



Health Center Association
OF NEBRASKA

There and Back Again

Solutioning for Successful Transitions of Care

Rachel Heinz, MPH, BSN, RN



ADVANCE
the
HEALTH CENTER
MOVEMENT.



Introduction

- **Clinician:** Psych, maternal health & public health
- **Nurse Informaticist:** Informaticists are the translators between health care and data
- **Community Health Centers:** Help make sure that EVERYONE gets access to health care





Objectives

1. Describe stages of a patient's transition of care between inpatient, outpatient, and emergency services.
2. Identify pain points in that cause breakdowns in interagency communication.
3. Generate solutions for care coordination between organizations.

What is Backward Design?



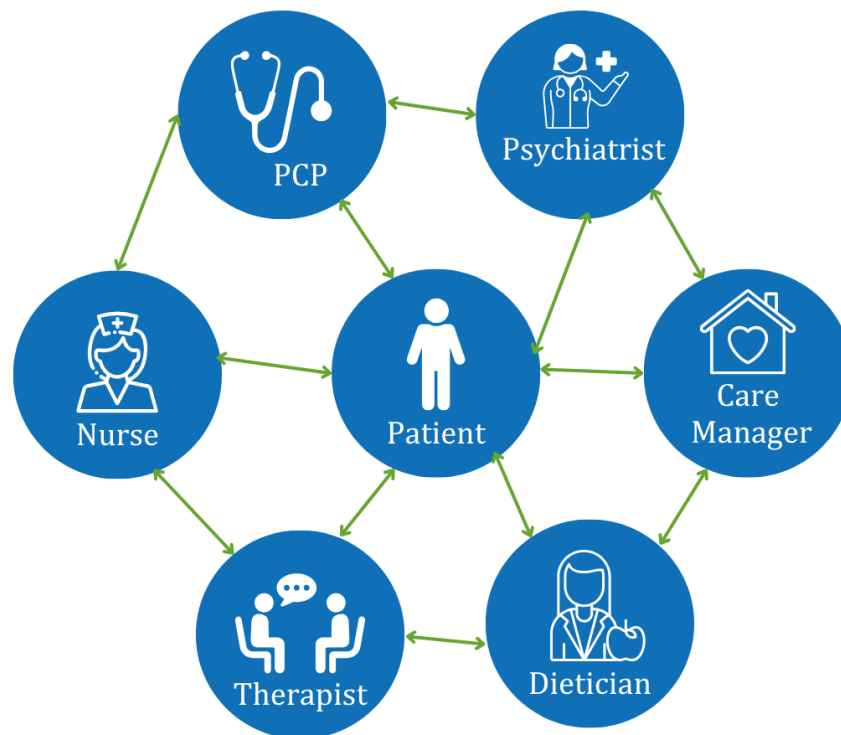


An Ideal Team-Based Integrated Care Set up



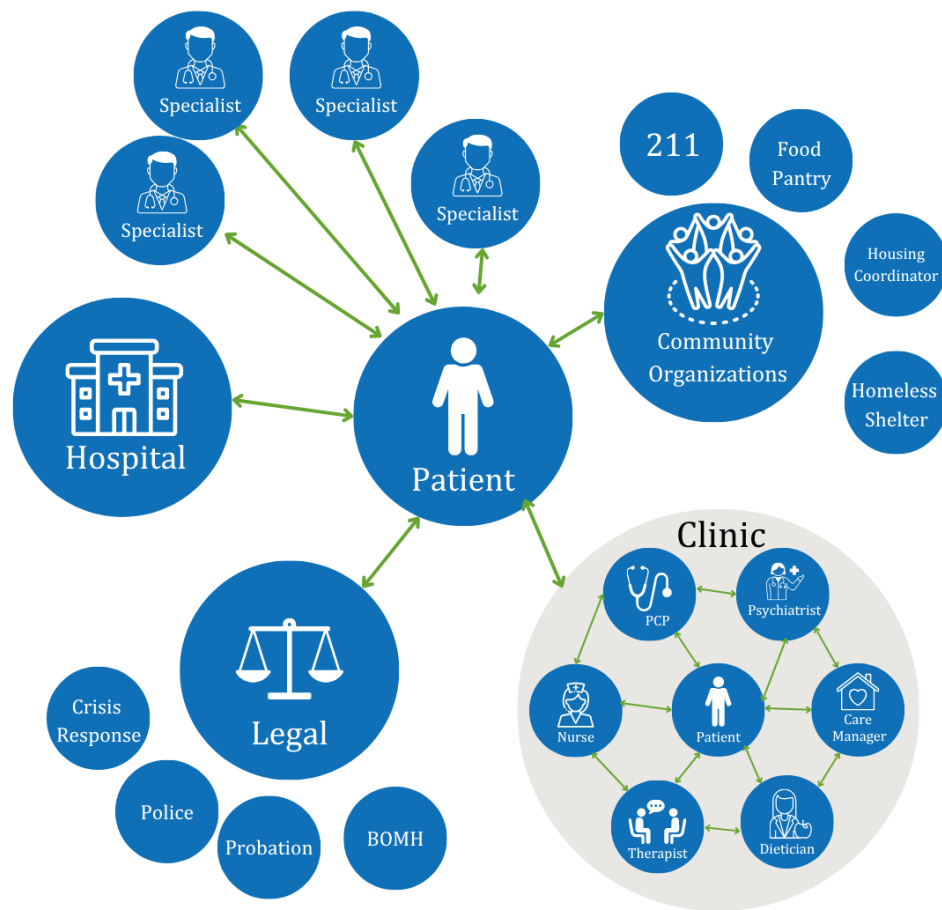


An Ideal Team-Based Integrated Care Set up



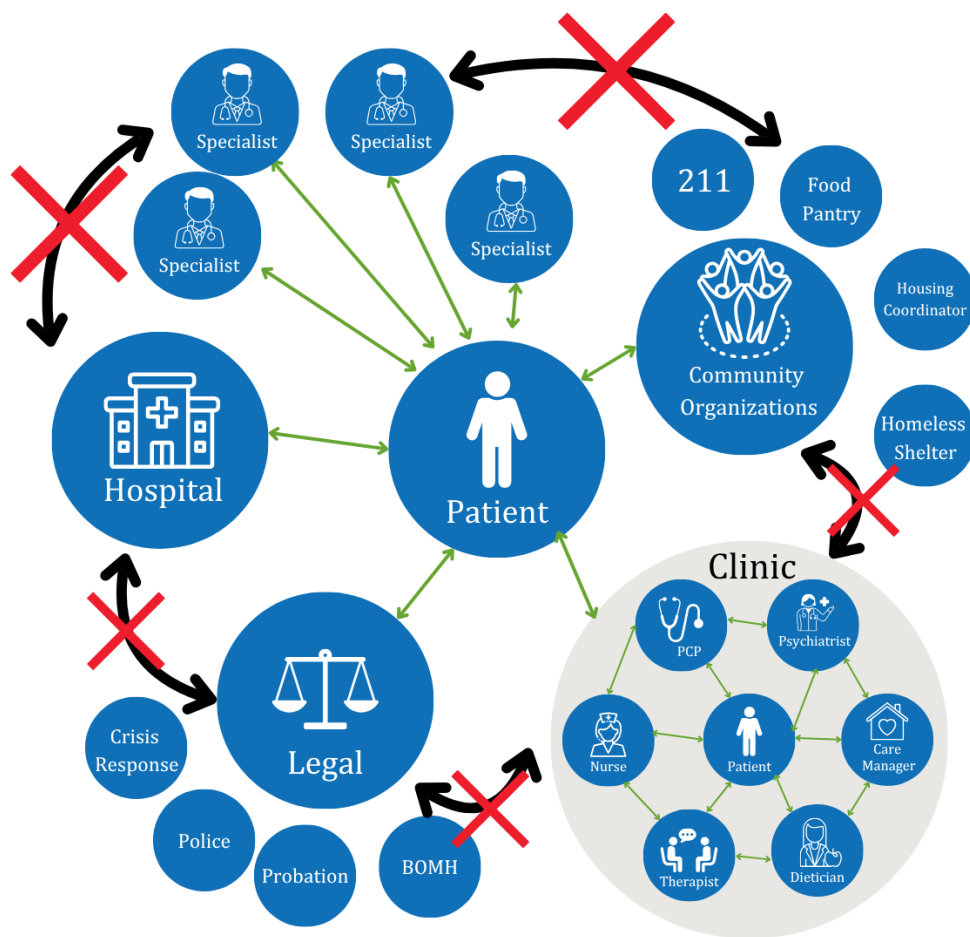


The Reality of the “TEAM”



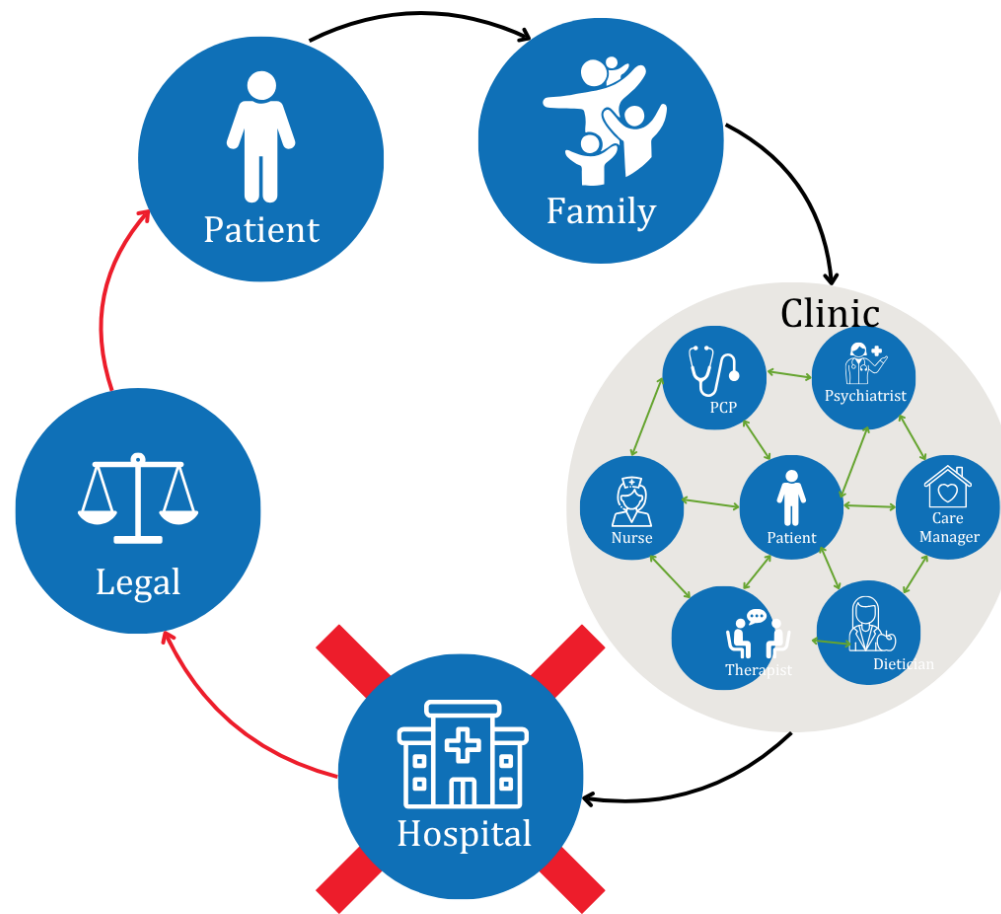


The Reality of the “TEAM”





My “Why”



This is where the system broke.

**We have the power to make
this better.**





Where are YOU seeing the breaks in the system?

Join at menti.com | use code 2480 5236

Where are YOU seeing the breaks in the system?

- All responses to your question will be shown here
- Each response can be up to 200 characters long
- Turn on voting to let participants vote for their favorites

Menti
BHECN 6.12

Choose a slide to present



Breaks in the System

Individual
Fear &
Disempowerment

Internal
Within an
Organization

External
Between
Organizations

Systems & Tech



Breakouts

Let's Solution

Continue	Stop
What helped us move forward?	What held us back?
Invent	Act
How could we do things differently?	What should we do next?

Agile coach

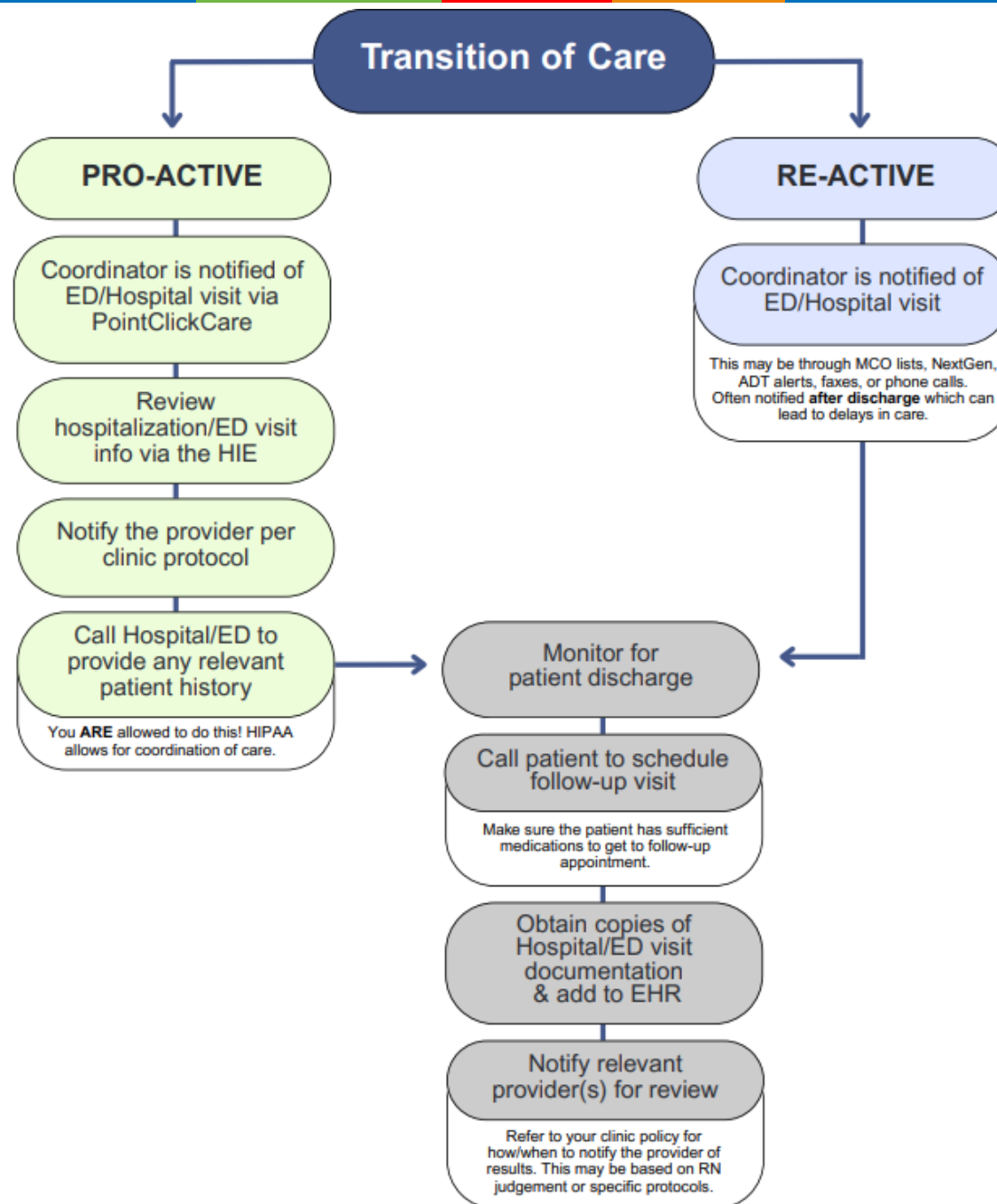


Internal Solutions:

Pro-active Care Coordination

1. Use available technology to know when patients are hospitalized.
2. Get direct phone numbers for key organizational contacts.
3. Offer support to the wider care team, even if they don't ask.

Make sure the patient knows who their care team is and how to contact them.





If we improve the system...

Improve patient
experience

Avoid hospital stays

Support recovery

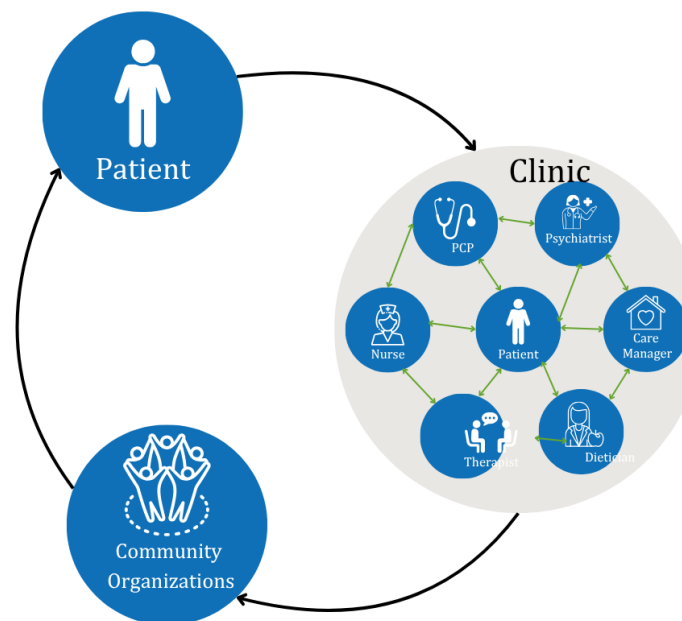
Prevent extra tests

Lower costs to the
patient & system

...what can we do with it?

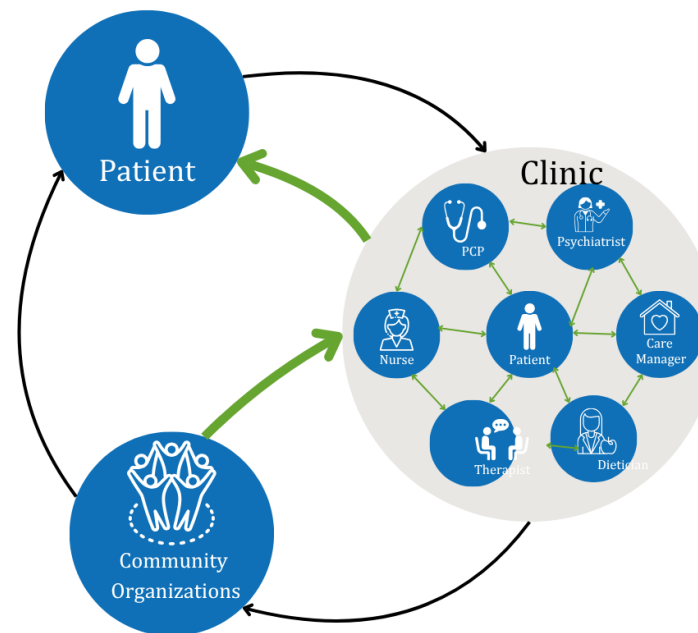


What Success Can Look Like





What Success Can Look Like



Questions?



Thank you for your time and attention!

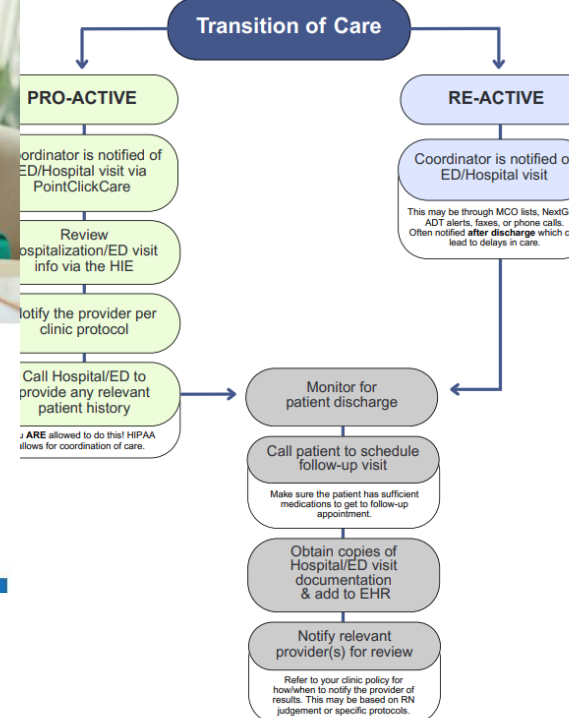


A healthcare professional, likely a nurse or doctor, is smiling and showing a small white device to an elderly man with glasses. They are sitting on a couch in a bright, indoor setting. The professional is wearing green scrubs and a stethoscope. The man is wearing a light blue polo shirt. The device is small and white, possibly a smartwatch or a small tablet. The background is a bright, indoor space with large windows and a plant.



Health Center Association
OF NEBRASKA

Sample Transition of Care Workflow



This daily planning tool can be used by care managers to help organize their day and monitor patient progress through the program

First, review your caseload and write in all the CM visits scheduled for the day and any associated notes. Then, review your caseload for any patients with other clinic visits that day and write them in the associated column. You may want to touch base with these patients as your availability allows. Review your hospital/ED admissions list and fill out the corresponding table with admitted patients information. Monitor these patients for discharge and notify providers as needed. Use the F/U List box to list any patients you need to connect with that day.

[Download PDF HERE.](#)

Scheduled OM Visits (Top Priority)		OM Patients in Clinic (Meet with as available)		Hospital/ED to Monitor for			
Patient	Reason	Pt	Reason	Patient	Heep	D/G?	Notes
Toby F	PCP: Holy N ^o ason: CM orientation	Pt:	Reason:	Kelly	ChE	Exp	Bodily Inj. Level To P
ason:	PCP:	Pt:	Reason:	Erin H	Kearney Eng	?	Call SW 422-444-4444
ason:	PCP:	Pt: Michael S. PCP: Dr. Lewis	Reason: Burn				
Roy A	PCP: Dr. Palmer	Pt:	Reason:				
ason:	Full Heart	Pt:	Reason:				
ason:	New diabetes, prior leg amputee	Pt: Darryl P. PCP: Dr. Nunez	Reason: Dental				
ason:	PCP:	Pt:	Reason:				
ason:	PCP:	Pt:	Reason:				
ason:	PCP:	Pt:	Reason:				
ason:	PCP:	Pt:	Reason:				
ason:	PCP:	Pt:	Reason:				
ason:	PCP:	Pt:	Reason:				
ason:	PCP:	Pt: Angela M. PCP: <i>ask for Reason: Phyllis E</i>					
ason:	PCP:	Pt: Stanley R. PCP: Dr. Smith	Reason: <i>ask for BP log</i>				
ason:	PCP:	Pt:	Reason:				
ason:	PCP:	Pt:	Reason:				
ason:	PCP:	Pt:	Reason:				
ason:	PCP:	Pt:	Reason:				
ason:	PCP:	Pt:	Reason:				
ason:	PCP:	Pt:	Reason:				
ason:	PCP:	Pt:	Reason:				
ason:	PCP:	Pt:	Reason:				

F/u List

☐ Phyllis V. - F/u mammogram

☐ Creed B. - d/c? unresponsive

☐ Mercedes P. - check in call date
For annual visit

☐

☐

☐

☐

☐

☐

Notes

<https://hcanabraska.org/page/OnDemand>

