Get Started Implementing the Care Transitions Intervention® in Your Community

A Tool Kit for Washington State's Area Agencies on Aging

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Washington State Department of Social & Health Services
ADSA Aging & Disability Services Administration

QUALIS HEALTH
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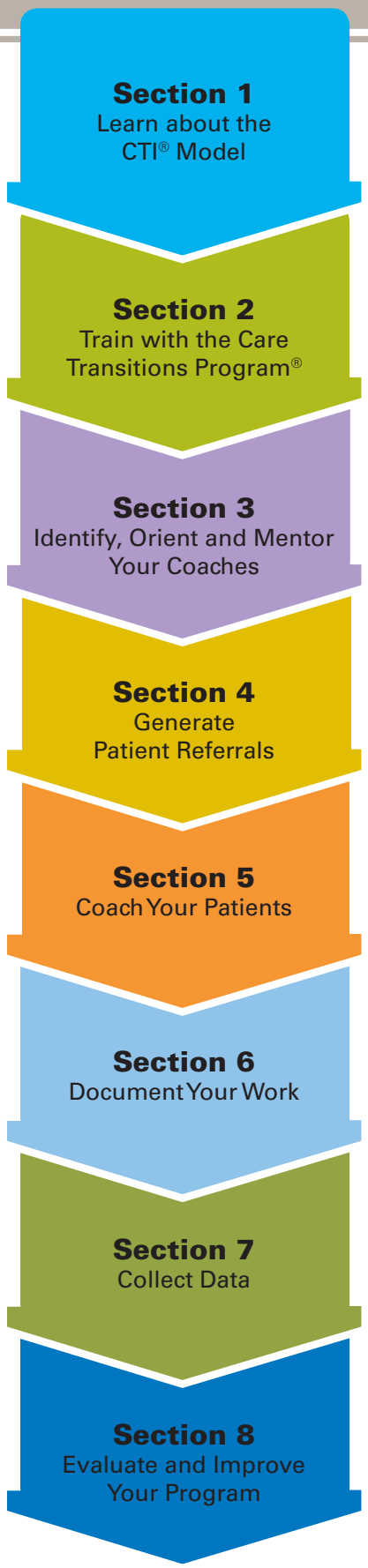
Get Started Implementing the Care Transitions Intervention® (CTI®) in Your Community



WHY CTI®?

In the Medicare Payment Advisory Commission's Report to the Congress: Promoting Greater Efficiency in Medicare (2011), nearly one in five people with Medicare who are admitted to the hospital will be readmitted with 30 days with 75% of those readmissions preventable. Ensuring a smooth transition from one care setting to another can help reduce readmissions and improve the health and quality of life of patients in your community.

The Aging and Disability Resource Center (ADRC) Care Transitions Intervention® Tool Kit was developed to provide you with the tools to support a Care Transitions Program® implementation in your community. The CTI® has been shown to effectively engage patients in managing their own care, resulting in a reduction of readmissions.

This tool kit is a supplement to Washington Area Agencies on Aging (AAA) that have been, or will be, officially trained in the Care Transition Intervention® (CTI) model. This toolkit is not intended as a substitute for training by the Care Transitions Program®, and does not authorize the user to implement the model independently. Interested organizations can contact the Care Transitions Program® to learn about training options through the website www.caretransitions.org®.

The Tool Kit includes a description of the model from the Care Transitions Program® website, and an overview of the organizational preparation required prior to scheduling training through the Care Transition Program®.

This Tool Kit is an interactive PDF document with web links for all of the tools. Customizable tools can be found here. The Tool Kit comprises eight sections (seen on the left), each focusing on an aspect of the Care Transitions Intervention® Model and/or tools and resources that you can use during implementation of the Care Transitions Intervention® Model. The section you are in will be highlighted in the Tool Kit graphic on the Section Overview page.

Each section starts with a description of what you can expect to learn, along with links to tools for your use. This tool, along with training in the Care Transitions Intervention® Model by the Care Transition Program®, shows you how to implement a successful program in your community.

Let's get started.

SPONSORS

The ADRC Care Transitions Intervention Tool Kit was prepared by Qualis Health for the Washington State Department of Social & Health Services (DSHS) Aging and Disabilities Services Administration (ADSA) with funding from the U.S. Department of Health and Human Services (DHHS) Administration on Aging (AoA) and DSHS/ADSA. Materials developed are the property of the grantor, grantee, and the subgrantee except for noted copyrighted material. The contents presented do not necessarily reflect DSHS/ADSA policy.

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Insignia Health™ materials are referenced in the tool kit. Use of Insignia products requires a license agreement.

ADDITIONAL INFORMATION

The tools, forms and guidelines are based on actual model implementation via both the Stepping Stones Project and the Northwest Regional Council (NWRC) and Washington Southeast Aging and Long Term Care.

The Stepping Stones Project was funded by The Centers for Medicare & Medicaid Services (CMS) under contract with Qualis Health. The Project's goal was to engage community partners including healthcare providers, patients, and families to improve care transitions in Whatcom County, Washington in August, 2008 through July, 2011. The Stepping Stones Project was one of 14 such Medicare demonstration projects across the US.

ABOUT QUALIS HEALTH

Qualis Health is a national leader in improving care delivery and patient outcomes, working with clients throughout the public and private sector to advance the quality, efficiency and value of healthcare for millions of Americans every day. Qualis Health delivers solutions to ensure that our partners transform the quality, efficiency and value of the care they provide, with a focus on process improvement, care management and effective use of health information technology. For more information, see www.QualisHealth.org.

Section 1 – Learn about the CTI® Model

These days, it seems patients are discharged from hospitals "sicker and quicker." Hospital discharges often happen over the space of a few hours, without the opportunity for much advance preparation or teaching. Patients are given a bewildering amount of information, both verbal and written, and charged with completing a myriad of tasks after discharge. Their family caregiver may or may not be present when discharge teaching is done. While the nurse is providing information about new medications or the physical therapist is reviewing safety precautions or the doctor is talking about next steps to treating, managing or diagnosing a medical condition, the patient may be thinking about stopping at the store on the way home for milk or cat food. All the patient wants to do is to get home. No wonder many patients run into trouble once they get there!

In this section you will learn about the Care Transitions Intervention®, a coaching model developed by the Care Transitions Program®. Patients and families work with a Transitions Coach® to learn self-management skills during transitions of care. This model improves their chance of success at home and has been shown to decrease unnecessary hospital readmissions.

CTI® Summary is taken from the Care Transitions Program® website, and provides an overview of the model, its evidence base, elements and structure. Use these talking points in meetings with stakeholders and potential partners.

Four Pillars Table is taken from the Care Transitions Program® website, and provides a cross-walk between the five patient/coach encounters and the four CTI® domains (or pillars) describing the activities and processes employed by the Transitions Coach®. The table provides a nice depiction of the model that may be used as a handout.

Section 2 –Train with Care Transitions Program®

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First, contact the Care Transitions Program® to discuss your readiness for implementation and to prepare for training. CTI® might seem simple and easy to implement. However, the skill set required to coach successfully is subtle and unlike "doing" or "teaching". It is an entirely different paradigm from traditional care modalities. With that in mind, it is a good idea to think about your program design as you prepare to work with the Care Transition Program.

The Care Transitions Program® Training Coordinator will work directly with your organization every step of the way as you assess your readiness to implement CTI® and as you prepare for training by Care Transitions Program® staff. Please consult their website for information about training: www.caretransitions.org/training.asp

This section has tips to aid you in training preparation and program design.

CTI Program® Design provides a detailed outline of each element of program creation, development and implementation. It provides a framework on which you can build your coaching program and contains links to topically specific sections of the Care Transitions Program® website. Consider using this outline as the backbone of the program you design and ultimately implement.

CTI® Training with the Care Transitions Program® will help you prepare for calls with the Training Coordinator. The better prepared you are for these calls, the faster training dates and details may be finalized. The Care Transitions Program® has found that this rigorous training preparation method provides the best chance for program success, and that training preparation and program design/implementation go hand-in-hand.

Section 3 – Identify, Orient and Mentor Your Coaches

Coach selection and support in the field are essential to the success of your CTI Program®. Effective coaches are flexible under variable circumstances, open to a new way of supporting patient or caregiver empowerment and independence and excited about reshaping healthcare from the patient side of the equation. Your coaches will need to be able to shift out of their comfort zone. For those from a facility or office setting this may mean "meeting the patient where they live" with the home visit. For nurses this may mean sitting on their hands, taking extra time and patiently helping the patient or caregiver learn how to reconcile and set up their own medications. For social workers this may mean modeling the necessary language and skills so the patient or caregiver can access resources for themselves. Effective coaches are very creative in helping patients and caregivers devise strategies to get their needs met.

Effective supervisors develop a supportive framework to insure CTI® skill uptake, effectiveness in the field and model fidelity. Coaching can be isolating. Once your coaches receive training through the Care Transitions Program®, look for ways for them to interact with regional and national coach peers. The Care Transitions Program® Coordinator facilitates a monthly, national CTI® Learning call. The Care Transitions Program® also offers telephonic consultation and on-site shadowing.

This section contains tools to aid organizations and supervisors in selecting, orienting and deploying excellent coaches once trained by the Care Transitions Program®.

Transitions Coach® Qualifications is an excerpt from an interview given by the Care Transitions Program®. Selecting the right coaches is crucial to program success, and you are encouraged to refer to this excerpt during the screening and selection process.

Transitions Coach® Position Description* provides you with a job description template.

Transitions Coach® Interview Questions* will help you match the best person to the coaching role.

*Customizable documents can be found here.

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Section 3 – Identify, Orient and Mentor Your Coaches

Transitions Coach® Orientation Checklist* provides a way for supervisors to structure and document employee orientation to the coach role as well as to their position in the organization.

Field Orientation Guidelines*. Both the training and field orientation in CTI® Coaching are primarily experiential. These guidelines outline orientation and mentoring strategies employed by Qualis Health in a successful CTI® implementation.

Transitions Coach ® Debrief Form* is a way for coaches to document their experiences during shadowing. Both the coach shadowing and the coach being shadowed can use the form to track progress and identify ongoing learning needs.

Home Visit Log* provides a way for coaches' activities to be monitored, for safety purposes. Organizations track where coaches are in the field at any given time, when the visit is in process as well as when it is completed and the coach has left the home.

*Customizable documents can be found here.

Section 4 – Generate Patient Referrals

Now that your coaches are trained, the next step is to get them in front of patients! To get referrals rolling you must get the word out to providers, hospital care management, front line hospital staff, and patients.

As part of program design, you and your partners have discussed who to coach and who not to coach. This may be driven by which diagnoses tend to be readmitted most, what quality initiatives are underway, whether your organization has the ability to self-refer, etc.

Physicians may want to know who is seeing their patient and for what purpose. Family members may want to understand the program to which their loved one has consented or may be part of the consenting process. Front line staff will want to know who is chatting up their patient, and why. And coaches may need to depend on scripting until they develop their own verbiage.

This section provides examples of referral criteria and informational and outreach material that may be used as is or as a point-of-departure as you develop your own.

Transition Coach Referral Criteria-Example* is a template for organizations and their partners. Referral criteria may differ with different partner organizations, so it is important to set criteria collaboratively.

Emergency Department Referral Criteria-Example* is a template for organizations and their partners. As previously stated, it is important to set referral criteria collaboratively.

CTI® Talking Points for Front Line Staff* helps coaches "get the word out" on nursing units. Bedside staff will need to understand the CTI Program® and its benefits to patients.

Sample Scripts* provides coaches with verbiage to trial as they approach patients and their families for consent to participate in CTI®. Coaches will soon find their own voice and develop their own strategies for consenting.

*Customizable documents can be found here.

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Section 4 – Generate Patient Referrals

Physicians Need to Know About Coaches is taken from the Care Transitions Program® website. CTI® is different from other traditional approaches, and physicians will need to understand both who is seeing their patients and the purpose of the program. The Physicians Need to Know About Coaches can also be used as a marketing tool with clinics and individual physician practices.

SJH Care Transition Coach Program® Handout. Often, a patient will want to discuss participation with a loved one before consenting. Or perhaps the patient is out of the room when the coach stops by. The handout gives an overview of CTI® and can be left at the bedside.

NWRC CTI® Postcard was developed in Whatcom County, Washington by the Northwest Regional Council and is used by coaches as a half-page, card-stock leave behind tool. Its bulleted format and large print make it ideal for use with an older population. You can use this as a model to develop your own postcard.

Section 5 – Coach Your Patients

The coach follows the patient's agenda. If the patient leads with an issue related to medications, the coach goes there. If the patient leads with a barrier to setting up or getting to a follow-up appointment, the coach goes there. The coach introduces new strategies and concepts to the patient and may first model a skill (practicing the call to the physician's office) and then encourage the patient to practice the same skill (practicing the call with the coach and then perhaps actually calling the office while the coach is present). Though the patient "owns" the agenda, the coach is not passive. The coach weaves the patient goal into the four pillars. If the patient's goal is to go to church every week, she can improve her functional status and achieve her goal by:

- reconciling medications and having a medication self-management system in place,
- recognizing red flags and responding appropriately,
- setting up and keeping follow-up appointments, and
- going prepared with an accurate medication list and three top questions written in the Personal Health Record.

This section contains tips and suggestions that may help during the coaching process. Coaches should use these as reference material only. Each coaching encounter is unique within the structure and elements of CTI®.

CTI® Phone Call Guidelines are meant to aid coaches as they follow-up on individual patient needs and circumstances. There are suggestions for each of the Four Pillars of CTI® as well as general suggestions. These are guidelines rather than a checklist, to avoid shutting down open dialogue.

Transitions Coach® Trouble-Shooting Guide* was developed by Qualis Health during the Stepping Stones Project of Whatcom County, Washington. The Trouble-Shooting Guide was developed by the team of coaches so each wouldn't have to "reinvent the wheel" each time a situation was encountered. Examples:

- Patient or family seems resistant to writing in Personal Health Record (PHR) during visit.
- Patient resumes home meds rather than starting new dosing, after discharge.

*Customizable documents can be found here.

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Section 5 – Coach Your Patients

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Helpful Websites and Links is a repository of reliable resources used by coaches during the Stepping Stones Project of Whatcom County, Washington. The list is current as of April 2013.

Teach Back Presentation was developed by Qualis Health and is made available to organizations for staff training. Teach Back is a method to ensure understanding of information being communicated, used between a provider and a patient or caregiver, by asking the receiver of the information to "teach back" what was said. You may use the content to create your own presentation.

Teach Back Cards were developed by TMF Health Quality Institute, the Medicare Quality Improvement Organization for Texas. With permission from TMF Health Quality Institute, Qualis Health modified the cards and are available to organizations as a resource. The cards include quick reference information on Teach Back phrasing, the diagnoses of heart failure, acute myocardial infarction (heart attack) and pneumonia, and information on drug classifications used to treat these conditions. The cards may be printed and laminated for use by coaches in the field.

Personal Health Record is a PDF from the Care Transitions Program® website, and is used by the coaches as an integral part of CTI® coaching.

Shared Care Plan is a printable version of the web-based personal health record that originated in Whatcom County, Washington. You may find the web-based version at **www.sharedcareplan.org**

Section 6 – Document Your Work

Each organization will decide how they want coaches to capture their activities. There are many moving parts to record keeping. How should coaches comply with organizational confidentiality requirements? How should field records be protected? What records should be kept? Where, and for how long? Should the organization use a paper or electronic method? How best to document to the measurement requirements of the program? How should patients and records be identified for measurement purposes? What common "language" should be used?

This section contains tools directly from the Care Transitions Program® website. The coaching documents required by the Washington State Aging and Disability Services Administration (ADSA) for the Administration on Aging (AoA) grant-funded Care Transitions work taking place in specific regions are included. Tools developed and licensed through Insignia Health are also referenced. There are examples of forms and an abbreviations key used in the successful, CMS-funded Stepping Stones Project of Whatcom County, Washington.

Electronic documentation formats

- Coaching Database from the Care Transitions Program® website, available at www.caretransitions.org/provider_tools.asp
- Access database version of the Care Transitions Program® Coaching Database modified with permission and developed with funding from the Center for Technology and Aging www.techandaging.org provided through a Tech4Impact grant to the State of Texas

Transition Coaching® Abbreviations Key is provided as a reference to coaches and organizational staff of CTI® and basic medical terms and abbreviations.

Discharge Checklist is from the Care Transitions Program® website, and is used by the coaches during the facility visit. Spanish and Russian language versions are available on the Care Transitions Program® website: www.caretransitions.org/provider_tools.asp

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Section 6 – Document Your Work

ADRC—Required Forms

The following forms are to be completed by Aging and Disability Resource Centers (ADRCs) that have received Administration on Aging grant funding. For each form listed, the first link is to the form itself, the second describes the purpose and explains the process for completing the form and the third is an example of a completed form.

CTI® Intervention Coaching Sheet* documents coaching activity with individual patients on the Coaching Sheet. This de-identified information is then aggregated for reporting purposes.

CTI® Notes Page* allows the coach to review previous coaching activity and the progression along the four pillars prior to patient/caregiver contacts, which allows for continuity between coaching encounters.

Patient Activation Measure, Caregiver Activation Measure and Goal Action Worksheet

The Patient Activation Measure (PAM®), the Caregiver Activation Measure (CAM®) and the Goal Action Worksheet are licensed products of Insignia Health. The PAM® is used to identify any areas of health care self-management in which the patient feels less confident, and the CAM® is used to identify any areas of healthcare management on behalf of the patient in which the caregiver feels less confident. The Coach then targets coaching activities to address those areas, with the aim of increasing patient and caregiver competence, confidence and activation. The Goal Action Worksheet is used to document the patient's personal goal, coaching activity to support the patient in personal goal attainment.

Refer to Insignia Health training materials.
www.insigniahealth.com

*Customizable documents can be found here.

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Section 6 – Document Your Work

Activated Behaviors Assessment (ABA)* is a modification of the Care Transitions Program's® Patient Activation Assessment (PAA). Either provides coaches with a method of tracking patient's progress in skill transfer and activation along the Four Pillars during their participation in CTI®. The ABA uses a Likert Scale of 1-5 and the PAA scores elements as either a 0 or a 1 with 10 points possible. The PAA and PAA Guidelines may be found on the Care Transitions Program website:
www.caretransitions.org/documents/Activation_Assessment.pdf
www.caretransitions.org/documents/PAA_Tool_Guidelines.pdf

Multi-Event Medication Discrepancy Tool® (MDT). The optional Multi-Medication Discrepancy Tool can be useful in tracking trends and capturing resolution of discrepancies. Results can be reported back to discharging facilities and community partners to prompt discharge process improvement. These guidelines walk you through medication discrepancy identification, resolution and documentation.

Transitions Coach® Information and Consent* is an optional, customizable form for organizations whose partners or whose policies require a written consent for participation in CTI®.

CTI® Coach Referral Form* is an optional, customizable form that may be modified to bring it into accordance with confidentiality policies and procedures of all organizations involved, completed by the referring entity with limited Personal Health Information and Protected Individual Information. In instances when referrals cannot be made electronically, the Coach Referral Form can be completed by a facility staff member and faxed or scanned to the agency providing CTI® coaching.

Transitions Coach® Patient Report Form* is a method for coaches to provide prompt feedback to the discharging facility of discharge process improvement opportunities as well as best practices. This will allow the discharging facility to identify and support the adoption and spread of best practices and also to target gaps and fix broken processes.

*Customizable documents can be found here.

Section 7 – Collect Data

Coaches' documentation is distilled into data that are reported to internal and external stakeholders.

Examples of reportable coaching activity metrics:

- Coaching consent total per month
- Coaching consent rate compared to patients approached per month
- Initial and final PAMs, CAMs, PAAs (or ABAs) completed per month

Examples of outcomes:

- Patients completing all 5 coaching encounters
- Personal Goal attainment
- Movement along the PAM and/or CAM score or level, or
- Movement along the PAA score (or ABA Likert Scale)
- Number of patients with a medication discrepancy (resolved)
- Percentage of patients coached who make follow-up appointments
- Percentage of patients coached who keep follow-up appointments
- Percentage of patients coached able to repeat three red flags by case closure
- Percentage of readmissions per patients coached

Your organization may choose to track and trend community engagement data or other regionally-specific metrics. Consider tracking the same data points as similar organizations, so you may compare apples to apples.

This section provides spreadsheets and strategies for individual coach data collection and individual and aggregate data reporting.

CTI® Patient ID Log* allows organizations to track patients and admissions in a de-identified manner by providing a mechanism for assignment of consecutive ID numbers to patients and coaches alike. Organizations are encouraged to discuss the need for collecting and reporting de-identified data both with the State and with their external partners.

*Customizable documents can be found here.

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Section 7 – Collect Data

Data Guidelines describes the spreadsheets available in this Tool Kit and how they may be used.

Individual Transition Coach® Monthly Report* provides a mechanism for tracking individual coach activity by month. This form may be either completed and submitted by the individual coach or may be abstracted from individual coach spreadsheets.

Aggregate Transition Coach® Monthly Report* provides a mechanism for tracking aggregate coach activity by month. This form may be compiled from individual Coaching Monthly Reports.

Transitions Coach® Tracking Spreadsheet* provides a mechanism for each coach to track their activity electronically. Spreadsheets can be maintained on a shared drive, allowing supervisors and administrative staff to access them for monitoring, abstracting and reporting purposes.

*Customizable documents can be found here.

Section 8 – Evaluate and Improve Your Program

How do you know that a change is an improvement? Measuring your processes and outcomes is essential, and allows you to continuously adapt the CTI coaching program for success within a specific community. One of the most prevalent improvement approaches in healthcare is the "Model for Improvement". The first component of the model includes three fundamental questions that lay at the foundation for an improvement effort:

1) What are we trying to accomplish? (Aim)
2) How will we know that a change is an improvement? (Measures) and
3) What changes can we make that will result in an improvement (Ideas).

The goals of the ADRC Evidence-Based Care Transitions Project are to

- Increase ADRC capacity and expand areas of partnership with hospitals in the identified counties
- Improve rehospitalization rates for participating hospitals
- Improve health, and understanding of chronic conditions and their management, by older adults and people with disabilities participating in CTI coaching
- Improve efficiencies and / or cost savings

The Option D: ADRC Evidence Based Care Transitions Grantees Evaluation Plan provides comprehensive detail and tools to assist in tracking and measuring components of the CTI® intervention. Many of these measures are a standard part of the CTI Program® (for example, counting home visits completed and tracking medication discrepancies). Program process measures include how many patients enroll in and complete coaching and 30 day readmission occurrences for a specific patient. Outcome measures calculate readmission reduction for your population of clients enrolled in the coaching program.

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Section 8 – Evaluate and Improve Your Program

Washington State Care Transitions Model v.02 is a one page graphic that describes the ADRC Care Transitions Intervention Model in the Whatcom County, Washington Phase I project.

PDSA Rapid Cycle Improvement

An important part of improvement occurring in healthcare and long-term services and supports as a result of the Affordable Care Act, is being able to implement and test small changes within your organization to see if they lead to better outcomes and quality improvement. One such method for testing change is the Plan-Do-Study-Act (PDSA) Cycle, part of The Institute for Healthcare Improvement's Model for Improvement.