COLORADO
Department of Public Health & Environment

TRANSFERRING A HCP CLIENT TO ANOTHER LOCAL PUBLIC HEALTH AGENCY'S HCP PROGRAM

There is evidence that suggests that poor outcomes can be related to poor transitions. So how do we optimize opportunities for both improved outcomes and successful transitions?

Best practice indicates that the combination of a standardized verbal and written hand-off will result in improved outcomes for families! What does an optimal hand-off look like? And how do we standardize the process in order to meet the needs of HCP Care Coordinators?

Best Practices Associated with a Successful Care Transition

There is little research on transitions between care providers other than between hospital and home. However, we can and should look to the best-practices developed in "hospital to home models" to inform how we transition care between county level HCP Programs.

The American Medical Directors Association recommends three key elements to support "safe, patient-centered care as patients and families transition between sites of care": (1) Patient-Centered Care; (2) Communication; and (3) Safety. The following concepts have been modified to align with your HCP work:

1. Patient-Centered Care
    a. Transfers should take place only with the family's input. Always be sure to provide families with the name and contact information of the person to call with questions.
    b. Transfers include appropriate patient and caregiver education, which can help manage expectations. Furthermore, appropriate support from both the sending and receiving care coordinator will help families continue to set realistic goals and limit frustration for all parties.
    c. Action Plans should also always be provided to the family, in writing. Families should be part of action plan creation and maintenance, hopefully assuming ownership of that information.
    d. Follow up several days after transfer to ensure that the family has made contact with the receiving care coordinator.
2. Communication
    a. Information about the individual should be entered into CDS in an accurate and timely manner.
    b. Action Plans should be forwarded to the next care coordinator as soon as possible.

c. As part of your verbal/written hand-off, discuss work to date as well as goals that still need follow up.
d. Ensure that both the sending and receiving care coordinators have reliable contact information for each other, as well as the family.

3. Safety
   a. Patient safety relies on accurate and timely transfer of patient information.
   b. Ensure that the receiving care coordinating agency has capacity to take on a new care coordination client, thereby keeping most at-risk clients safe.
   c. Remember: the responsibility for the child does not end when the patient is transferred in CDS until the receiving care coordinator is contacted, appropriate information is shared, and the receiving HCP program has assumed responsibility for clinical care.

What is the Impact of Successful Care Transitions?

- increased satisfaction for families
- increased quality of services / continuity of care
- increase in number of successful hand-offs
- potential for improved patient care
- potential for reduced patient costs (e.g. ER, hospitalizations, duplicate services)
- reduced frustration and rework for HCP workforce
- increased satisfaction of HCP workforce
- improved communications between care providers (opportunity to ask/ answers questions about child/youth/family

HCP Guidelines

When a client transfers out of your service area, the goal should be to make sure that the receiving HCP program has relevant and accurate information about the child's condition, family, care, current treatment(including current action plan goals), and current and anticipated needs.

Questions to consider when transferring care:

1. Does the family want to continue receiving HCP Care Coordination?
2. Ask yourself "what information do I wish I received with every new referral? What information will help the receiving care coordinator start coordinating care for this child/family most accurately and effectively"?
   a. Be sure to provide relevant information to the best extent possible! More information helps to increase likelihood of continuity of care.
   b. Don't forget to obtain consent from the family.

3. Be sure to indicate whether or not services have begun. Another words, is this a referral for care coordination? Or do you simply want the receiving HCP program to provide information only.
4. Is CDS up-to-date? Ensure that CDS is up-to-date so that the receiving HCP Program has access to accurate data.

HCP Process

1. HCP Care Coordinator learns that child/youth/family are moving out of service area
2. DECISION: Does family still need & want HCP care coordination? Note: HCP Care Coordinator completes assessment as per the HCP Policy & Guidelines document and discusses options with family.
    a. If Yes,
        i. make a formal referral (first written then verbal once information has been shared) to receiving HCP Program care coordinator
        ii. inactivate client in CDS
        iii. use the "transfer" feature in CDS to transfer the client to the receiving HCP Program
    b. If No, provide client with contact information for HCP Program in the client's new county of residence and inactivate client in CDS.
3. Ensure that the receiving county has capacity for coordinating this child's services. Ask if there is a wait list. Advocate for quick intake if the child is at risk.
4. Will the child/youth need a new PCP?
    a. If Yes, remind family and be sure to include on referral to receiving HCP Program care coordinator.
    b. If No, no action is needed.
5. Receiving HCP Program care coordinator contacts family, completes intake, and begins coordinating care.

With a standard approach to transferring care between HCP Programs, we can improve satisfaction and outcomes for the families we serve. If you have other ideas to improve transitions for families, be sure to share them with us! Contact your HCP Consultant today with questions.

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References

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