Health Links Leadership Community of Practice

July 19, 2016

Transitions Discharge Bundle and Health Literacy

Guest Speaker: Kelly O'Halloran

	AGENDA
9:00-9:05	Welcome and Introduction
9:05-9:15	Health Link Leadership Community of Practice: Setting the context
9:15-9:25	Innovative Practices
9:25-9:55	Guest speaker: Kelly O'Halloran "Transitions Discharge Bundle and Health Literacy"
9:55-10:05	Patient Story
10:05-10:20	Discussion: Practical application in your Health Link
10:20-10:25	Polling for future topics and webinar evaluation
10:25-10:30	Closing Comments

Webinar Learning Objectives

- **Understand Discharge Transition Bundle (DTB) decision making tools for staff and self-management tools for patients**
- **Describe components of Chronic Obstructive Pulmonary Disease (COPD) and heart failure teach back methods**
- **Share experiences and learnings with other colleagues across the province**

Health Links
Community of Practice

Communities of practice can be defined as groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly.

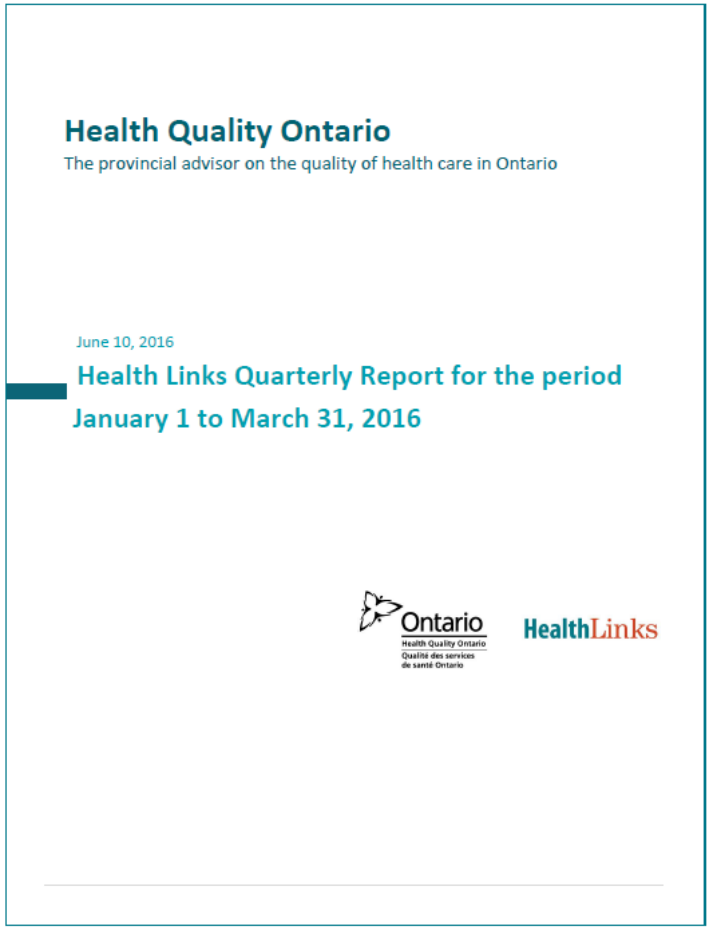
Health Links Community of Practice

This is an opportunity to meet (virtually and in person) with others for networking, sharing and learning:

- Hear from leaders to better understand what it takes to lead change in the Health Links environment
- Be inspired to spread innovative approaches in your Health Link
- Contribute to the collective learning about what works best in a Health Links approach.

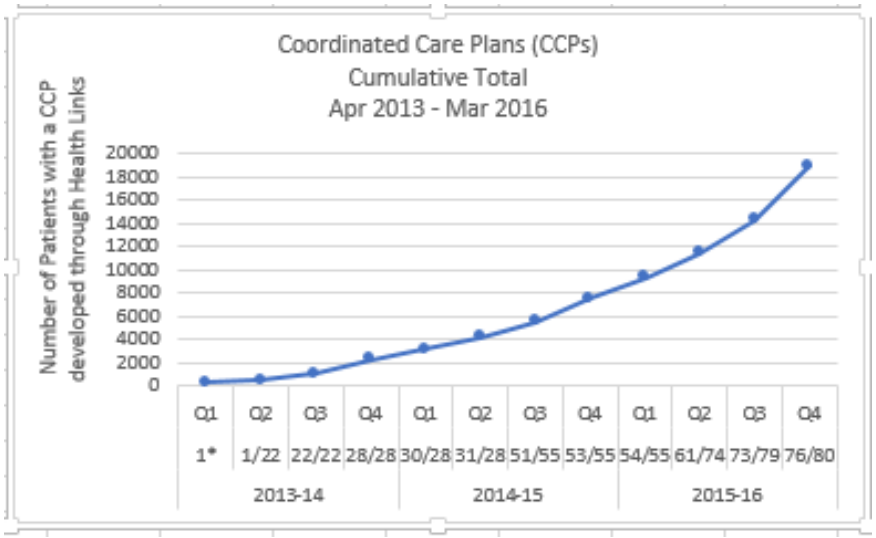
Quarterly Reports

- Circulated broadly with full transparency among Health Links
- Includes:
  - Self reported data on two key measures (Coordinated Care Plans and attachment to Primary Care Providers)
  - Local and provincial targets
  - Summaries of discussion on how Health Links are approaching
  - Patient stories
- Future reports will include uptake of innovative practices endorsed by the Clinical Reference Group



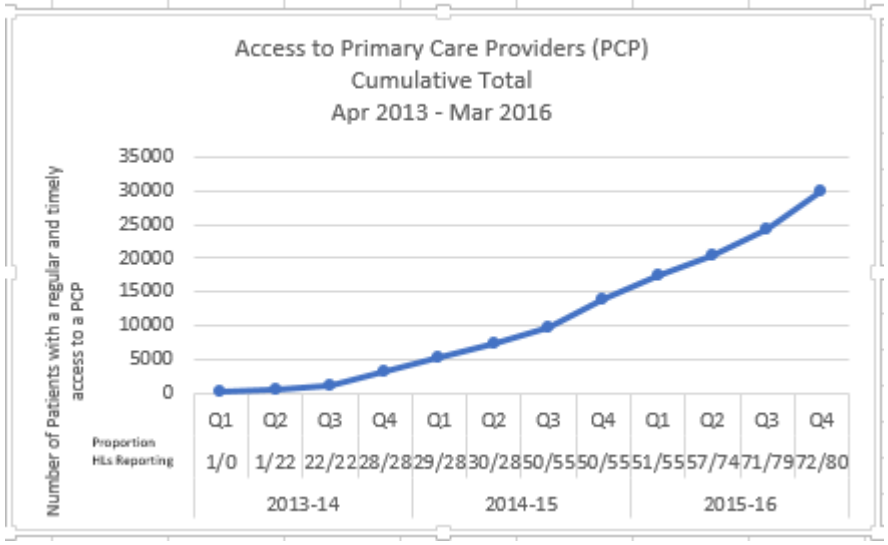
Impact of Health Links – Q4 Update

Coordinated Care Plans



18,926 complex patients have been provided with coordinated care plans through Health Links

Access to Primary Care

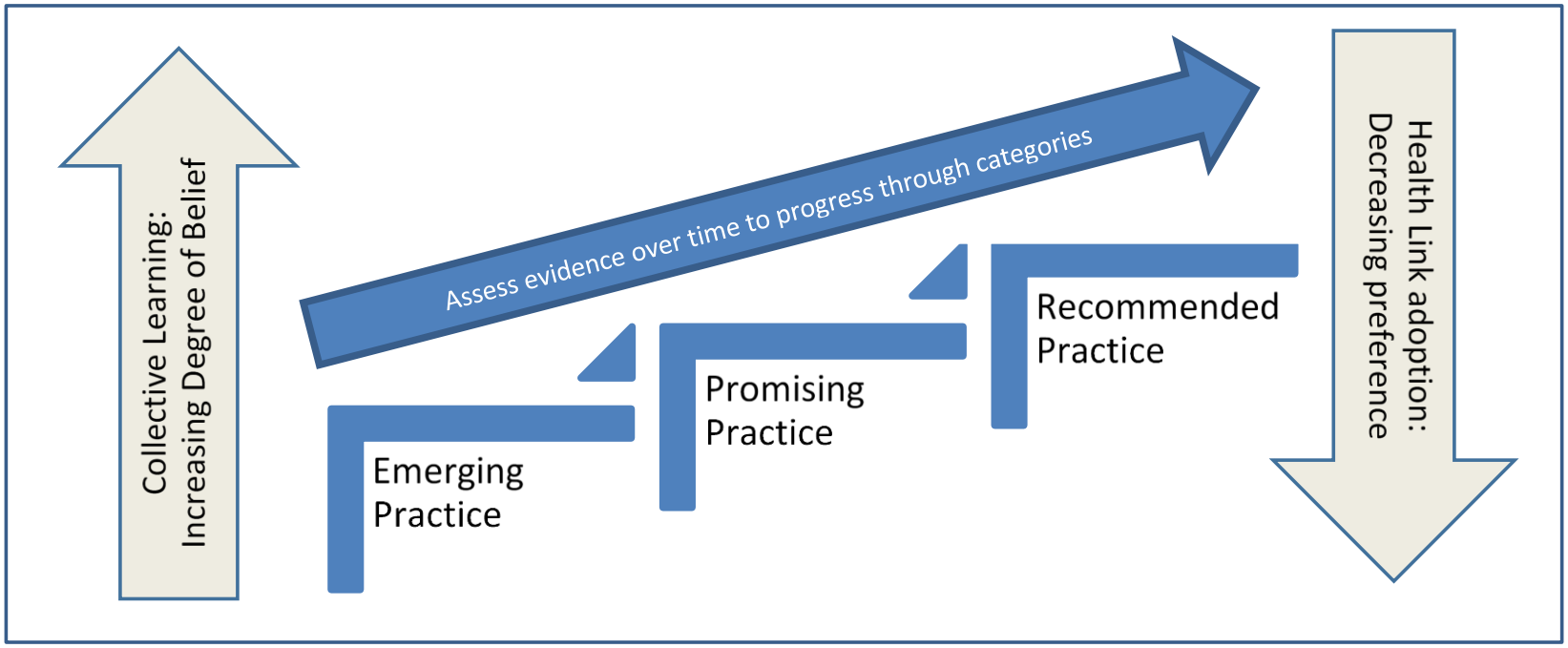


29,946 Health Links patients have been connected to regular and timely access to Primary Care

Data Source: Health Quality Ontario's Quality Improvement Reporting and Analysis Platform (QIRAP) – self-reported by Health Links

Assessing Innovative Practices

Innovative Practices Evaluation Framework



Transitions between Hospital and Home

Early in the hospital admission

- Perform med rec on admission
- Assess patient risk of readmission
- Assess health literacy
- 1. Notify community providers of patient admission to hospital
- 2. Collaborate with community providers to begin/update the coordinated care plan

Throughout the hospital stay and transition process

- Use teach back when building caregiver and patient capacity
- Enhance patient and caregiver communications with the use of visual tools

Close to time of discharge

- Ensure personal clinician to clinician information transfer
- Perform med rec at discharge
- 3. Identify one lead to perform med rec in community
- 4. Schedule primary care visit before leaving hospital

In the community after a hospital stay

- 5. Ensure discharge summary available within 48 hours
- 6. Follow-up with patient within 48 hours of transition home
- 7. Designate a person in the community to support non-clinical needs in the immediate post-hospital period.

Evidence-informed best practices

Innovative practices

Innovative Practices

FOCUS ON COORDINATED CARE MANAGEMENT AND TRANSITIONS IN CARE

Guest Speaker: Kelly O'Halloran

TRANSITIONS DISCHARGE BUNDLE AND HEALTH LITERACY

Health Literacy, Teach-back & the HNHB LHIN Discharge Transitions Bundle

Hamilton Health Sciences


Rx
COLEMAN
" TAKE WITH MEALS ? NO PROBLEM !
I EAT ALL THE TIME ! "

Health Literacy

According to the Canadian Public Health Association (2006),

Health Literacy is the ability to access, understand, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course.

The World Health Organization (1998) states,

…..*health literacy is essential to taking control of and managing one's health. It means more than being able to read pamphlets and successfully make appointments. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment.*

Canadian Public Health Association (2008). A Vision for a Health Literate Canada: Report of the Expert Panel on Health Literacy
World Health Organization (1998). Health Promotion Glossary

Some Facts about Health Literacy

- Figures show that 60% of adults and 88% of seniors in Canada are not health literate.

- People over age 65, recent immigrants and those with low income, low education or low capacity in English or French are most likely to have low levels of health literacy.

- Studies have shown that 40-80% of the medical information patients receive is forgotten immediately and nearly half of the information retained is incorrect.

Canadian Public Health Association (2008). A Vision for a Health Literate Canada: Report of the Expert Panel on Health Literacy
Public Health Agency of Canada: http://www.phac-aspc.gc.ca/cd-mc/hl-ls/index-eng.php

A Vision for a Health Literate Canada

Report of the Expert Panel on Health Literacy

Irving Rootman and Deborah Gordon-El-Bihbety

CPHA ACSP

WHO/HPR/HEP/98.1
Distr.: Limited

Health Promotion Glossary

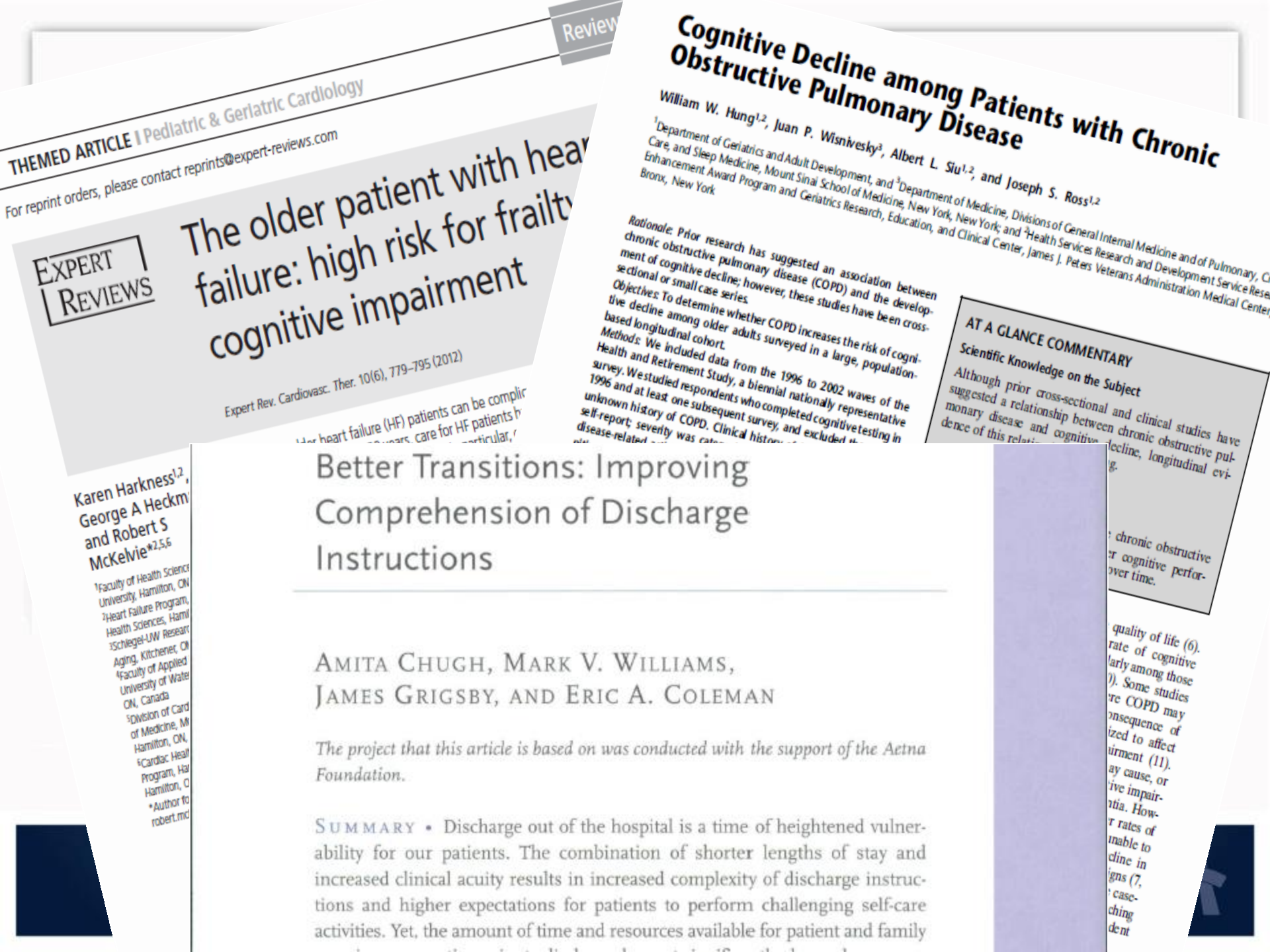
World Health Organization
Geneva

CPHA ACSP
CANADIAN PUBLIC HEALTH ASSOCIATION
LE LEADER CANADIEN EN SANTÉ PUBLIQUE

The Impact of Low Health Literacy on Chronic Disease Prevention and Control

Canadian Public Health Association

2006



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EXPERT REVIEWS

The older patient with heart failure: high risk for frailty cognitive impairment

Expert Rev. Cardiovasc. Ther. 10(6), 779–795 (2012)

Karen Harkness[1,2], George A Heckman and Robert S McKelvie*[2,5,6]

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[2]Heart Failure Program, Health Sciences, Hamil
[3]Schlegel-UW Research Aging, Kitchener, ON
[4]Faculty of Applied University of Water ON, Canada
[5]Division of Card of Medicine, Mc Hamilton, ON,
[6]Cardiac Healt Program, Ha Hamilton, O
*Author fo robert.mc

Cognitive Decline among Patients with Chronic Obstructive Pulmonary Disease

William W. Hung[1,2], Juan P. Wisnivesky[3], Albert L. Siu[1,2], and Joseph S. Ross[1,2]

[1]Department of Geriatrics and Adult Development, and [3]Department of Medicine, Divisions of General Internal Medicine and of Pulmonary, C
Care, and Sleep Medicine, Mount Sinai School of Medicine, New York, New York; and [2]Health Services Research and Development Service Rese
Enhancement Award Program and Geriatrics Research, Education, and Clinical Center, James J. Peters Veterans Administration Medical Center
Bronx, New York

Rationale: Prior research has suggested an association between chronic obstructive pulmonary disease (COPD) and the development of cognitive decline; however, these studies have been cross-sectional or small case series.

Objectives: To determine whether COPD increases the risk of cognitive decline among older adults surveyed in a large, population-based longitudinal cohort.

Methods: We included data from the 1996 to 2002 waves of the Health and Retirement Study, a biennial nationally representative survey. We studied respondents who completed cognitive testing in 1996 and at least one subsequent survey, and excluded [illegible] unknown history of COPD. Clinical history [illegible] self-report; severity was [illegible] disease-related [illegible]

AT A GLANCE COMMENTARY

Scientific Knowledge on the Subject

Although prior cross-sectional and clinical studies have suggested a relationship between chronic obstructive pulmonary disease and cognitive decline, longitudinal evidence of this relati[illegible]g.

[illegible] chronic obstructive [illegible]r cognitive perfor- [illegible]over time.

[illegible] quality of life (6). [illegible]rate of cognitive [illegible]larly among those [illegible]). Some studies [illegible]re COPD may [illegible]onsequence of [illegible]ized to affect [illegible]irment (11). [illegible]ay cause, or [illegible]ive impair- [illegible]ntia. How- [illegible]r rates of [illegible]inable to [illegible]cline in [illegible]igns (7, [illegible] case- [illegible]ching [illegible]dent

Better Transitions: Improving Comprehension of Discharge Instructions

AMITA CHUGH, MARK V. WILLIAMS, JAMES GRIGSBY, AND ERIC A. COLEMAN

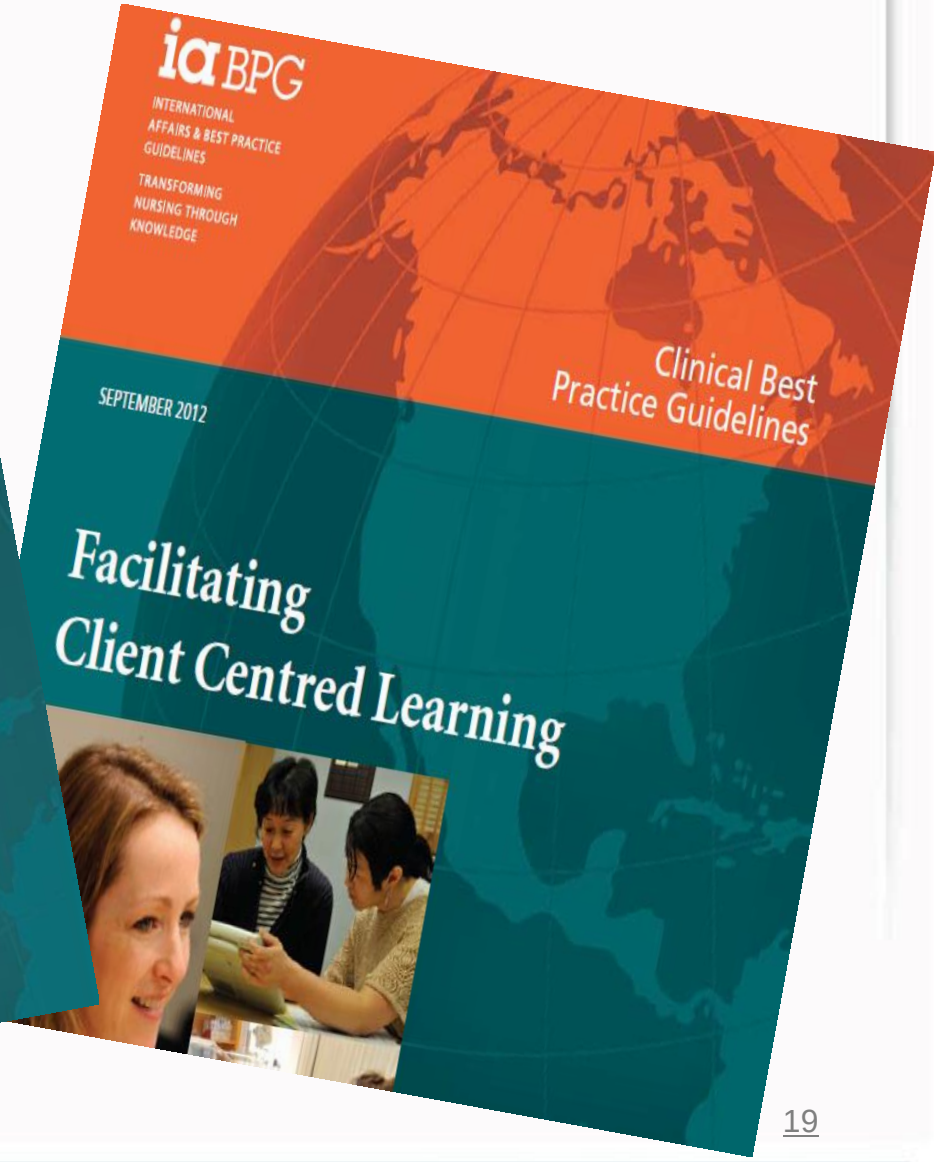
The project that this article is based on was conducted with the support of the Aetna Foundation.

SUMMARY • Discharge out of the hospital is a time of heightened vulnerability for our patients. The combination of shorter lengths of stay and increased clinical acuity results in increased complexity of discharge instructions and higher expectations for patients to perform challenging self-care activities. Yet, the amount of time and resources available for patient and family

Teach-back

Teach-back is a method used to confirm that you have explained to the patient what they need to know in a manner the patient understands.


RNAO
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario
Clinical Best
Practice Guidelines
SEPTEMBER 2010
Strategies to Support Self-Management
in Chronic Conditions: Collaboration
with Clients


ia BPG
INTERNATIONAL
AFFAIRS & BEST PRACTICE
GUIDELINES
TRANSFORMING
NURSING THROUGH
KNOWLEDGE
Clinical Best
Practice Guidelines
SEPTEMBER 2012
Facilitating
Client Centred Learning

HNHB LHIN Discharge Transitions Bundle

Staff COPD Teaching Tool

COPD Teach-back

Please begin Teach-back when patient able. If patient unable to Teach-back please attempt to do this with caregiver (living with patient). Please document whether patient or caregiver is able to Teach-back on reverse and make referral to CCAC RRTT if patient or caregiver is not able to Teach-back for Teach-back # 1 or 2 or 3 or 4.

Please Document Who You are Completing Teach-back With: ☐ **Patient** ☐ **Caregiver (living in home) Name:** _____

Teach-back #1 : I would like to talk to you about what you can do when you are feeling more short of breath than what is normal for you.

If you feel/have:	Actions:
• Stressed or have been exposed to things that make your breathing worse. • More short of breath than usual. • Coughing or wheezing more than usual. • More sputum than usual.	• Take your medications, especially your quick relief or rescue inhaler (Bronchodilator - Ventolin). • Use oxygen as prescribed. • Try to avoid or stay away from what is making your breathing worse (e.g. stress, cigarette smoke, dust). • Breathe from your diaphragm or with pursed-lips. When sitting, lean forward, relax your neck, shoulders and arms. • Call your doctor or nurse practitioner if you feel you are getting more short of breath.

I want to make sure I have explained everything clearly to you. Can you please tell me what you will do when you feel more short of breath than what is normal for you?

Teach-back #2 : I would like to talk to you about your COPD Medications.

COPD Medications:	Actions:
• HandiHaler (Spiriva) • AeroChamber with an Aerosol Inhaler (Ventolin, Atrovent, Advair, Flovent) • Diskus (Flovent, Advair, Serevent, Ventolin)) • Turbuhaler (Symbicort, Pulmicort, Bricanyl)	• Take your medications as prescribed (right med, right time, right technique). • Understand which inhaler is your relief or rescue inhaler (Bronchodilator - Ventolin). • Understand purpose of all COPD medications.

I want to make sure I have explained your COPD medications clearly to you. Can you please tell me what each of your COPD medications are for and show me how you will take each of them?

Teach- back #3 : I would like to talk to you about what you can do when you feel your shortness of breath is getting worse and when you need to call your doctor or nurse practitioner. I would also like to talk about when you may be in danger.

If you have:	Actions:
• Increasing shortness of breath. • More sputum than usual. • Green or yellow sputum with or without a fever.	• Call your doctor or nurse practitioner. • Take your medications, especially your quick relief or rescue inhaler (Bronchodilator - Ventolin). • Use oxygen as prescribed. • Start any new medications prescribed. • If your symptoms do not improve within 48 hours call your doctor or nurse practitioner again. • If you cannot contact your doctor or nurse practitioner go to a Clinic, Urgent Care or Hospital.

You may be in DANGER and need to go to the Hospital if you are/have:

If you feel/have:	Actions:
• Extremely short of breath. • Not able to do any activity because of breathing. • Not able to sleep because of breathing. • Fever or shaking chills. • Feeling confused, drowsy or agitated. • Sudden chest pain.	• Call 911 or have someone take you to the hospital. • Take your medications, especially you quick relief or rescue inhaler (Bronchodilator - Ventolin). • Use oxygen as prescribed.

I want to make sure I have explained how you can stay safe when you are at home. Can you please tell me when you will call your doctor or nurse practitioner and when you may need to go to a Clinic, Urgent Care or the Emergency Department?

Teach-back #4: You are being discharged from the hospital today. I would like to talk to you about your discharge instructions and how to manage your COPD at home.

- Review Teach-back # 1, 2, 3.
- Review Discharge prescription, specifically review COPD medications including purposes, doses, and frequencies. Discuss patient's ability to fill prescription without delay. Review relief or rescue inhaler (Bronchodilator - Ventolin). Have patient demonstrate use of inhalers. Instruct patient to take all medications with new prescription to their pharmacy.
- Review follow-up appointments and ensure appointments are made. Discuss patient's ability to get to all appointments.

We have talked about your COPD and what the hospital doctor would like you to do when you go home. To make sure I have explained this clearly, can you tell me what you will do when you are discharged today? Do you have any questions or concerns?

Patient COPD Action Plan

COPD Signs & Symptoms	Action Plan
I feel well • My breathing problems have not changed (normal shortness of breath, cough and sputum). • My appetite is normal. • I have no trouble sleeping. • I can exercise and do my daily activities as usual.	**What should I do?** • Take my medications as prescribed. • Use oxygen as prescribed. • Continue my regular exercise and diet. • Avoid cigarette smoke, dust and other allergens.
I feel different • I am more short of breath than usual. • I am coughing or wheezing more than usual. • I have more sputum than usual. • I feel stressed or have been around things that make my breathing worse.	**What should I do?** • Take my medications, especially my quick relief or rescue inhaler (Ventolin) as prescribed. • Use oxygen as prescribed. • Avoid things that make my breathing worse such as cigarette smoke, dust and stress. • Breathe from my diaphragm or with pursed-lips. • When sitting, lean forward, relax my neck, shoulders and arms.
I feel I am getting worse • I have increased shortness of breath. • I have increased sputum. • I have green or yellow sputum with or without a fever.	**What should I do?** • Call my doctor or nurse practitioner. • Take my medications, especially my quick relief or rescue inhaler (Ventolin) as prescribed. • Use oxygen as prescribed. • If there is no improvement after 48 hours, call my doctor or nurse practitioner again. • If I cannot contact my doctor or nurse practitioner, go to a clinic, urgent care or hospital.
I am in danger • I am extremely short of breath. • I cannot do any activity because of breathing. • I am not able to sleep because of breathing. • I have fever or I am shaking (chills). • I feel confused, drowsy or anxious. • I have sudden chest pain.	**What should I do?** • Call 911 or have someone take me to the hospital. • Take my medications, especially my quick relief or rescue inhaler (Ventolin) as prescribed. • Use oxygen as prescribed.

The facts about COPD
(Chronic Obstructive Pulmonary Disease)

What is COPD?

COPD is a chronic disease that slowly damages your lungs and makes your breathing difficult. There is no cure but you can manage your COPD in many ways.

How do I stay healthy:

- Take your medications properly.
- Get a pneumonia shot.
- Eat well.
- Wash your hands regularly to prevent infection.
- Quit smoking (very important).
- Get an annual flu shot each fall.
- Exercise regularly.
- Follow your COPD action plan (on reverse).

What is a flare-up?

A flare-up is what happens when your COPD starts getting worse. You may have one or more of these signs for 48 hours or longer:

- More shortness of breath than usual.
- More sputum than usual.
- More coughing.
- Your sputum color is different..

What causes a flare-up?

- Stress or infections.
- Air pollution, dust or other allergens.
- Weather changes (cold, hot or humid air).
- Smoke.
- Strong fumes or odours.

What should I do if I start to have a flare-up?

- **Manage your flare-up as early as possible (see reverse side).**
- **Contact your doctor or nurse practitioner if your symptoms do not improve after 48 hours.**

Need more information?

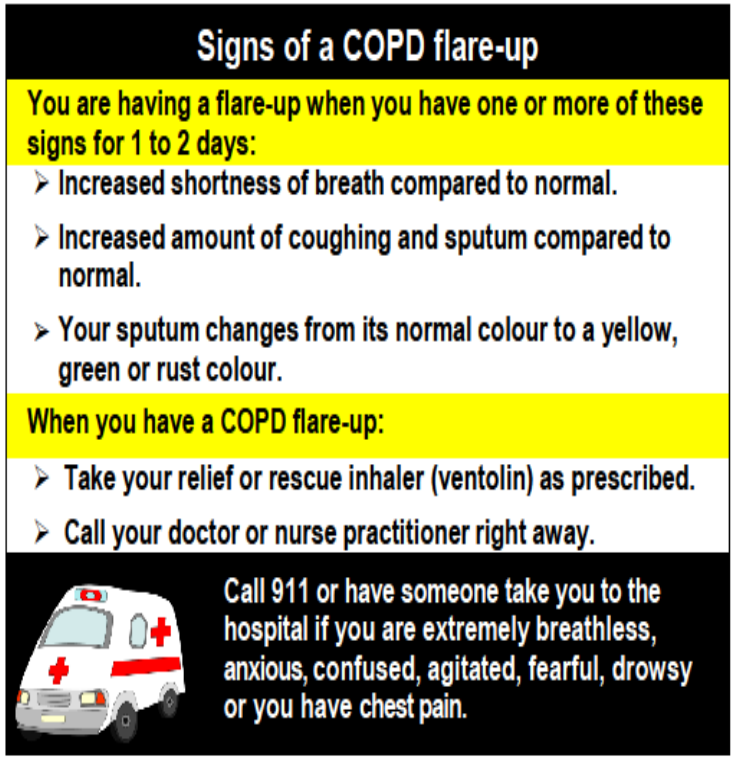
Get the information and support you need from a Breathworks COPD educator:
- 1-866-717-COPD (ext. 2673) or www.lung.ca/breathworks

If you are still smoking and would like help to stop please phone the Smoker's Helpline:
- 1-877-513-5333 or www.smokershelpline.ca

Adapted from The Canadian Lung Association – Breathworks (2013) http://www.lung.ca/diseases-maladies/copd-mpoc_e.php

Additional Knowledge Transfer Tools

COPD Fridge Magnet



Audio Visuals

- COPD & HF Teach-back videos playing at various times over 24 hrs on patients' bedside televisions
- Locally made Health Literacy video for staff and physicians

The facts about Heart Failure

at is Heart Failure?

Heart failure means the heart does not pump enough blood throughout the body.
Heart failure is a serious medical condition that can range from mild to severe.
Heart failure cannot be cured but medications can make it easier for your heart
and may help you feel better.

ake your Heart Failure medications as prescribed:

- Some medications may prevent your heart failure from getting worse.
- It may take months for your medications to help you feel better.
- Talk to your doctor or nurse practitioner before stopping any of your medic

Paying attention to change is a very important part of managing your

- Sudden weight gain can be an early sign of fluid build-up.
- Sudden weight loss can be a sign that you are losing too much fluid.
- Call your doctor or nurse practitioner right away if you notice sudden
  or any of the signs of worsening heart failure (listed on the back of th
- Your doctor or nurse practiti

Choose the right diet:

- Eat foods that are low in salt
  food.

Limit salt (or sodium) in you

- Salt (or sodium) acts like a
- Extra fluid may cause swe

Limit the amount of fluid y
include: water, soup, coffee,

- When you have heart fail
- Extra fluid may cause sw

Exercise as instructed by

- Staying active makes y
- Walking is one of the b
- Rest when you feel mo

Talk to your doctor if y

- Alcohol can make yo
- Smoking is one of th

Heart Failure Signs and Symptoms Action Plan

I feel well if:

- My weight has not changed.
- My appetite is normal.
- I have no trouble sleeping.
- I can exercise and do my daily activities as usual.
- I don't have any new swelling in my stomach, feet, ankles or legs.

What should you do?

- Weigh yourself daily in the mornin
  after using the bathroom. Keep a re
- Take your medications as prescribe
- Continue your salt restricted diet as
- Do not drink more than 6-8 cups of fl
- Balance activity with rest periods.

I feel different if:

- I have gained or lost 2 pounds (1 kg) in a day.
- I have gained or lost 5 pounds (2 to 3 kg) in a week.
- I have swollen feet, ankles or legs.
- I feel more short of breath than usual.
- I feel short of breath

What should you do?

- Call your doctor or nurse practitioner right
  your symptoms.
- Take your medications as prescribed.

ications or make changes to

gh yourself every morning be
e bathroom. Record your weig

icted diet and fluid restriction
se practitioner.
ou feel more short of breath,
illows when laying down.
rest periods.
o not improve within 24 ho
ctitioner again.
t your doctor or nurse prac
re or the Emergency Depar

one take you to the hospi
daily weights and your me

Signs of Worsening Heart Failure

Your heart failure may be getting worse if you have:

- **Gained more than 2 pounds (1 kg) in one day.**
- **Gained more than 5 pounds (2 to 3 kg) in one week.**
- **An increase in swelling in your feet, ankles, or legs.**
- **Fullness or bloating in your stomach.**
- **More shortness of breath than usual.**
- **More difficulty breathing when lying flat.**

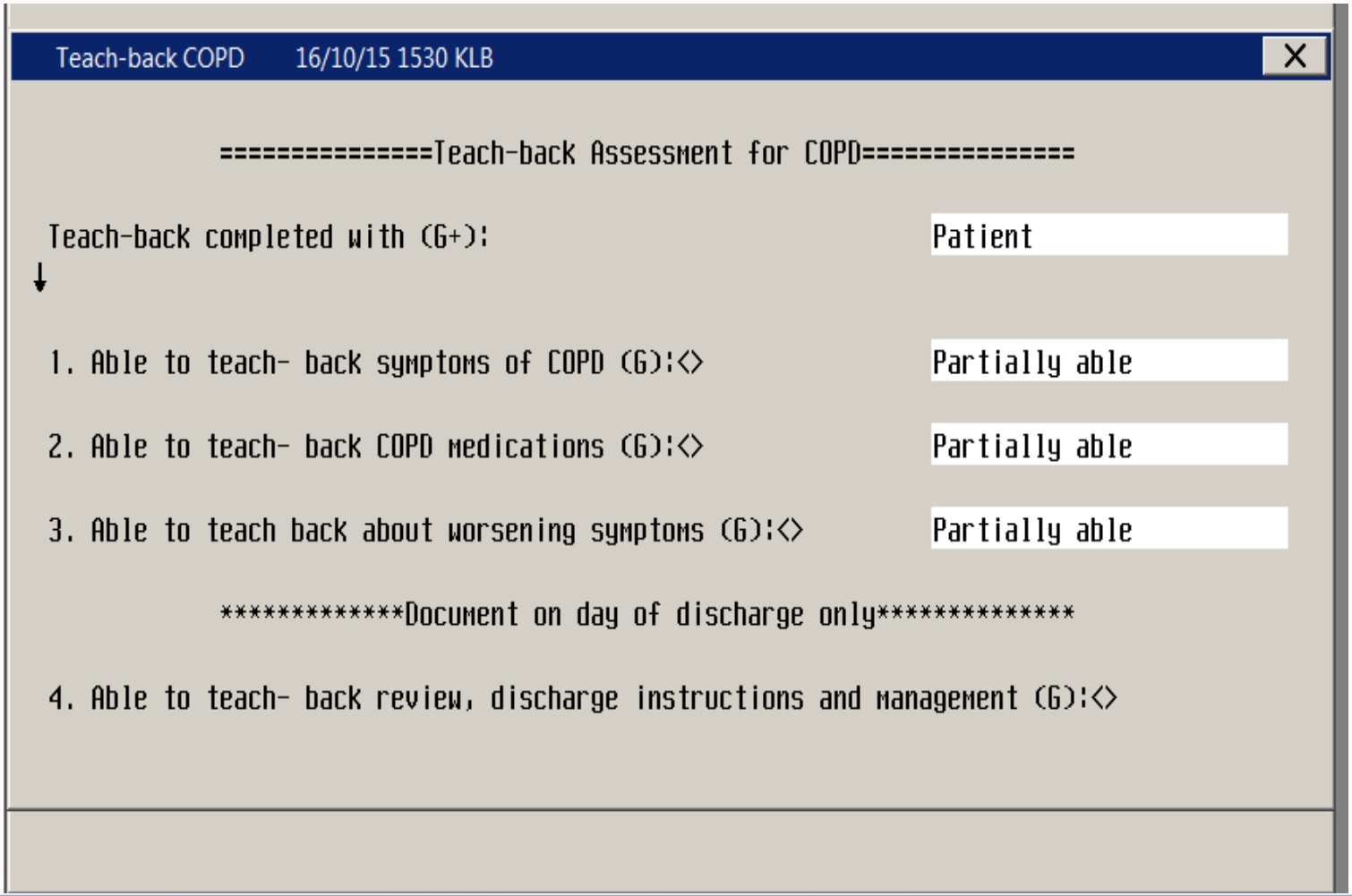
When you have any of the symptoms listed above:

- **Call your doctor or nurse practitioner right away because your medications may need to be changed.**

Go to the Emergency Department if you are extremely short of breath, have chest pain that is not relieved with nitrospray, feel like your heart is "racing", or you are coughing up frothy or pink sputum.

Standardizing Communication

Electronic Documentation Tool



Hamilton Health Sciences

Discharge Order Set for Patients with COPD or Heart Failure

Instructions

- Prior to discharge, please schedule an appointment with the Family Doctor 7 business days from the date of discharge. Please document the date/time in the follow-up section of the Discharge Orders and discuss appointment date/time with patient/caregiver. If unable to reach the Family Doctor by telephone, please complete the **Discharge Alert – Hospital Request for Follow-up Appointment** form and fax this to the Family Doctor.

- If an appointment is required with the Family Doctor in less than 7 business days from the date of discharge, please contact the Family Doctor to discuss this request. If unable to reach the Family Doctor by telephone, please complete the **Discharge Alert – Hospital Request for Follow-up Appointment** form and fax this to the Family Doctor.

- Please **ONLY sign original pages** of the Discharge Orders including the Medication Reconciliation/Prescription and make photocopies of the original pages. **Only the original signed Medication Reconciliation/Prescription will be accepted/filled by pharmacy**.

- Please give original signed Discharge Orders including Medication Reconciliation/Prescription to the patient/caregiver. Also, provide 1 photocopy for the patient/caregiver to take to their appointment with the Family Doctor and place 1 photocopy on the hospital chart.

- Please fax a copy of the Discharge Orders to the Family Doctor's office including the Medication Reconciliation/Prescription.

- Please request permission from the patient to fax a copy of the Medication Reconciliation/Prescription to their pharmacy. Document on original copy in writing or with stamp, date faxed, pharmacy prescription faxed to and initials

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ADDRESSOGRAPH

Patient's Name:

Discharge Orders for COPD or Heart Failure Patients

Date of Admission: _____ (dd/mm/yyyy) Date of Discharge _____ (dd/mm/yyyy)

Hospital Physician: _____ Patient Discharged From: _____

Primary Diagnosis: _____

_____

Other Diagnoses Affecting Hospitalization: _____

_____

_____

Recommended Follow-up by Family Doctor/Nurse Practitioner: ☐ CBC ☐ Na,K,Cl ☐ Urea

☐ Creatinine ☐ INR ☐ X-Ray Chest Reason: _____

☐ Additional Investigations: _____

☐ _____

Follow-up Appointments Arranged by Hospital Physician/Nurse Practitioner:

If patient needs to be seen by Family Doctor in less than business 7 days call to discuss. If unable to contact complete Discharge Alert on page 4 and fax.

Appointment With	Date & Time	Phone #	Address
Family Dr:			

Above appointments scheduled and documented by: _____

Referrals Completed:

CCAC ☐ Yes ☐ No **CCAC Rapid Response** ☐ Yes ☐ No CCAC contact # (905)523-8600

Original & one photocopy given to patient by: _____

Copy faxed to Family Doctor by: _____

Hamilton Health Sciences

ADDRESSOGRAPH

Patient's Name:

Discharge Medication Reconciliation & Prescription (only original signed copy) for COPD or HF Patients

☐ McMaster & McMaster Children's, 1200 Main St. W. Hamilton ON L8N 3Z5
☐ General, 237 Barton St. E Hamilton ON L8L 2X2
☐ Juravinski, 711 Concession St. Hamilton ON L8V 1C3
☐ St. Peter's, 88 Maplewood Ave Hamilton, ON L8M 1W9
☐ Juravinski Cancer Center, 699 Concession St Hamilton ON L8V5C2
☐ Chedoke, Sanatorium Rd Hamilton ON L8C7N4

Phone (for all sites): 905-521-2100

☐ No Allergies ☐ Allergies (attach hospital allergy record) Height ________ cm Weight ________ kg

Medication Reconciliation Include Pre-admit medications				No prescription required Place X in applicable boxes			New Prescription Place X in applicable boxes				
Medication (generic name preferred)	**Dose** (include units)	**Route**	**Frequency** (note if PRN)	**Unchanged** Meds to be continued	**Discontinued** Pre-Admit Meds	**Discontinued** Narcotics or Benzodiazepines used in hospital	**New**	**Changed Meds** dose or frequency	**Quantity/unit**	**Repeats**	**Limited Use Code**
				☐	☐	☐	☐	☐			
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				☐	☐	☐	☐	☐			
				☐	☐	☐	☐	☐			

Medication Reconciliation completed by: ______________________________

Signature/printed name/ designation

This is your Prescription when signed – Original Copy Only

Take this prescription to your pharmacy along with all medications in your home

Signature: ______________________________ Pager # ______________ ☐

Signature/Printed Name/Designation

Hamilton Health Sciences

Discharge Alert

Hospital Request for Follow-Up Appointment

Date: _____

Dear Dr._____

I am discharging your patient _____
Patient's Name

on _____and I am requesting a follow-up appointment in

_____ business days from the date of discharge. I am recommending that the following be

addressed at this appointment :

_____

_____

_____

Please note a copy of the Discharge Orders which includes Medication Reconciliation/ Prescription will be faxed to your office on the day of discharge.

Prior to discharge from the hospital we would like to provide the patient with an appointment to see you. If your office is not able to contact the hospital to provide an appointment prior to the patient's discharge, please contact the patient directly and provide the appointment.

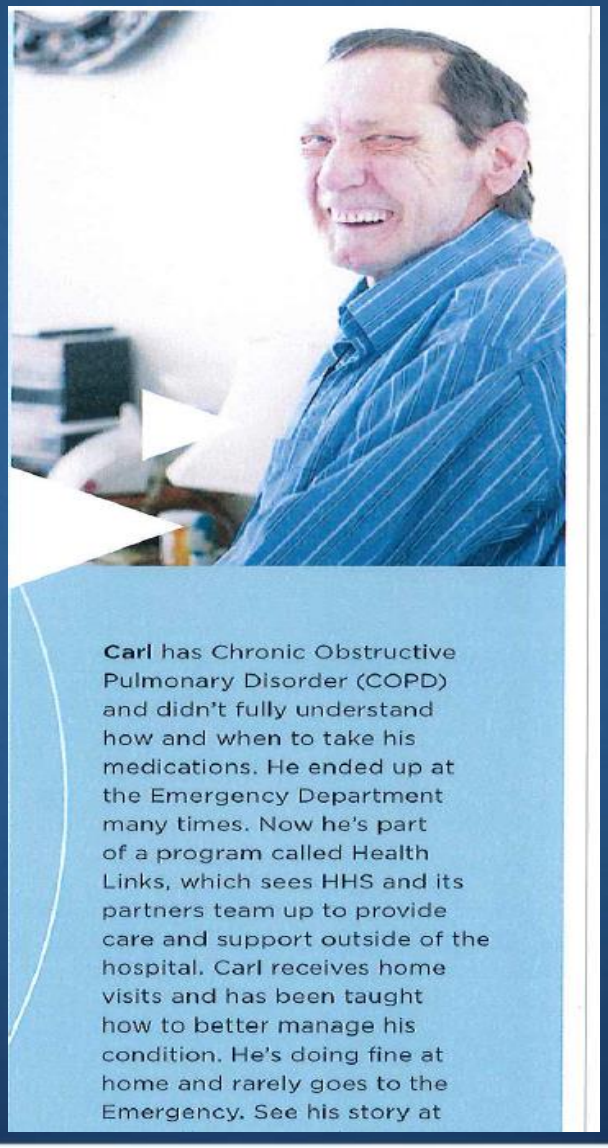
Thank you!

_____
Physician's name (please print) and Pager # and Service

_____ _____
Hospital Name/Telephone # Unit patient being discharged from/Extension

Please fax this form to the Family Doctor as soon as possible

Learning to Self-Manage COPD: Carl's Success Story



Carl has Chronic Obstructive Pulmonary Disorder (COPD) and didn't fully understand how and when to take his medications. He ended up at the Emergency Department many times. Now he's part of a program called Health Links, which sees HHS and its partners team up to provide care and support outside of the hospital. Carl receives home visits and has been taught how to better manage his condition. He's doing fine at home and rarely goes to the Emergency. See his story at


Questions

Discussion

PRACTICAL APPLICATION IN YOUR HEALTH LINK

Polling

Health Link Leadership Community of Practice

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