Measures" section.

Problems that were identified and have been resolved since the program began in 2012 include limited time available to the outpatient NP or RNs for seeing Veterans while they were inpatient (the inpatient NP position was added with backup from the PharmD and outpatient NP); need for improved discharge planning for high-risk population with unmet psychosocial needs (LCSW position was added as did not have an LCSW when the program initiated in 2012); medication discrepancies (PharmD position was added and full-time equivalent [FTE] was increased from 0.5 FTE to 1.0 FTE within a year); and identified Veterans with transitional needs outside the VAMC 50-mile radius (initiated a telephone clinic with current RN CMs and PharmD as well as pursing additional RN CM FTEs to staff the telephone clinic).

Limitations and Recommendations for Future Initiatives

The NTOCC Measures Work Group (2008) lists four outcomes in their Key Elements of the Framework for Measuring Transitions of Care: patients and/or family's experience and satisfaction with care received; providers' experience and satisfaction with the quality of interaction and collaboration among providers involved in care transitions; health care utilization and costs (e.g., readmissions); and health outcomes with patient wishes (e.g., functional status, clinical status, medical errors, and continuity of care). This TCP has adequately addressed health care utilization and cost outcomes but has not yet put into place a means for Veterans, their families, and providers to provide feedback about their level of satisfaction with the program in general as well as care provided by individual team members. Although no formal satisfaction or quality-of-life surveys were conducted, Veterans and caregivers reported to the RN CMs and LCSW that the program was helpful and provided them with much needed support. PCPs and especially non-VA providers (home health and hospice agencies) expressed appreciation for TCP interaction and collaboration. Record reviews conducted 90-days post-TCP participation recorded patient self-management improvement. This TCP may want to consider developing patient and family as well as a provider satisfaction surveys for process improvement projects and data mining.

Although Veterans are given the opportunity to express their wishes by sharing their personal goals, which are integrated into the TCP plan of care, measurement of health outcomes to include functional status is lacking. This program may want to consider utilizing a instrument such as the 36-Item Short-Form Health Survey as reported by Watkins et al. (2012) or the Vulnerable Elders Survey-13 as described by Guzman-Clark, Oglesby, Mather, and Williams (2014) to formally measure health care quality-of-life outcomes for this population pre- and postprogram.

Implications for Case Management

As life expectancy of Veterans with chronic health care conditions continues to increase, extending independent living at home remains an important patient goal. This population is fiercely independent and does not want to spend additional time in the hospital, at the ED, or in rehabilitation facilities. This TCP assists Veterans in attaining additional support and resources to increase their potential to function successfully in a home setting; it focuses on improving and encouraging communication with PCP by providing Veterans and caregivers with access to essential services and assigning a single point person (RN CM) to ensure continuity of care. The RN CM is the TCP team member who connects

TABLE 1
Transitional Care Program

	Cost Avoidance	
	2013	2014
Cost avoided admissions	$2,406,000	$1,920,754
Cost avoided ED visits	306,600	284,008
Total	$2,712,600	$2,204,762
Program cost per year	−$528,708	−$574,927
Medical center net savings	$2,194,483	$1,629,835

Please note, sample size for FY 2013 was 200 Veterans and FY 2014 was 146 Veterans.

As life expectancy of Veterans with chronic health care conditions continues to increase, extending independent living at home remains an important patient goal. This population is fiercely independent and does not want to spend additional time in the hospital, at the ED, or in rehabilitation facilities.

all the dots for the Veterans' care as they transition from the hospital, ED, or NH to home. As per Lattimer et al. (2013), the professional case manager is the hub for patient care engaging with the team, the patient, the family, and others beyond the team. They are uniquely positioned to coordinate care and improve transitions to serve as the hub to which all parties are connected.

The outcomes of this TCP demonstrate that using an interdisciplinary approach in developing patient-centered transition plans of care, using intensive case management interventions, improves resource utilization with substantial financial savings. This program represents a feasible option for other VAMCs as well as civilian hospitals seeking to provide cost-effective transitional care to patients upon discharge and prevent untimely readmissions. This TCP includes all of the NTOCC seven essential transition interventions, medication management, transition planning, patient and family engagement and education, information transfer, follow-up care, health care provider engagement, and shared accountability across providers and organizations (Lattimer et al., 2013), with the RN CM leading the way in successful demonstration of the value of smooth care transitions.

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Sabrina S. Hughes, MSN, RN, is an RN case manager in the Transitional Care Program at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia. She has been an RN for 13 years with a focus of educating patients on preventative health measures. She is currently enrolled in a Family Nurse Practitioner program and scheduled to graduate in June 2016.

Phyllis R. Wyche, FNP-BC, MSN, RN, works in Geriatrics and Extended Care as the NP for the Inpatient Transitional Care Program at the Hunter Holmes McGuire Veterans Administration Medical Center in Richmond, Virginia. She has been an RN for 34 years and an NP for 17 years with a focus on inpatient medicine and geriatrics.

Claire Jenkins, PharmD, BCPS, is the Transitional Care Program Clinical Pharmacy Specialist at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia. After graduating from the South Carolina College of Pharmacy, she completed her PGY-1 Residency at the McGuire VA Medical Center.

Cindy Logan, LCSW, provides psychosocial assessments and assists Veterans in accessing needed community services and Veteran benefits in the Transitional Care Program, Home Based Primary Care and Mobile Medical Unit at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia. She has been a social worker for 15 years specializing in community mental health specifically crisis work.

Appendix A

TCP Tracking Log															
Open Cases															
Last Name	**First Name**	**Last 4 SSN**	**Posted Date**	**Discharge Diagnosis**	**RN Assigned**	**PCP**	**Visit/Call #1**	***VisitCall #2***	***VisitCall #3***	***VisitCall #4***	***VisitCall #5***	***VisitCall #6***	**Dates of TCT**	**Med Rec**	
							(For tracking RN CM & LCSW contacts)							yes/no	
TCP Pending Enrollments							**Comments**		**Scheduled Enrollment Date**						
Vets in Nursing Homes							**Comments**								
Vets in Outside Hospitals															
Inpatient at VAMC															
Open TCP Telephone Clinic (TC)															
Last Name	**First Name**	**Last 4 SSN**	**Posted Date**	**Discharge Diagnosis**	**Staff Assigned**	**PCP**	**Call #1**	***Call #2***	***Call #3***	***Call #4***	**Dates of TC Clinic**				
Pending TC Enrollments															
LAST	**FIRST**	**Last 4 SSN**	**Posted**	**Discharge Diagnosis**	**Staff Assigned**	**PCP**	**Comments**								
Still inpatient at VA -															
Vets in Nursing Homes															

Appendix B
Example Pill Box Fill Chart

Name: Current Date:

Medication	AM	Noon	Dinner	Bedtime	Notes
Albuterol nebulizer every 6 hrs as needed for shortness of breath and tightness					
Albuterol inhaler 2 puffs every 4 hrs as needed for wheezing or shortness of breath					Use when unable to use nebulizer
Artificial tears 1 drop in left eye four times daily	1 drop	1 drop	1 drop	1 drop	
Docusate 100 mg once daily	1 cap				
Levothyroxine 0.175 mg once daily	1 tab				Take before breakfast
Lisinopril 5 mg once daily	½ tab				
Moxifloxacin 1 drop in left eye four times daily	1 drop	1 drop	1 drop	1 drop	
Boost Plus supplement 1 carton twice daily	1 carton		1 carton		
Omeprazole 20 mg once daily	1 cap				
Prednisolone acetate 1 drop in left eye four times daily	1 drop	1 drop	1 drop	1 drop	To control inflammation/swelling
Pregabalin 150 mg twice daily	1 cap			1 cap	May cause drowsiness
Tamsulosin 0.4 mg once daily	1 cap				
Tiotropium 18 MCG cap once daily					Inhale through Handihaler device
Tramadol 100 mg three times daily as needed for feet pain					
Non-VA aspirin 81 mg once daily	1 tab				
Non-VA sennosides with stool softener once daily				1 tab	

Appendix C
Patient Log

Month	Blood Pressure		Heart Rate		Blood Sugar				Weight	0_2	Comment
	AM	PM	AM	PM	AM	Lunch	Dinner	Bedtime	AM	AM	
1											
2											
3											
4											
5											
6											
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31											

Appendix D

Date:

Transitional Care Program Plan for:

_____

(Veteran's name inserted above).

You have been enrolled in the Transitional Care Program in the Home Based Primary Care Program at the Richmond, VAMC from _____ to _____.

(Dates of enrollment in TCP inserted above).

Your assigned RN is:

(*Insert RN's Name Here*)

and can be reached at (804) 675-6746.

Contact your Primary Care Provider _____ or care manager _____ in the _____ Clinic at _____ for any medical needs.

(*Names of Primary Care Provider, care manager, clinic name and phone number are inserted in corresponding blanks above*)

What you need to do:

Obtain and record at frequency listed below:

- Bp and Heart rate (pulse)_____
- Weight _____
- Blood glucose/sugar_____
- O_2 Sats _____

Take medications as ordered.

Use ambulation device (cane/walker) when you get up to walk around.

Other:

What RN will do:

Request:

- Medications:
- Supplies
- Consults:

Other:

(The RN enters the collaborative Veteran & RN plan on this page which includes interventions by the RN CM)

Helpful Phone Numbers

Outpatient Pharmacy:

- For refills call: (804) 675-5010
- For questions: (804) 675-5000 extension 3482

Prosthetics: (804) 675-5121

Central Registration: (804) 675-6675 (to update address, phone number and or emergency contacts)

Travel: (804) 675-5000 extension 4680

Diabetes clinic: (804) 675-5367

Veterans Crisis Line: (800) 273-8255

Billing: (804) 675-5000 ask operator for Billing office

Anticoagulation clinic: (804) 675-5292

DAV Transportation: (804) 675-5313

Follow-up Plan for: *(Insert Veteran's Name)* **Date:**

What you need to do:

Obtain and record at frequency listed below:

- Bp and Heart rate (pulse)_____
- Weight _____
- Blood glucose/sugar_____

O_2 Sats _____

Take medications as ordered.
Use ambulation device (cane/walker) when you get up to walk around.
Other:
What RN will do:
Request:
Medications:
Supplies
Consults:
Other:
(The RN enters the collaborative Veteran & RN follow-up plan on this page which includes interventions by the RN CM)

Appendix E
Transitional Care Program (TCP) Interventions by Team Member

Team Member	Interventions
Inpatient nurse practitioner (NP)	• Identifies and screens Veterans for TCP • Enters TCP consults • Collaborates with inpatient medicine team • Verifies Veteran's contact information • Provides coverage for outpatient NP
Outpatient nurse practitioner (NP)	• Collaborates with and advises RN CMs and LCSW while on home visits • Reviews RN CM assessment to include medications • Consults with PCP on current plan of care • Provides coverage for inpatient NP
RN case manager (CM)	• Visits hospitalized Veterans prior to discharge or makes phone contact to schedule home visit • Obtains consent to provide home services • Performs home safety evaluation and assessment of current needs • Provides weekly home visits or telephone calls • Provides disease and medication management to include educating Veteran and caregiver on self-management • Develops goals and care plan with Veteran and Veteran's caregiver(s) • Reports and collaborates with inpatient NP, Pharm D and PCP, and care manager concerning abnormalities/discrepancies • Collaborates/coordinates with Veteran's PCP and care manager • Supports TCP telephone clinic • Develops and provides transition plan to Veteran's PCP and care manager
Licensed clinical social worker (LCSW)	• Maintains TCP tracking log • Tracks Veterans in nursing homes • Provides and links Veteran to benefit and community resources • Provides caregiver assessment, support, and counseling
Clinical pharmacist (Pharm D)	• Supports inpatient NP • Collaborates with inpatient medicine team • Completes medication review prior to discharge from hospital or nursing home • Manages TCP telephone clinic

All TCP team members document their interventions in the VAMC medical record (CPRS).

Appendix F
Veterans Accepting Transitional Care Program Services

Last Name	First Name	Age	Last 4 SSN	Date Enrolled	Discharge Diagnosis	Zip Code	Rural	Phone Clinic	Primary Care Provider

Veterans Not Accepting Transitional Care Program Services

Last Name	First Name	Last 4 SSN	Date Posted	Discharge Diagnosis	RN Assigned	Primary Care Provider	Reason for Non-Acceptance

Appendix G
Transitional Care Program Outcomes

Fiscal Year Month	Total Number of Patients Enrolled	90 Day Pre-Enrollment Hospitalizations	90 Day Post-Enrollment Hospitalizations	90 Day Pre-Enrollment ER Visits	90 Day Post-Enrollment ER Visits
2013					
October 12	13	30	11	6	17
November 12	13	22	9	4	0
December 12	9	19	26	12	13
January 13	10	30	0	8	4
February 13	11	15	9	6	7
March 13	19	19	9	4	5
April 13	27	53	13	11	4
May 13	17	27	9	46	11
June 13	9	16	1	17	4
July 13	30	36	4	52	15
August 13	11	18	2	25	3
September 13	15	24	4	21	5
Totals	**200**	**309**	**96**	**212**	**66**
2014					
October 13	10	18	8	22	17
November 13	9	22	3	9	2
December 13	11	28	9	25	11
January 14	10	17	5	3	8
February 14	8	15	4	15	8
March 14	6	12	8	14	8
April 14	14	26	8	30	10
May 14	11	21	6	23	6
June 14	27	48	19	57	28
July 14	18	38	9	41	8
August 14	9	21	17	5	7
September 14	13	25	6	27	25
Totals	**146**	**291**	**102**	**271**	**138**

Note. The sample size for FY 2013 was 200 Veterans and for FY 2014 was 146 Veterans.

Instructions:

- Read the article. The test for this CE activity can only be taken online at www.nursingcenter.com/ce/PCM. Tests can no longer be mailed or faxed.
- You will need to create (its free!) and login to your personal CE Planner account before taking online tests. Your planner will keep track of all your Lippincott Williams & Wilkins online CE activities for you.
- There is only one correct answer for each question. A passing score for this test is 13 correct answers. If you pass, you can print your certificate of earned contact hours and access the answer key. If you fail, you have the option of taking the test again at no additional cost.
- For questions, contact Lippincott Williams & Wilkins: 1-800-787-8985.

Continuing Education Information for Certified Case Managers:
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Registration Deadline: October 31, 2017

Continuing Education Information for Certified Professionals in Healthcare Quality (CPHQ):
This continuing education (CE) activity is provided by Lippincott Williams & Wilkins and has been approved by the National Association for Healthcare Quality (NAHQ) for 2.5 CE Hours. CPHQ CE Hours are based on a 60-minute hour. This CE is approved for meeting requirements for certification renewal.

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The ANCC's accreditation status of Lippincott Williams & Wilkins Department of Continuing Education refers only to its continuing nursing educational activities and does not imply Commission on Accreditation approval or endorsement of any commercial product.

Registration Deadline for Nurses: December 31, 2018

Disclosure Statement:
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Payment and Discounts:

- The registration fee for this test is $24.95

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