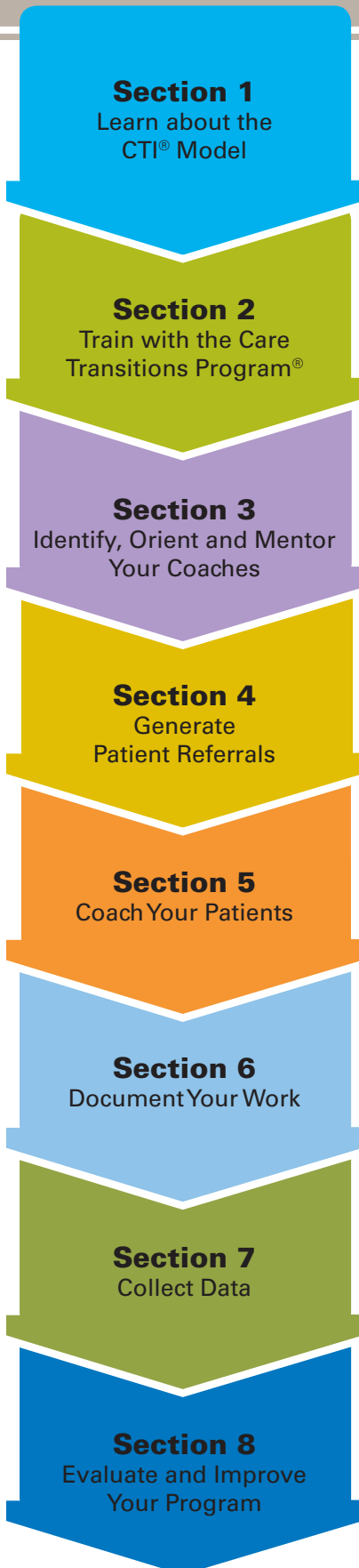# Get Started Implementing the Care Transitions Intervention® in Your Community

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

August 2012
Version 2.0

Section 1
Learn about the
CTI® Model

Section 2
Train with the Care
Transitions Program®

Section 3
Identify, Orient and Mentor
Your Coaches

Section 4
Generate
Patient Referrals

Section 5
Coach Your Patients

Section 6
Document Your Work

Section 7
Collect Data

Section 8
Evaluate and Improve
Your Program

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 tells you the purpose of that section and what you can expect to learn. Additionally, each section contains a list, a description, and a link to each tool that will enable you to download for your own 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.

COPYRIGHTED MATERIALS

The Coaching Tool Kit includes materials from the Care Transition Intervention®. The Terms of Use for the Care Transitions Program® materials developed by Eric A. Coleman, MD, MPH, advises all users that they may not remove any copyright or trademark notices from the materials, and that users are not authorized to sell, rewrite, modify, or redistribute materials from the site without express written permission from the Care Transitions Program® office. The links included in the Tool Kit are current as of July, 2012.

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

Section 2
Train with the Care
Transitions Program®

Section 3
Identify, Orient and Mentor
Your Coaches

Section 4
Generate
Patient Referrals

Section 5
Coach Your Patients

Section 6
Document Your Work

Section 7
Collect Data

Section 8
Evaluate and Improve
Your Program

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®. In this model, patients and families work with a Transitions Coach® to learn self-management skills that ensure their needs are met during transitions of care, which 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.

Encouraging Patients and Family Caregivers to Assert a More Active Role During Care Hand-Offs: The Care Transitions Intervention®

What is the Model?

During a 4-week program, patients with complex care needs and family caregivers receive specific tools and work with a "Transitions Coach®," to learn self-management skills that will ensure their needs are met during the transition from hospital to home.

What Are the Key Findings?

Patients who received this program were significantly less likely to be readmitted to the hospital, and the benefits <u>were sustained for five months after the end of the one-month intervention</u>. Thus, rather than simply managing post-hospital care in a reactive manner, imparting self-management skills pays dividends long after the program ends. Anticipated cost savings for 350 chronically ill adults with an initial hospitalization over 12 months is $ 295,594. Patients who received this program were also more likely to achieve self-identified personal goals around symptom management and functional recovery.

What Makes this Model Unique?

In contrast to traditional case management approaches, the Care Transitions Intervention® is a self-management model. The Care Transitions Program® has modeled national Medicare data sets to demonstrate the frequency with which older adults making care transitions across settings will experience this again in the near future. In other words, for most of these individuals, there will be a "next time". Using qualitative techniques, the Care Transitions Program® worked with older adults to identify the key self-management skills needed to assert a more active role in their care. Next a Transitions Coach® was introduced to help impart these skills and help the individual (and the family caregivers) become more confidence in this new role. Although critics are quick to point out that this is only applicable to highly educated or motivated patients, our studies have shown that most patients and family caregivers are able to become engaged and do considerably more for themselves. In essence, the model is about making an investment in helping older adults and family caregivers more comfortable and competent in participating in their care during care transitions. Five months after the Transitions Coach® signed off, these patients continued to remain out of the hospital demonstrating a sustained effect from investing in a self-care approach.

The Intervention Focuses on Four Conceptual Domains Referred to as Pillars:

1. Medication self-management
2. Use of a dynamic patient-centered record, the Personal Health Record
3. Timely primary care/specialty care follow up
4. Knowledge of red flags that indicate a worsening in their condition and how to respond

The Following Materials Are Available at No Cost:

- The business case for implementing the Care Transitions Intervention® model
- Training manual, video clips of the model in action, training DVD request form
- Medication reconciliation tool, the Medication Discrepancy Tool® (MDT®)
- NQF endorsed quality measure, the Care Transitions Measure® (CTM®)

Project Sponsors

The John A. Hartford Foundation and The Robert Wood Johnson Foundation
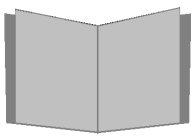
© Eric A. Coleman, MD, MPH

The Evidence Base for the Model

1. Coleman EA, Parry C, Chalmers S, Min SJ. "The Care Transitions Intervention: Results of a Randomized Controlled Trial" Archives of Internal Medicine 2006;166:1822-8.
2. Coleman EA, Smith JD, Frank JC, Min S, Parry C, Kramer AM. Preparing Patients and Caregivers to Participate in Care Delivered Across Settings: The Care Transitions Intervention. J. of the Amer Geriatrics Society. 2004;52(11):1817-1825.
3. Parry, C., Kramer, H, Coleman, EA. 'A Qualitative Exploration of a Patient-Centered Coaching Intervention to Improve Care Transitions in Chronically Ill Older Adults'. Home Health Care Services Quarterly. 2006;25(3-4):39-53.
4. Parry C, Coleman EA, Smith JD, Frank JC, Kramer AM. The Care Transitions Intervention: A Patient-Centered Approach to Facilitating Effective Transfers Between Sites of Geriatric Care. Home Health Services Quart. 2003;22(3):1-18.
5. Coleman, EA, Mahoney E, Parry C. Assessing the Quality of Preparation for Post-Hospital Care from the Patient's Perspective: The Care Transitions Measure. Medical Care. 2005;43(3):246-255.
6. Coleman EA, Smith JD, Raha D, Min SJ. Post-Hospital Medication Discrepancies: Prevalence, Types and Contributing Factors. Arch of Int Med 2005;165(16)1842-1847.
7. Smith JD, Coleman EA, Min S. Identifying Post-Acute Medication Discrepancies in Community Dwelling Older Adults: A New Tool. American Journal of Geriatric Pharmacotherapy. 2004;2(2):141-148.

Where Can I Learn More?

Please visit www.caretransitions.org where you can learn more about the model and its evidence base and to access patient tools, performance measures, medication safety tools and much more.

Care Transitions Intervention Coaching Activities and Processes

	Medication Self-management	Red Flags	Follow-up	Dynamic Patient-centered Record
Pillar				
Goal - Content	Patient is knowledgeable about medications and has management system	Patient is knowledgeable about indications that condition is worsening and how to respond	Patient schedules and completes follow-up visit with Primary Care Provider and Specialist	Patient understands and manages a Personal Health Record (PHR)
- Process	Coach empowers patient to take charge of medications and complete medication reconciliation	Coach helps patient identify an action plan based on red flags of condition and reason for hospitalization	Coach helps patient feel comfortable and able to communicate effectively with providers, through role play and practice	Coach facilitates patient use and ownership of PHR
Hospital Visit	Patient understands the importance of knowing medications	Discuss symptoms and possible drug reactions	Recommend Primary Care Provider follow-up visit	Explain PHR
Home Visit	Coach facilitates patient reconciliation of pre- and post-hospitalization meds Coach helps patient identify discrepancies and questions about medications. Patient records in PHR for clarification by doctor. Coach helps patient practice how to ask questions. Coach helps patient refine or develop med management system	Coach asks patient about symptoms that indicate worsening condition or side effects of medications. Patient identifies 3-5 main red flags to monitor	Coach emphasizes importance of the follow-up visit Coach helps patient develop questions, practice asking questions, and role-playing for visit with Primary Care Provider	Patient reviews and updates PHR Patient and coach review discharge summary Coach encourages patient to share the PHR with primary care doctor and specialist
Follow-Up Calls	Discuss any remaining medication questions	Ask the patient to identify when/if Primary Care Provider should be called	Coach provides advocacy in getting appointment, if necessary, and revisits communication skills.	Discuss outcome of visit with Primary Care Provider or Specialist: Did patient get questions answered? What did s/he ask? Help develop new questions if necessary and role-play as needed

Section 2 – Train with Care Transitions Program®

Section 1
Learn about the CTI® Model

Section 2
Train with the Care Transitions Program®

Section 3
Identify, Orient and Mentor Your Coaches

Section 4
Generate Patient Referrals

Section 5
Coach Your Patients

Section 6
Document Your Work

Section 7
Collect Data

Section 8
Evaluate and Improve Your Program

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.

CTI® Program Design

Review the Frequently Asked Questions from the Care Transitions Program® website as you consider the following questions (http://www.caretransitions.org/CTI_FAQ.asp)

What do you hope to accomplish through use of the intervention?

What are the goals?

Desired outcomes?

How will you measure outcomes?
- Tools
- Metrics
- Timelines
- Other:

How will outcomes be collected/reported?

To whom will outcomes be reported?

What data over which time frame will determine the success of the program?

Who are your partners and stakeholders?
- Internal stakeholders
    - Committed leadership
    - Committed to model fidelity
- External stakeholders
    - Champions of CTI®
    - Leadership buy-in

Allocation of resources
- Internally
    - Funding
        - Dedicated staff
        - Printing and incidental costs
        - Administrative support
        - Scheduling staff and coaching activities
        - Tracking/trending/reporting metrics and outcomes
    - Home visit support
        - Mileage
        - Infrastructure
    - Barriers or challenges
    - Ongoing support of coaches
    - Caseload expectations
    - Training
    - Turnover

- Externally
  - Referral source (facility, clinic, community agency, etc)
  - Referral staff (DC planner, floor staff, hospitalist, bedside staff, etc.)
  - Barriers or challenges

REFERRAL PROCESS
- Target population
- Inclusion criteria
- Exclusion criteria
- Patient identification
- Mechanism

COMMUNICATION PLAN
- How will you "market" CTI®?
- Timeline
- To whom will you "market" CTI®?
  - Facilities
  - Physicians/clinics
    http://www.caretransitions.org/documents/Physicians_Need_to_Know_About_Coaches.pdf
  - Patients
  - Caregivers

CONSENT PROCESS
- Verbal?
- Written?
- Who obtains consent?

DOCUMENTATION
- Use of CTI® Tools?
  - Paper?
    - Personal Health Record & Discharge Preparation Checklist
      http://www.caretransitions.org/documents/phr.pdf
      http://www.caretransitions.org/documents/checklist.pdf
    - Medication Discrepancy Tool (Single or Multiple event version)
      http://www.caretransitions.org/mdt_main.asp
    - Patient Activation Assessment®
      http://www.caretransitions.org/documents/Activation_Assessment.pdf
    - Care Transitions Measure (CTM-3)
      http://www.caretransitions.org/ctm_main.asp
    - Sample Transitions Coach Charting Form from www.caretransitions.org
    - Internal tools/documents

- Electronic?
  - Spreadsheet of coaching activities
  - Monthly Aggregate Report
  - From http://www.caretransitions.org/provider_tools.asp
    - Coach Database
    - Run Chart Templates:
      - Patient Activation Assessment
      - CTM-3 Scripting example:
        http://www.caretransitions.org/documents/CTM%20Scripts.pdf
- Access database: CTI® Coaching Tool Texas Version

PROGRAM EXPANSION
- Phone call to set up home visit scripting sample:
  http://www.caretransitions.org/documents/Home%20visit%20scripts.pdf

CTI®Training with the Care Transitions Program®

The Training Coordinator is available by phone, and will assist you in completing a Readiness Assessment Tool. The Coordinator is a valuable resource to you as you consider coach selection, patient inclusion and exclusion criteria, partnering and implementation strategies, etc.
Once the Readiness Assessment Tool has been completed and you've discussed it in detail with the Training Coordinator, the training date and time can be finalized.

Once your Transition Coaches® are identified, you will be asked to provide basic demographic information for each Transition Coaches® on a single, combined registration form so The Care Transitions Program® can arrange access to the web-based E-Learning Modules developed and supported by The Care Transitions Program®. Each coach will need to complete an hour-long module as pre-work for the training. Transition Coaches® who do not complete Module 1 prior to training often unnecessarily disrupt the training with questions due to a lack of understanding of the difference and value of the CTI® coaching approach in the context of imparting self-management skills to patients and caregivers compared to familiar "teaching" or "doing" roles. There are valuable Modules and information in the E-learning environment to which each coach will have ongoing access for 12 months.

Once you have established a relationship with the Training Coordinator, next steps include:
- Identifying and partnering with organizations in your community
- Spreading the word and getting buy-in
- Jointly determining:
    - What you want to achieve
    - How to go about it
    - What CTI® coaching will look like in your community
    - How to measure and report outcomes
- Completing and submitting the Readiness Assessment Tool provided by the Training coordinator
- Selecting coaches
- Preparing for training
- Coaches and supervisors/administrators attending training in Denver or hosting an on-site training
- Implementing coaching in your community with your partners
- Supporting and mentoring coaches in the field
- Tracking, trending and reporting coaching activities and patient outcomes
- Program expansion
    http://www.caretransitions.org/training.asp

Section 3 – Identify, Orient and Mentor Your Coaches

Section 1
Learn about the CTI® Model

Section 2
Train with the Care Transitions Program®

Section 3
Identify, Orient and Mentor Your Coaches

Section 4
Generate Patient Referrals

Section 5
Coach Your Patients

Section 6
Document Your Work

Section 7
Collect Data

Section 8
Evaluate and Improve Your Program

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.

continued on next page

Section 1
Learn about the CTI® Model

Section 2
Train with the Care Transitions Program®

Section 3
Identify, Orient and Mentor Your Coaches

Section 4
Generate Patient Referrals

Section 5
Coach Your Patients

Section 6
Document Your Work

Section 7
Collect Data

Section 8
Evaluate and Improve Your Program

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.

Transition Coach® Qualifications

Excerpt of an Interview with Eric Coleman, MD, MPH
From The Center for Excellence in Primary Care E-Letter, December 2007, Issue 14

Eric Coleman: As we have partnered with many of the nation's leading health care systems in disseminating the model, we have moved away from delineating the precise initials that should follow the name of the coach and now are emphasizing "key attributes" of coaches. The most important quality the coach needs to have is the ability to encourage the patient and/or caregiver to do as much as possible independently. This can be harder than it seems, since most of us in healthcare are trained to be "doers" rather than "enablers". The coach also needs to have some experience in helping patients communicate their needs to different healthcare professionals. Finally, although we don't specify a professional background for the coach, the coach does need some competence in medication review and reconciliation, so as to be able to teach the patient those skills as well. As such, in addition to nurses, some of our partners are using social workers or other retired health care workers.

We currently recommend a 1.5 day training program for coaches. We really try to encourage our partners to not make coaching an add-on to someone's existing responsibilities, as we feel the coach should have time explicitly dedicated to this job.

The most important quality the coach needs to have is the ability to encourage the patient and/or caregiver to do as much as possible independently. This can be harder than it seems, since most of us in healthcare are trained to be "doers" rather than "enablers".

Transitions Coach® Position Description

PURPOSE

The Care Transition Coach®, empowers the patient and/or family/caregiver to play an active and informed role in their health care. The Transition Coach® helps the patient to become good at, and comfortable with, managing their care after hospital discharge. The Transition Coach® provides guidance to the patient for effective care transitions, improved self management skills and enhanced patient-provider communication. The Transition Coach® also facilitates interdisciplinary collaboration and care continuity across care settings. The Transition Coach® does not provide direct patient care or treatment.

PRIMARY RESPONSIBILITIES

- Coach the patient in building confidence and competence in four conceptual areas, or "pillars": medication self management, use of a patient-centered health record, primary care and specialist follow-up and knowledge of red flags of their condition and how to respond.
- Explain the Care Transitions Intervention® (CTI®) to the patient and obtain signed, informed Consent.
- Assess the patient's baseline activation level for self-care through use of the Patient Activation Measure (PAM).
- Perform the facility visit, developing the coaching relationship, empowering the patient to take an active, informed role in their discharge planning and introducing the patient-centered personal health record.
- Perform the home visit by the next business day after discharge, identifying the patient's biggest health concern and the patient's immediate goals for recovery, and coaching the patient through the patient-centered personal health record and all four pillars. Role-play interactions with providers as appropriate.
- Perform three follow-up phone calls to the patient, on or about days two, seven and fourteen after discharge.
- Assess the patient's activation level for self-care after participation in the CTI® through use of the PAM.
- Track coach-related metrics and report on intervention progress.
- Direct all urgent /extraordinary requests or incidents to appropriate staff.

QUALIFICATIONS
- Associate or Bachelor's degree in health care field preferred.
- Work experience in a health care setting preferred.
- Ability to commit to implementing CTI® with patient population within one to two months after being trained.
- Ability to provide continuity to patients throughout the CTI® interactions.
- Ability to work independently with minimal supervision as well as part of a team.
- Exemplary customer service skills and ability to handle stressful situations with compassion and understanding.
- Understanding of [organization] mission and core values.
- Ability to understand and operate a computer, copy machine and fax machine.

COMPETENCIES
- Ability to make mental and cultural shift from care provider to coaching paradigm, and able to adjust to associated process changes.
- Ability to track and trend transition coach-related metrics and report on intervention progress.
- Excellent verbal and comprehension skills.
- Ability to maintain discretion with regard to patient information with absolute integrity.

TRAINING AND EDUCATION
- Formal training in the CTI® by Eric Coleman's team.
- On-the-job training provided by shadowing an experienced Coach and being shadowed by same.
- On-going training and in-services as mandated by Supervisor.

UNIFORM
- Modest, semi-casual attire.
- [Name badge]
- Conservative make up and jewelry.
- Perfume or shave lotion not recommended.

HOURS
Coaching typically takes place Monday through Friday, between the hours of 8:00 am and 5:00 pm. Weekend hours at the Coach's discretion.

SUPERVISOR

Transitions Coach® Interview Questions

Name _____ Phone_____

Email _____ Interviewer _____ Date _____

1. What experience have you had with transitions of care?

2. Please share with me what you know about the Care Transitions Intervention® (CTI®). Can you describe the essential elements of the intervention?

3. Have you had a chance to review the web site (www.caretransitions.org®)? From your study of the website, what questions do you have about the CTI®?

4. Please share with me any experiences you may have had coaching patients and/or their families.

5. How did it differ from "doing for," or "teaching" patients/caregivers?

6. Have you had experience with motivational interviewing?

7. What has inspired you to pursue a career as a Transitions Coach®?

8. What do you feel are the most critical characteristics essential to successfully helping a person learn how to care for themselves and communicate their needs to their healthcare team?

9. The coaching role is about skill transfer. It is designed to help patients learn how to become comfortable and confident in managing their own health care and achieving their health goals. Can you describe a circumstance in which you helped someone accomplish a goal without doing it for them?

10. Work through a coaching scenario. Discuss how Transitions Coaching® is different from 'doing' or 'teaching' roles.

11. What experience do you have meeting with patients and families in a hospital/healthcare setting?

12. Active listening skills: talk about training you've had/work you've done.

13. Regarding the home visits:

    a. Do you have home visiting experience? If so, describe:

    b. Do you perceive any barriers to/issues with home visiting? If so, describe:

14. What strengths do you have that you will help you in your new role as a coach?

15. What does coaching self-empowerment mean to you?

16. What is going to be most difficult for you in moving into this new role as a coach?

17. Describe how you might support self-empowerment for a CTI® participant during the follow-up phone calls (after the home visit) who has increased her capacity to manage her healthcare in the four pillar areas but is not yet fully independent in each domain.

18. Describe an experience you observed, or had, that did not support self-empowerment - what was that like? What would you have done to change that experience?

19. Please explain why self-empowerment of patients and their family caregivers is important to you.

Transitions Coach® Orientation Checklist

COACH INFORMATION

Name: _____   Start date: _____

Position: Stepping Stones Coach   Orientation completion goal: _____

Manager: _____   Coordinator: _____

FIRST DAY

☐ Provide Coach with Coaching Handbook.   ☐ Provide Coach with Teach Back cards.

☐ Assign Clinician "buddy": _____   ☐ Obtain signature on Letter of Agreement

POLICIES

☐ Review key policies.   Signature: _____   Date: _____

- Coaching Communication Book
- Reporting time worked
- Security
- Safety: in facility / in field
- Documenting availability
- Performance reviews
- Confidentiality
- Cafeteria

ADMINISTRATIVE PROCEDURES

☐ Review key policies.   Signature: _____   Date: _____

- Office / desk / work stations
- Keys: office and file cabinet
- Telephones
- ID badge / dress code
- File Cabinets / personal folders
- Office Supplies Inventory
- Phone Lists
- Email / Cell Phone / VM

INTRODUCTIONS AND TOURS

☐ Give introductions to department staff and key personnel during tour.

☐ Tour of facility.   Signature: _____   Date: _____

- Printers
- Copier
- Emergency exits
- Nursing Units
- Calendar
- Parking
- Restrooms
- Bulletin board
- Cafeteria
- Lactation room / phone use
- Mail
- Conference Rms

POSITION INFORMATION

☐ Introductions to team members.

☐ Review initial job assignments and training plans.

☐ Review job description and performance expectations and standards.

Signature: _____   Date: _____

TRANSITION COACHING® PROCESS

☐ Shadow: Facility Visit / Documentation

☐ Be shadowed: Facility Visit / Documentation

☐ Independent Facility Visit / Documentation

☐ Shadow: Administration of PAM/CAM*

☐ Be shadowed: Administration of PAM/CAM

☐ Independent Administration of PAM/CAM

☐ Shadow: Home Visit / Documentation

☐ Be shadowed: Home Visit / Documentation

☐ Independent Home Visit / Documentation

☐ Shadow: Follow-up TCs® / Documentation

☐ Be shadowed: Follow-up TCs® / Documentation

☐ Independent Follow-up TCs® / Documentation

☐ Review of Teach Back Principles

☐ Independent use of Teach Back

☐ Review of Monthly Data Reporting

☐ Shadow Monthly Data Documentation

☐ Independent Monthly Data Documentation

☐ Review Caseload Spreadsheet

☐ Independent use of Caseload Spreadsheet

☐ Review Coach Trouble-shooting Guidelines

☐ Review Monthly Coach Meetings

☐ Review Shared Care Plan

☐ www.MedlinePlus.gov website review

MENTOR SIGNATURE

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

*Licensed by Insignia

Field Orientation Guidelines

Field orientation in CTI® Coaching is primarily experiential, as is CTI training.

The most important thing for a newly trained coach is to **get field experience as soon as possible** in order to solidify the new skill set. There's danger of the old, better established patterns of behavior such as "teaching" and "doing" creeping back in if too much time passes.

If possible, start by having the **new coach shadow an experienced one**. If not, have **two new coaches work together**, alternating between taking the lead in coaching and serving as observer providing feedback.

As comfort level permits, coaches can go it alone. It is essential for the new coach to be able to **debrief** with another coach or coaches after home visits. Each coaching encounter is different. Coaches can learn from each other's experiences and be better prepared when faced with a similar circumstance.

Once the coach is feeling comfortable in the role, the frequency of debriefs can be scaled down to a **monthly case conference** for group discussion, and episodic debriefs as needed. There is a **Transition Coach® Debrief Form** that may be used if a face-to-face debrief is not possible. These can be collected and reviewed at meetings or used during the orientation process. In the Stepping Stones Project of Whatcom County, the coaches developed a **Trouble Shooting Guide** as a reference to avoid re-inventing the wheel with each new circumstance encountered. (i.e.: Patient left against medical advice and has no prescriptions. Consider _____ strategy)

Progression through the Coach orientation process can be captured on the **Transition Coach® Orientation Checklist form**, which can be modified to meet your agency's needs.

It may be useful to have a **Communication Book** for the coaches. This allows coaches to jot down process suggestions, issues for clarification, ideas for ongoing training, meeting agenda topics, coaching/scripting strategies etc. Forms and process updates can be placed in the book for review, as can data reports. This can improve time management and decrease the need for hallway conferences.

For lay- or non-clinician coaches, it's helpful to **assign a clinician "buddy"** for questions about medical conditions and procedures, medications and red flags.

In the spirit of supporting and empowering coaches as well as patients, an excellent resource for self-study is the National Library of Medicine medical search engine www.Medlineplus.gov which contains a medical dictionary, drug and supplement information, interactive video tutorials, etc. in lay-terms. Lay- and non-clinician coaches are very clear about the fact they are not responsible for teaching patients and caregivers about anything clinical in nature, but some feel they like to have a basic understanding before the home visit.

For agencies new to home-visiting, there are considerations of mileage expenses, maps, hand-gel for use before and after visits, and field safety. **A Home Visit Log** may be useful to track field visits, and coaches may be asked to check-in after visits.

Transition Coach® Debrief Form

Name _____ Date _____

Organization _____

☐ Partnered practice ☐ Shadowed a coach ☐ Was shadowed by a coach

What went well? _____

_____

_____

What are the opportunities to improve coaching skills? _____

_____

_____

_____

General comments/questions; opportunities for ongoing training/support of coaches:

_____

_____

_____

_____

Based on this experience, what are the next steps?

☐ Practice with peers
☐ Shadow a coach
☐ Add Activated Behaviors Assessment (ABA) or
   Patient Activation Assessment® (PAA)
   to independent coaching
☐ Coach shadow me

☐ Independent coaching
☐ Add Patient Activation measure
   (PAM) to independent coaching

My plan to achieve the next step is: _____

_____

_____

_____

What I need now from the coach mentors is: _____

_____

_____

_____

Home Visit Log

Coach	Home Visit Date	Home Visit Time	Patient Name & Address

Section 4 – Generate Patient Referrals

Section 1
Learn about the
CTI® Model

Section 2
Train with the Care
Transitions Program®

Section 3
Identify, Orient and Mentor
Your Coaches

Section 4
Generate
Patient Referrals

Section 5
Coach Your Patients

Section 6
Document Your Work

Section 7
Collect Data

Section 8
Evaluate and Improve
Your Program

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.

continued on next page

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.

Transition Coach® Referral Criteria-Example

Inclusion criteria:

- A willing participant
- Cognitive or with cognitive caregiver
- English-speaking or with an English-speaking caregiver*
- Disposition at discharge to home or to skilled nursing facility (SNF) for short-term stay
- Payer type: _____
- Resident of specific geographic area: _____
- Specific diagnosis(es): _____
- Specific patient population: _____
- Recipient of specific service type: _____
- Patient of a specific provider: _____
- Other: _____

Exclusion criteria:

- Unwilling to participate
- Cognitive deficits or without cognitive caregiver
- Non-English-speaking or without an English-speaking caregiver*
- Payer type: _____
- Resident of, or will convalesce outside of, specific geographic area: _____
- Specific diagnosis(es): _____
- Specific patient population: _____
- Recipient of specific service type: _____
- Patient of a specific provider: _____
- Disposition at discharge to hospice care
- Disposition at discharge to extended skilled nursing facility stay or extended care facility (ECF)
- Disposition at discharge to assisted living facility (ALF) or adult family home (AFH)
- Privacy Patient/Do Not Announce/Behavioral Health admission
- Significant chemical dependency/behavioral health co-morbidity
- Cancer diagnosis with chemotherapy/radiation treatment ongoing
- Daily physician office infusion or other care
- Daily Home Health RN visits
- Other: _____

*Non-english language needs cannot be met by coaches unless the coach is proficient in language needed.

Emergency Department Transition Coach® Referral Criteria-Example

Inclusion criteria:

- Inpatient stay (not observation status) within the preceding 7 days
- Disposition at discharge from ED to home
- Cognitive or with cognitive caregiver
- Non-English-speaking with English-speaking caregiver*
- Payer type: _____
- Resident of specific geographic area: _____
- Specific diagnosis(es): _____
- Specific patient population: _____
- Recipient of specific service type: _____
- Patient of a specific provider: _____
- Other: _____

Exclusion criteria:

- Unwilling to participate
- Cognitive deficits or without cognitive caregiver
- Non-English-speaking or without an English-speaking caregiver*
- Payer type: _____
- Resident of, or will convalesce outside of, specific geographic area: _____
- Specific diagnosis(es): _____
- Specific patient population: _____
- Recipient of specific service type: _____
- Patient of a specific provider: _____
- Disposition at hospital discharge or from ED to hospice care, or hospice care ongoing
- Disposition at hospital discharge or from ED to skilled nursing facility (SNF) stay or to extended care facility (ECF)
- Disposition at hospital discharge or from ED to assisted living facility (ALF) or adult family home (AFH)
- Privacy patient/Do not announce
- Significant chemical dependency/behavioral health co-morbidity
- Cancer diagnosis with chemotherapy/radiation treatment ongoing
- Daily physician office infusion or other care
- Daily Home Health RN visits
- Other: _____

Non-english language needs cannot be met by coaches unless the coach is proficient in language needed.

CTI®Talking Points for Front Line Staff

Patient Identification
- The Coach Coordinator or Care Management staff screens _____ and approaches the patient and caregiver for consent.
- Other: _____

Staff Member Role
- At admission, introduce coaching as part of the discharge plan. This will prepare the patient to expect a visit from the coach.
- After coaching is introduced, call _____, email _____ referral into Electronic Medical Record.
- A coach will visit the patient.

Coaching Intervention: Answers to Frequently Asked Questions
- Goal is to ensure safe and effective transitions of care and prevent unnecessary re-hospitalizations
- No physician order is required
- There is no cost to the patient
- The Coach is not a caregiver or direct treatment provider
- Consists of a hospital visit, a home visit and three phone calls over a 4-week period.
- Four Pillars:
  - Medication self-management
  - Recognizing and responding to red flags (symptoms)
  - Prompt scheduling of follow-up appointments after discharge
  - Organizing health information in a personal health record

Program Referral Criteria
- Payer type: _____
- County resident
- English-speaking
- Cognitively able to participate in coaching (or has suitable caregiver)
- Discharging to: home, home health, skilled nursing facility for a short stay (exclusion: long term, custodial care facility)
- Patients with inpatient status, at risk for re-admission
- Patients with a new diagnosis, treatment or regimen
- Isolated patients, or those who are without an adequate support system

Sample Scripts

I'm a Transition Coach® and I'm here to help you make a successful move from the hospital to home.

Benefits of participation: this is a free service; it helps prevent hospital readmission; the Coach serves as a resource for finding answers questions that may arise after hospital discharge.

This free, voluntary program is part of the hospital discharge plan.
_____ Clinics are encouraging their patients to participate.

I'd like to visit you at home to help you review your medications and prepare for your follow-up doctor visit. This program also includes family members and caregivers.

This will be a different kind of visit from others you may have had such as with the visiting nurse.

After you are discharged, please call me at (phone) to let me know you are home.

After you get home, I will visit you once.

After this visit, I will call you three times to check on how you are doing and answer any questions you might have.

If you go to a rehabilitation center/nursing home before going home, I will visit you once you get back home.

_____

You have been chosen, and qualify for this free, special benefit: Coaching!

It's designed to make your life easier, and is not meant to be time-consuming or intrusive.

It is to help you recover, help you prevent re-hospitalization and help you stay healthy.

Coaching will help you:
• Prepare for discharge
• Organize and understand your medications
• Understand what to look for and what to do, to prevent re-admission
• Arrange follow-up and doctor appointments

The Coach will be available for you to call if you get home and have questions.

The Coach will visit with you in the hospital, visit you once at home and make 3 follow-up phone calls.

10 FACTS

Physicians Need to Know About Coaches

1. There is NO cost to you or your patients for coaching.
2. Coaches DO NOT interfere with your patient care.
3. Coaches DO NOT practice clinical medicine or direct patient care.
4. Coaches DO empower patients with their health care.
5. Coaches can assist you and your patients with their Medication Reconciliation.
6. Coaches will be trained professionals.
7. Selected patients will be visited in the hospital by the coach with one follow-up in their home (NOT to give direct care) and several phone contacts over a four   week period.
8. Coaches assist patients with transitions across care settings.
9. Coaches will be assigned to patients with high risk for readmissions.
10. To learn more about coaches and their role visit: www.caretransitions.org.

Care Transition Coaching ™ is a model designed to:
- Transfer skills
- Build patient/caregiver confidence
- Provide tools to support self management.

The goal is to coach patients/caregivers to actively engage
in self-management skill development.

The primary role of the Care Transition Coach ℠ is to empower the patient/caregiver to:
- Assert a more active role during care transitions and
- Develop lasting self-management skills.

Quality Insights
Quality Insights of Pennsylvania

Palliative and Supportive Care Team
Care Transition Coach Program

The Palliative and Supportive Care Program has additional support to help patients and their families when they are discharged from the hospital or from a health care facility to home.

Care Transition Coaching:

- **Free**
- Lasts about 4 weeks
- Can help you or your loved one:
    o Safely stay at home, and/or
    o Transition smoothly between health care settings or from a care setting to home

A Transition Coach can help you:

- **Understand** your medications and help you set up a medication self-management system that works for you

- **Create** a personal health record to carry with you to all appointments and healthcare settings

- **Be aware** of "red flags" that mean your condition is worsening, and to know what to do if red flags occur

- **Prepare** for follow-up appointments and get your post-discharge questions and concerns addressed

- **Support** you in your personal health care goals

The Care Transition Coach Program is different from services such as home health or outpatient care in that the Coach does not provide hands-on care. Rather, the Coach works with you (and/or your family) to help you feel better prepared to manage your health conditions and help you get your needs met during transitions from one care setting to another, or from a care setting to home.

The program consists of one home visit within a few days of discharge, and three follow-up phone calls at times that are convenient for you and your family. The Coach will also meet with you and your family before discharge, if time permits.

If you have any questions or would like to talk to one of our Care Transition Coaches, please call the Palliative and Supportive Care office at **360-788-6340**.

PeaceHealth St. Joseph Medical Center Palliative and Supportive Care Program

Hospitalized Patients in Whatcom County
You can have a free Transitions Coach!

After discharge, a Stepping Stones Transitions Coach can help you:

- Understand your medications and help you set up a medication self-management system that works for you;

- Be aware of "red flags" that mean your condition is worsening and you should contact your provider;

- Schedule follow-up appointments and get your medical questions addressed;

- Create a personal health record and support you in your personal health goals.

Your **Coach** is_____(360) 676-6749

Hospitalized Patients in Whatcom County
You can have a free Transitions Coach!

After discharge, a Stepping Stones Transitions Coach can help you:

- Understand your medications and help you set up a medication self-management system that works for you;

- Be aware of "red flags" that mean your condition is worsening and you should contact your provider;

- Schedule follow-up appointments and get your medical questions addressed;

- Create a personal health record and support you in your personal health goals.

Your **Coach** is_____(360) 676-6749

Need help locating Aging and Long-term Care Services?
Senior Information and Assistance offers…

- *Free information about services, and help identifying the programs that meet your individual needs.*
- *Assistance with applications and paper work, including a personal health record.*
- *Referrals to community resources and follow up to ensure service delivery.*
- *Advocacy if you have difficulty obtaining the services you need.*

(360) 738-2500
iandawhatcom@dshs.wa.gov

Need help locating Aging and Long-term Care Services?
Senior Information and Assistance offers…

- *Free information about services, and help identifying the programs that meet your individual needs.*
- *Assistance with applications and paper work, including a personal health record.*
- *Referrals to community resources and follow up to ensure service delivery.*
- *Advocacy if you have difficulty obtaining the services you need.*

(360) 738-2500
iandawhatcom@dshs.wa.gov

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.

continued on next page

Section 5 – Coach Your Patients

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 July 2012.

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**

CTI® Phone Call Guidelines

Try to schedule calls around upcoming appointments or test results

TELEPHONE CALL CONTENT, MD FOLLOW-UP
- What happened in the MD appointment(s)?
- When is the next appointment(s)?
- Are there any lab or radiology tests due or pending?
- If there are pending tests, how will patient find out the results and/or how is patient notified of related medication, or other changes? (If they don't know, coach them on strategies.)
- If the patient says they will just be seen as needed, ask them what would be a trigger for them to call for an appointment.

TELEPHONE CALL CONTENT, PERSONAL HEALTH RECORD (PHR)
- Did patient take their PHR to MD appointment(s)?
- If so, did they review the Medical History/Red Flags, the Medications List and the Questions with the doctor?
- If they forgot, suggest placing a call to the MD or nurse if warranted.
- If they remembered to do so, discuss the answers they got, any medication changes that may have occurred, etc.
- Ask if they found the PHR helpful. If so, how was it helpful? If not, ask for details.
- Do they feel they can keep their med list up-to-date? Discuss strategies for them to remember to do so.
- If personal health record is electronic, does MD have access?

TELEPHONE CALL CONTENT, MEDICATIONS
- Ask how things are going with any new or changed medications.
- Ask how things are going with any medications that are specific to the hospitalization. A talking point is that some medications may be tapered off by the MD once the patient is recovered from this episode of illness/surgery and that is a good reason to review the medication list every visit and to ask whether new medications and medication changes are temporary or "forever."
- If they set up a new medication management system, discuss how that's working for them.

TELEPHONE CALL CONTENT, RED FLAGS

- Ask if they have experienced any red flags.
- If they have, what did they do? Coach based on the answers.
- If they are confused about red flags, refer them to the D/C instructions or to direct care providers.
- Role-play with them as appropriate.

TELEPHONE CALL CONTENT, GENERAL

- Ask open-ended questions about how things are going. Get them to tell their story. Follow where it leads.
- Ask about progress towards stated personal goal.
- Talk about any new treatment they have had to start at home: daily weights, BP checks, new diet considerations, etc., and ask how that's going.
- If they are struggling, consider suggesting they ask for a nurse visit at their MD office to get further instruction.
- If they are home-bound, consider suggesting they talk to the MD or RN about a home health assessment for further instruction.
- If they have home health in place, discuss how that is going. The patient may write questions for home health staff in their PHR.

Transition Coach® Trouble Shooting Guide

Issues	Suggestions	Notes
Patient in hospital wants to talk to spouse or a son/daughter about the program before deciding to consent.	• Ask permission to give the significant other a phone call to describe the program. *Tip:* Patient's children are often more willing to engage coaching help and may convince their parent to consent. Try to make the Home Visit (HV) when offspring can be present, or follow up with them if you think the patient won't.	
Patient is to be discharged (DC'd) on a Friday afternoon, particularly if before a three-day weekend.	• Cue patient to consider how they will get medications (most important for patients living alone, get meds mail-order or get pre-filled medi-sets delivered from a retail pharmacy). • Coach patient to alert unit social worker/Nurse Team Lead (NTL) to have meds changes faxed or called to pharmacy if necessary. • Prompt patient to ask what to do if red flags occur outside of physician office hours.	
Patient with new or multiple needs is being discharged.	• Encourage patient talk to nurse or unit social worker • Role play how patient can phrase request or describe issues so they get their needs met • Talk to NTL or to patient's lead nurse about his/ her biggest concerns, as a last resort. *Tip:* When following a patient in a Skilled Nursing Facility (SNF), make a point of developing a relationship with their primary nurse, social worker, and therapist. They may have concerns about patient that can alert you to follow-up coaching.	

Issues	Suggestions	Notes
You want to make a Home Visit, but learn that a Home Health Agency (HHA) is also visiting patient.	• If patient doesn't know when HHA visits are scheduled, encourage them to call Agency and speak with scheduler or Nurse Manager.	
Patient was told they'd have Home Health but don't know which agency and have received no call.	• Encourage patient or caregiver to call Social Services at hospital for clarification if same-day as discharge (DC). • Suggest calling Primary Care Provider (PCP) or HHA.	
Patient is overwhelmed by number of people coming into home from HHA.	• Focus of coaching might be to develop questions and goals for their time with HHA professionals. • If patient is feeling supported enough with visits from HHA patient may not need coaching.	
Patient living alone needs additional help to get meds, meals, for transportation to medical appointments, etc.	Explore these options with patient: • Engage family members wherever they live or friends/neighbors to assist (they often do not know about deficits and are quite willing to help). • Give Aging and Disabilities Resource Center (ADRC) number • If patient doesn't want to call, ADRC can make an outbound call. • Manager of apartments may know of a "helper bee" who lives in complex. • Does patient belong to a religious congregation? Encourage reaching out. • County Transportation Authority for specialized transportation. *Tip:* Primary Clinic may have a social worker who can help. *Tip:* Encourage presence of a significant other during the home visit. This is very helpful.	

Issues	Suggestions	Notes
Patient recently d/c'd from a Skilled Nursing Facility (SNF) is having short-term difficulty making the transition home and is at risk.	• Encourage patient/caregiver to call Medical Social Worker (MSW) at SNF, as the MSW may be able to arrange services post-DC or arrange a short readmission and pick the patient up. *Tip:* When following a patient in a SNF, make a point of developing a relationship with their primary nurse, social worker, therapist. They may have concerns about patient that can alert you to ongoing coaching.	
Diabetic patient with multiple needs.	• Inform about diabetes classes given in your region. Medicare will pay for classes, with physician order, under Part B with 20% cost-sharing, even if diabetes is diet-controlled: 10 hrs within 12 months (1 hour one-on-one and 9 in group) and then 2 hours a year thereafter with physician order. • Do they keep a blood glucose record to take to doctor? Make part of Personal Health Record (PHR), or encourage patient to bring it and PHR to appointments. • Ask if they have talked about blood sugar parameters with their physician: what's too high or too low, and what should pt do if Blood Sugar falls outside parameters? If not, suggest they write a question in the PHR. • Do they know what their hemoglobin A1c is? What their A1c goal is? If not, suggest PHR question. • Has glucometer been calibrated recently? Take to next doctor visit to check against office glucometer.	

Issues	Suggestions	Notes
Patient or family seems resistant to writing in Personal Health Record (PHR) during visit.	• "I'm getting the feeling you don't want to use this PHR. (Pause). Is there something keeping you from doing it?" (Literacy, poor vision or handwriting may be issues. Or people may use their own system.) • "Do you already have another system in place? • Does it include a medication list that you keep current and take to all doctor appointments? • Does it have a way for you to write questions down for the doctor or other providers? • If not, this PHR may serve as a template or guide for you with your existing system."	
Patient having trouble hearing over the phone	• Using speaker phone on their end might help.	
You want to call patient from your home or cell phone and want to block your number. Patient unwilling to pick up unknown caller (if they have caller ID)	• Alert patient/ family if this might be the case. Might you call right back to signal that it's you calling?	
Patient left facility AMA (against medical advice) and therefore doesn't have meds, orders or supportive systems in place.	• Have patient call pharmacy to see if prescriptions (Rxs) have been faxed and have been filled. Have patient arrange a ride to pick up Rxs. • If transportation is a continual problem, have patient call ADRC for ride resources and Transit Authority. Ask patient if they are connected with a congregation/parish nurse program. • Ask patient to check with family/ friends/ neighbors for rides.	

Issues	Suggestions	Notes
Patient doesn't want to make appt. with PCP within a week. They often think that doctors' offices reliably get and read timely information about the recent hospitalization.	• Remind the patient that this is not the case, that they themselves are the primary information source for their docs. Having an organized PHR available will get their questions and concerns answered.	
Patient hasn't made it to any follow-up appointments.	• Have patient call PCP to let them know that he has not made any of his follow-up appointments/lab tests and what they would suggest as to next step of action. • Explore further what the issue is for non-adherence, e.g., transportation, etc.	
Patient doesn't have discharge instructions or med list.	• Ask patient if any family members might have the hospital discharge information. If not, encourage patient/family to call nursing unit NTL or Nurse Manager if same day as discharge. They can mail copies. • If not day of discharge, patient will need to sign a written request for a copy from medical records. • Encourage patient/family to call PCP or Specialist. They may have access to the electronic medical record and may print medication list for pick-up. • Have patient call pharmacist. They may have faxed copy of orders.	
You arrive at a home visit and the patient has no meds.	• If meds are not at pharmacy, have patient call SNF or hospital floor/NTL/ SW to see if med list had been faxed to pharmacy. • Prompt patient/caregiver to call PCP. Role play call first.	

Issues	Suggestions	Notes
Patient has missed doses, or is off one or more meds entirely.	• Have patient alert PCP of situation of being off meds and to ask for instructions on how to start them again. • Have patient also let pharmacist know of situation when picking up medications, in case more teaching is needed for patient.	
Patient uses mail-order pharmacy (Medco, Express Scripts, Veteran's Administration (VA), etc.	• Prompt patient or caregiver to ask nurse or social worker to fax discharge med orders to mail-order pharmacy and arrange a short-fill to tide patient over till mail meds arrive.	
Patient uses a pharmacy-filled medi-set at home. Meds have been changed during hospitalization, but medi-set is filled with old Rx's and pharmacy doesn't have current information. (Once patient is DCed, hospital will not call in changes.)	• Best course of action: have patient/caregiver tell nurse & social worker discharge med orders must be faxed to pharmacy before discharge. • Does patient have written Rx's? Get someone to take these to pharmacy to fill (taxi as last resort). Some retail pharmacies will deliver corrected medi-set and pick up old one. Have patient or caregiver call pharmacy to arrange. • Coach patient/caregiver to call PCP, who may be able to get changes from electronic medical record & call in changes to pharmacy (usually takes at least 24 hours) • Coach patient to let all providers know about their med system and to write in PHR.	
Patient needs medi-set set-up and delivery.	Some retail pharmacies provide this service for a fee. Many private-pay home care providers will perform this service for a fee.	

Issues	Suggestions	Notes
Patient/family set up their own medi-set, but things have changed since their hospitalization.	Have family or patient do the following: • For few pills in the medi-set, may identify any that have been stopped and pick them out, otherwise, during home visit,… • Have patient/family empty entire medi-set into a bowl. Have patient/family open bottles and put sample pill of each medication into its bottle cap for reference. Have patient/family refill medi-set using pills from bowl, discarding discontinued meds and adding new medications.	
Patient has expired meds.	• Alert patient to fact of expiration, talk about checking meds periodically for expiration date, and have them contact PCP for new prescription and instructions on taking the med.	
Patient taking med incorrectly of for wrong reason (eg. pain med as antibiotic and antibiotic for pain).	• Alert patient to mistake. Prompt patient to count pills to know how many were taken. Have pt. alert PCP to med error and further instructions while you are at HV. • Review new instructions with patient • Devise way for patient to label med more clearly : eg."ANTIBIOTIC"	
Patient has old and current prescriptions together, or has their bottles and another person's bottles in the same place.	• Suggest sequestering old prescriptions away from current ones. • Suggest separating each person's meds from the other.	
Family holds vital med for fear it may interact with other meds.	• Have family contact PCP right away with concerns and further instruction. If unable to get hold of PCP, then have family/patient contact hospitalist services at hospital that prescribed medication for instructions. • Continue to follow–up to make sure it is resolved that day.	

Issues	Suggestions	Notes
Patient resumes home medications rather than starting new dosing, after discharge (eg. resuming pre-admission Coumadin dose or Lasix dose.)	• Teach patient and caregiver how to reconcile meds and doses and find and correct these discrepancies. • Encourage them to write question in PHR for physician, or prompt them to call office during home visit to address discrepancy. • Role play before the call.	
Patient can't afford meds.	• If it's a cardiac drug ordered by a cardiology practice, they may have staff to assist with applications to pharmaceutical companies' Prescription Assistance Programs. • Explain/role play asking PCP or specialist to provide samples or prescribe a less expensive alternative. • Patient can request a partial fill if it's a new med for new condition and physician is fine-tuning med regimen. • Partnership for Prescription Assistance 1-888-477-2669 www.PPARx.org • www.needymeds.org	
Patient needs help with insurance.	Washington State Health Insurance Commissioner has free counseling through the State Health Insurance Benefit Advisor program, or SHIBA: 1-800-562-6900 Provides free, unbiased healthcare coverage counseling to people of ALL ages: • Understand healthcare coverage options and rights • Find affordable healthcare coverage • Evaluate and compare health insurance plans	

Issues	Suggestions	Notes
Patient needs to dispose of unwanted medications	Some pharmacies accept unwanted and expired medications from households for secure and legal disposal. These pharmacies can legally accept most prescription and over the counter medications, except prescription narcotics and prescription controlled substances. PATIENT SHOULD CALL AHEAD FIRST TO SCHEDULE APPOINTMENT:	
Patient needs assistance with healthcare access.		
Transportation		
Meals		
Emergency Food		
Housing		
Medicaid-DSHS		
Basic Resources		

Helpful Websites and Links

AoA—The Aging Network and Care Transitions: Preparing Your Organization Tool Kit
www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_caretransitions/Toolkit/index.aspx

Spanish Language PHR (provided to the Care Transitions Program® by one of their partners, Visiting Nurse and Hospice Care)
www.caretransitions.org/documents/spanishphrnologo.pdf

Spanish Language Medication List and MD Questions
www.caretransitions.org/documents/Medication%20Record%20Spanish.pdf

National Library of Medicine Medical Search Engine "Medline Plus"
www.nlm.nih.gov/medlineplus/

Drugs and Supplements
www.nlm.nih.gov/medlineplus/druginformation.html

Interactive Tutorials
www.nlm.nih.gov/medlineplus/tutorial.html

Health Topics
www.nlm.nih.gov/medlineplus/healthtopics.html

The Remington Report—Mobilizing Community Volunteers To Improve Care Transitions: Lessons Learned From Stepping Stones, The Care Transitions Project of Whatcom County
www.cfmc.org/integratingcare/files/rem_ja11-Care%20Transitions.pdf

Teach Back

Increasing Understanding

QUALIS HEALTH. Advancing Healthcare Improving Health

Overview

- Patients and family members understand what we tell them – don't they?
- Why don't they just do what we tell them to do?
- What's the big deal about "health literacy"?
- I know how to teach – not my responsibility if they don't understand
- Take action

Patient-Centered?

- Painful questions
  - I do the best I can – why don't they listen?
  - They don't ask questions, how am I supposed to know they don't understand?
  - With all I have to do, when will I have time to do something additional?
  - Why do I have to change how I talk to patients? I have not gotten any complaints about what I do.

Story Time

Teach Back - Definition

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.

Background

Grew out of concerns about the informed consent process and educational components for patients with limited health literacy

Health Literacy

The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions

10

Factors Limiting Health Literacy

- Challenged by sickness
- Feelings of vulnerability
- Too much medical jargon
- Too many pieces of information
- Very stressful situation
- Too much happening at once

11

Implications

If patients do not understand the implications of their diagnosis and importance of prevention and treatment plans, there is the potential for errors, adverse events, or unnecessary re-hospitalizations

12

Keys to Success with Health Literacy

- Use universal health literacy communications principles to redesign written teaching materials
- User-friendly written materials use:
  - Simple words (1-2 syllables)
  - Short sentences (4-6 words)
  - Short paragraphs (2-3 sentences)
  - No medical jargon
  - Headings and bullets
  - Highlighted or circled key information
  - Lots of white space
  - Two-word explanations: "water pill/blood pressure pill"

THE COMMONWEALTH FUND

13

Evidence Base

"Recounting" or teaching back provides greater recall and comprehension

- Increases patient retention
- Provides a gauge of patient understanding of instructions
- Actively involves patients in discussion
- Improves safe transitions of care

14

Endorsements for Teach Back

- National Quality Forum
- American Academy of Family Physicians
- American College of Surgeons
- American Hospital Association
- American Nurses Association
- Federation of American Hospitals
- Joint Commission

15

Teach Back Process

- Who?
- What?
- When?
- Why?
- How?

16

Who?

All staff interacting with patients
- Discuss implications in your setting
- Challenges
- Opportunities

17

What?

Patients should be able to explain, in their everyday words:

- Diagnosis/health problem for which they need care
- Name/type/general nature of the treatment, service, or procedure
- Issues or "red flags" to watch for and what to do when they occur

18

When?

Early in the care process and at each decision point or transition

- List these points in your care setting
- Consider time frames when they occur
- Consider other competing factors
- Sharing by more than one person

19

Why?

Many patients have difficulty understanding basic health information; it is important for providers to gauge how well patients and caregivers understand – not just education which is historically passive in nature

20

How?

Patients should be able to show they understand, and not just repeat back or nod - It is important to have the provider own the concern

- "I want to be certain I explained this clearly"
- "I want to be sure we have the same understanding"
- "Can you tell me, in your own words…"

21

When a Gap is Identified

- Offer additional teaching or explanation
- Consider use of additional visual aids
- Ask more leading questions to determine the specifics of the gap
- Follow up with second request for teach back by patient

22

Important Concepts

- Don't want to make the patient feel like they are being tested, but double checking on how well the provider explained content
- Avoid causing patients to feel shame at not understanding
- When not understanding, patients can feel embarrassed, ashamed, stupid, angry, anxious
- Be sensitive to patients not wanting to "bother" busy providers

23

"Shame Free" Environment

- Comfortable to speak up about concerns
- More likely to contact provider later
- More alert to recognizing potential symptoms and seeking care
- Easier to assess patient's ability and confidence to perform self-care goals

24

Teach Back Practice #1-B

Read the following exactly as written as if you are interacting with a patient.

"Mrs Jones, you have just been given several new medications. It is very important to be sure you keep track of all of your medicines with a complete current list, what they are for, when and how you take them, and all the possible interactions and contraindications.

"Do you understand and are you doing this?"

25

Teach Back Practice #1-G

Read the following as written as if you are interacting with a patient:

"Mrs Jones, I know you have been given several new medications and I know there is a lot to remember here and it can be confusing. I want to be sure I take good care of you and am here when you need me. Can you tell me about the new medicines and what the doctor told you about them?"

"Can you share with me how you keep track of your medicines?"

"Can we work together to add these to your previous list so we can be clear about what you are taking when?"

26

Teach Back Practice #2-B

Read the following as if you are quizzing the patient. You are making the patient feel like they are on the spot by asking them to repeat the information you just told them. It sounds like a test for the patient.

"Mrs. Jones, don't you know what medications you take?"

27

Teach Back Practice #2-G

Read the following as written as if you are interacting with a patient., in a calm, unhurried, and pleasant voice.

"Mrs. Jones, I know there is a lot that we tell you about medications and it can be very confusing. Sometimes I am trying so hard to cover everything that I go over it quickly or may not be clear."

"I want to make sure I give you what you need to know about these new medicines and how they fit in with your other medications."

"Your daughter will be coming tonight to visit, can you tell me what you will share with her about your current medications?"

28

Teach Back Practice #3-B

Participants share examples of teaching moments from their experience and their usual presentation of the content.

- Include content when there are multiple elements and more to cover than there is time
- Consider situations when you presented information and found out later that the receiver of the information clearly did not understand at all
- Think of one of your most frustrating conversations where you felt completely unheard

29

Teach Back Practice #3-G

Consider instead how you can take each of those examples and deliver the content in a more relaxed and effective manner.

- How can I simplify the language?
- How can I shorten the messages and check out understand at each small section?
- What is the most important thing I want to be certain I communicate?
- How is the individual responding to me?
- If it is not a positive response, can I figure out why and change how I am teaching?

30

Shift in Communication Style

Not difficult to learn – just takes practice

- Takes only minutes to complete
- More time effective than re-training
- Increases provider's confidence with patient knowledge level
- Opportunity to enhance provider skill level
- Increases patient satisfaction

31

Reminder Cards

- **Who** - *me*
- **What** – *anything important I want them to understand*
- **When** – *every time*
- **Why** – *I need to know they understand*
- **How** – *ask them to tell me about what I taught, in their own words*

32

Health Literacy

"If they don't do what we want, we haven't given them the right information."

Vice Admiral Richard Carmona, Former Surgeon General

33

5

Speak Up

- What works well at your organization?
- What doesn't work well (pain points)?

34

Leadership Teach Back

#1 – Practice using Teach Back techniques within your leadership team
- Can you tell them the reasons for using Teach Back?
- Do they understand the difference in the approach?
- Can you recognize the difference when using Teach Back?
- How do they feel when taught with Teach Back?
- Try using the videos for examples
- Consider making reminder cards

35

Leadership Teach Back

#2 Teach 1-3 staff to use Teach Back
- Use the module attached
- Use videos if needed
- Determine their understanding level modeling Teach Back techniques yourself
- Discuss with them how they can use the techniques
- Share reminder card option
- Discuss barriers and opportunities

36

Resources

Health Literacy site with three short video examples of Teach Back:
www.nchealthliteracy.org/toolkit/tool5.pdf

Project BOOST website includes Teach Back curriculum and video which can be purchased:
www.hospitalmedicine.org/BOOST

37

Questions or Concerns

Carol Higgins, BS, OTR, Ret., CPHQ
Qualis Health
206-288-2454
carolh@qualishealth.org

38

Qualis Health

Qualis Health, an independent nonprofit organization established in 1974, is dedicated to developing and applying best practices as we deliver an extensive range of patient-centered, evidence-based healthcare quality improvement and care management services. We provide leadership, expertise and innovation in improving the health of individuals and populations across the healthcare continuum through our core services in:
- Utilization management
- Care coordination
- Clinical quality improvement
- Health information technology and operations improvement consulting

Qualis Health serves as the Medicare's Quality Improvement Organization (QIO) in Idaho and Washington.

39

Teach-Back

"I want to make sure I explained this clearly.

When you get back home in a few days, what will you tell your

[friend or family member]

about

[key point just discussed]?

Care Transitions Project of Whatcom County

STEPPING STONES
Bridging Healthcare Gaps

Teach-Back

"I want to make sure I explained this clearly.

When you get back home in a few days, what will you tell your

[friend or family member]

about

[key point just discussed]?

Care Transitions Project of Whatcom County

STEPPING STONES
Bridging Healthcare Gaps

Teach-Back

"I want to make sure I explained this clearly.

When you get back home in a few days, what will you tell your

[friend or family member]

about

[key point just discussed]?

Care Transitions Project of Whatcom County

STEPPING STONES
Bridging Healthcare Gaps

FRONT
Card 1 of 14

Teach-Back

Teach Back Medication Cards developed by and used with permission from TMF Health Quality Institute, the Medicare Quality Improvement Organization for Texas, under contract with the Centers for Medicare & Medicaid Services (CMS).

Care Transitions Project of Whatcom County

STEPPING STONES
Bridging Healthcare Gaps

Teach-Back

Teach Back Medication Cards developed by and used with permission from TMF Health Quality Institute, the Medicare Quality Improvement Organization for Texas, under contract with the Centers for Medicare & Medicaid Services (CMS).

Care Transitions Project of Whatcom County

STEPPING STONES
Bridging Healthcare Gaps

Teach-Back

Teach Back Medication Cards developed by and used with permission from TMF Health Quality Institute, the Medicare Quality Improvement Organization for Texas, under contract with the Centers for Medicare & Medicaid Services (CMS).

Care Transitions Project of Whatcom County

STEPPING STONES
Bridging Healthcare Gaps

ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS

These drugs improve symptoms and prevent symptoms from worsening by relaxing blood vessels, controlling fluid, and slowing the progression of heart failure. You may receive one of these drugs in a combination tablet with other drugs.

Your doctor may slowly increase the dose over time to a level that is just right for you. Your doctor may also perform blood tests to make sure the drug is working properly for you.

Seek medical attention if you experience:

- Lightheadedness, dizziness, falls
- Swelling of the lips, throat, or eyes
- Skin rash
- New or persistent cough

FRONT

Card 3 of 14

ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS

Angiotensin-Converting Enzyme (ACE) drugs:

- Amlupril (Quinopril)
- Zestril, Prinivil (Lisinopril)
- Altace (Ramipril)
- Lotensin (Benazepril)
- Capoten (Captoril)
- Mavik (Trandolapril)
- Vasotec (Enalapril)
- Univasc (Moexipril)

ANGIOTENSIN II RECEPTOR BLOCKERS (ARBS)

These drugs are similar to ACE Inhibitors, but are less likely to cause a bothersome cough. You may receive one in a combination tablet with other drugs. Your doctor may perform blood tests to make sure the drug is working properly for you.

Seek medical attention if you experience:

- Light-headedness, dizziness, falls
- Swelling of the lips, throat or eyes
- Skin rash
- New or persistent cough

ANGIOTENSIN II RECEPTOR BLOCKERS (ARBS)

Angiotensin II Receptor Blockers (ARBs) drugs:

- Atacand (Candesartan)
- Diovan (Valsartan)
- Avapro (Irbesartan)
- Hyzaar
- Benicar (Olmesartan)
- Cozaar (Losartan)

ANGIOTENSIN II RECEPTOR BLOCKERS (ARBS)

Angiotensin II Receptor Blockers (ARBs) drugs:

- Atacand (Candesartan)
- Diovan (Valsartan)
- Avapro (Irbesartan)
- Hyzaar
- Benicar (Olmesartan)
- Cozaar (Losartan)

ANGIOTENSIN II RECEPTOR BLOCKERS (ARBS)

Angiotensin II Receptor Blockers (ARBs) drugs:

- Atacand (Candesartan)
- Diovan (Valsartan)
- Avapro (Irbesartan)
- Hyzaar
- Benicar (Olmesartan)
- Cozaar (Losartan)

BETA BLOCKERS

These drugs control heart rhythm, relax the heart and slow the progression of heart failure. Do not crush or chew tablets unless directed to do so by your doctor. Do not stop taking the drug without medical supervision, because stopping too quickly can cause problems. If you are diabetic, be sure to closely monitor your blood sugar while taking beta blockers.

Seek medical attention if you experience:

- Trouble breathing
- Leg pain
- Chest pain
- Lightheadedness, dizziness or falls
- Worsening heart failure symptoms

BETA BLOCKERS

Beta Blocker drugs:
- Coreg (Carvedilol)
- Tenormin (Atenolol)
- Inderal
- Ziac (Bisoprolol, Zebeta)
- Metoprolol (Toprol-XL, Lopressor)

BETA BLOCKERS

Beta Blocker drugs:
- Coreg (Carvedilol)
- Tenormin (Atenolol)
- Inderal
- Ziac (Bisoprolol, Zebeta)
- Metoprolol (Toprol-XL, Lopressor)

BETA BLOCKERS

Beta Blocker drugs:
- Coreg (Carvedilol)
- Tenormin (Atenolol)
- Inderal
- Ziac (Bisoprolol, Zebeta)
- Metoprolol (Toprol-XL, Lopressor)

DIGOXIN (LANOXIN™)

This drug is used to help control heart rhythm and to make the heart beat stronger. Remember to take it exactly as prescribed by your doctor.

Seek medical attention if you experience:

- Nausea, vomiting
- Chest pain, palpitations or abnormal heart rhythm
- Changes in vision (see yellow or blue "halo" around objects)

DIGOXIN (LANOXIN™)

This drug is used to help control heart rhythm and to make the heart beat stronger. Remember to take it exactly as prescribed by your doctor.

Seek medical attention if you experience:

- Nausea, vomiting
- Chest pain, palpitations or abnormal heart rhythm
- Changes in vision (see yellow or blue "halo" around objects)

DIGOXIN (LANOXIN™)

This drug is used to help control heart rhythm and to make the heart beat stronger. Remember to take it exactly as prescribed by your doctor.

Seek medical attention if you experience:

- Nausea, vomiting
- Chest pain, palpitations or abnormal heart rhythm
- Changes in vision (see yellow or blue "halo" around objects)

FRONT

Card 9 of 14

DIGOXIN (LANOXIN™)

Digoxin (Lanoxin)

DIGOXIN (LANOXIN™)

Digoxin (Lanoxin)

DIGOXIN (LANOXIN™)

Digoxin (Lanoxin)

DIURETICS

These medications help your body remove extra fluid by causing you to urinate more. Remember to stay close to a bathroom for approximately one hour after you take your medication, in case you should have to urinate.

Your doctor may have you take a diuretic every day, or may instruct you to take it more or less often. Make a point of talking to your doctor about how often you take your diuretics and how well they are working.

Seek medical attention if you experience that:

- You are not urinating as much as usual.
- Your heart failure symptoms are getting worse.
- Your weight has gone up more than two pounds in a day, or more than four pounds in a week.
- Swelling has gotten worse.
- You are dizzy, confused, or fall.
- You are experiencing palpitations, or skipped heart beats.
- You have leg cramps, rash, or change in hearing.

DIURETICS

Caution: Taking extra diuretics without approval of your doctor or nurse can be harmful to your kidneys, especially to a diabetic.

If you have nausea/vomiting, diarrhea, or are unable to eat or drink, notify your health care provider as your diuretic prescription may need to be adjusted before you become too dry (dehydrated).

Diuretic drugs:

- Bumex (Bumetanide)
- Zaroxolyn (Metolazone)
- Demadex (Torsemide)
- Lasix (Furosemide)
- HCTZ (hydrochlorothiazide)

DIURETICS

Caution: Taking extra diuretics without approval of your doctor or nurse can be harmful to your kidneys, especially to a diabetic.

If you have nausea/vomiting, diarrhea, or are unable to eat or drink, notify your health care provider as your diuretic prescription may need to be adjusted before you become too dry (dehydrated).

Diuretic drugs:

- Bumex (Bumetanide)
- Zaroxolyn (Metolazone)
- Demadex (Torsemide)
- Lasix (Furosemide)
- HCTZ (hydrochlorothiazide)

DIURETICS

Caution: Taking extra diuretics without approval of your doctor or nurse can be harmful to your kidneys, especially to a diabetic.

If you have nausea/vomiting, diarrhea, or are unable to eat or drink, notify your health care provider as your diuretic prescription may need to be adjusted before you become too dry (dehydrated).

Diuretic drugs:

- Bumex (Bumetanide)
- Zaroxolyn (Metolazone)
- Demadex (Torsemide)
- Lasix (Furosemide)
- HCTZ (hydrochlorothiazide)

ALDOSTERONE BLOCKERS

These medications are a special type of diuretic (water pill) that has been shown to improve the health of people with heart failure. Aldosterone is a hormone in the body that causes salt and fluid build-up. Aldosterone inhibitors block this hormone. While this type of medication may cause some increase in urination, their main action is to prevent fluid from building up.

Seek medical attention if you experience:

- Lightheadedness, dizziness or falls
- Breast enlargement (in men)

ALDOSTERONE BLOCKERS

These medications are a special type of diuretic (water pill) that has been shown to improve the health of people with heart failure. Aldosterone is a hormone in the body that causes salt and fluid build-up. Aldosterone inhibitors block this hormone. While this type of medication may cause some increase in urination, their main action is to prevent fluid from building up.

Seek medical attention if you experience:

- Lightheadedness, dizziness or falls
- Breast enlargement (in men)

ALDOSTERONE BLOCKERS

These medications are a special type of diuretic (water pill) that has been shown to improve the health of people with heart failure. Aldosterone is a hormone in the body that causes salt and fluid build-up. Aldosterone inhibitors block this hormone. While this type of medication may cause some increase in urination, their main action is to prevent fluid from building up.

Seek medical attention if you experience:

- Lightheadedness, dizziness or falls
- Breast enlargement (in men)

ALDOSTERONE BLOCKERS

Aldosterone Blocker drugs:
- Aldactone (Spironolactone)
- Inspra (Eplarinone)

ALDOSTERONE BLOCKERS

Aldosterone Blocker drugs:
- Aldactone (Spironolactone)
- Inspra (Eplarinone)

ALDOSTERONE BLOCKERS

Aldosterone Blocker drugs:
- Aldactone (Spironolactone)
- Inspra (Eplarinone)

VASODILATORS OR NITRATES

These drugs relax blood vessels and improve health in patients with heart failure. They are typically used in people who cannot take Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs), or in people who need additional medications to control blood pressure or chest pain.

Nitroglycerine and other nitrates are vasodilators and come in a variety of forms, including tablets, capsules, and skin patches. Your doctor may also prescribe nitroglycerine used under the tongue for chest pain.

Nitrates may need special storage. Be sure to speak to your doctor or pharmacist about the proper way to use the nitrate product prescribed for you.

Seek medical attention if you experience:

- Lightheadedness, dizziness or falls
- Skin rash
- Severe headaches
- Infections
- Numbness or tingling
- Joint pain or swelling

VASODILATORS OR NITRATES

Vasodilators or Nitrates:

- Hydralazine (Apresoline)
- Imdur (Isosorbide mononitrate)
- Isosorbide dinitrate (Isordil, Isobid)
- Nitroglycerin

VASODILATORS OR NITRATES

Vasodilators or Nitrates:

- Hydralazine (Apresoline)
- Imdur (Isosorbide mononitrate)
- Isosorbide dinitrate (Isordil, Isobid)
- Nitroglycerin

VASODILATORS OR NITRATES

Vasodilators or Nitrates:

- Hydralazine (Apresoline)
- Imdur (Isosorbide mononitrate)
- Isosorbide dinitrate (Isordil, Isobid)
- Nitroglycerin

BACK
Card 16 of 14

POTASSIUM

Potassium is a mineral that your heart needs to function properly. Because some water pills cause you to lose potassium in your urine, your doctor may prescribe potassium supplements.

Potassium can irritate your throat and stomach, so be sure to take with plenty of water and with food, and to remain upright for a period of time after swallowing. Do not crush or cut potassium capsules or tablets. Liquids are available if you have difficulty swallowing—ask your doctor.

Blood tests should be performed to check your potassium levels. Some foods and salt substitutes are high in potassium, such as bananas, dried apricots, oranges and salt substitutes. Discuss your potassium levels with your doctor frequently.

Seek medical attention if you experience:
- Uneven heartbeat
- Muscle weakness or limp feeling
- Severe stomach pain
- Numbness or tingling in your hands, feet or mouth
- Confusion or feeling like you might pass out

POTASSIUM

Potassium supplements:

• Potassium Chloride
(Cena K, K-Dur, K-Lor, K-Tab, Kaon-CL,
Kay Ciel, Klor-Con, Micro-K, Rum-K)

POTASSIUM

Potassium supplements:

• Potassium Chloride
(Cena K, K-Dur, K-Lor, K-Tab, Kaon-CL,
Kay Ciel, Klor-Con, Micro-K, Rum-K)

POTASSIUM

Potassium supplements:

• Potassium Chloride
(Cena K, K-Dur, K-Lor, K-Tab, Kaon-CL,
Kay Ciel, Klor-Con, Micro-K, Rum-K)

BLOOD THINNERS

Heart failure sometimes increases your risk for developing blood clots, so your doctor may prescribe one or more "blood thinners." These are drugs that slow down clotting or keep certain blood cells (platelets) from clumping. Be sure to take them exactly as directed. Report any bleeding to your doctor right away.

If you are taking a blood thinner, you may need to have your blood tested regularly.

Seek medical attention if you experience:

- Bleeding from gums, nose, rectum or vagina
- Blood in urine or stool
- Red, dark brown or black bowel movements
- Bruising or soreness
- Severe or persistent headaches
- Abdominal pain

FRONT

BLOOD THINNERS

Blood thinners:

- Coumadin (Warfarin)
- Lovonox
- Heparin

BLOOD THINNERS

Blood thinners:

- Coumadin (Warfarin)
- Lovonox
- Heparin

BLOOD THINNERS

Blood thinners:

- Coumadin (Warfarin)
- Lovonox
- Heparin

Nurse Quick Reference for National Quality Indicators

HEART FAILURE

- Documentation of LV function (EF)
- ACE inhibitor/ARB if EF < 40% / or contraindication documented
- Documentation of smoking cessation counseling
- Discharge instructions specific to HF

CORE CARD

HEART FAILURE

- LVF assessment (document if prior, during stay or if planned after discharge)
- ACEI/ARB for LVSD: EF < 40%, mod-severe LVSF (if not, document reason)
- Smoking cessation advice / counseling
- Discharge instructions to address:
  - Activity
  - Diet
  - Follow-up
  - Medications (list ALL names)
  - What to do when symptoms worsen
  - Weight monitoring

CORE CARD

HEART FAILURE

- LVF assessment (document if prior, during stay or if planned after discharge)
- ACEI/ARB for LVSD: EF < 40%, mod-severe LVSF (if not, document reason)
- Smoking cessation advice / counseling
- Discharge instructions to address:
  - Activity
  - Diet
  - Follow-up
  - Medications (list ALL names)
  - What to do when symptoms worsen
  - Weight monitoring

CORE CARD

HEART FAILURE

- LVF assessment (document if prior, during stay or if planned after discharge)
- ACEI/ARB for LVSD: EF < 40%, mod-severe LVSF (if not, document reason)
- Smoking cessation advice / counseling
- Discharge instructions to address:
  - Activity
  - Diet
  - Follow-up
  - Medications (list ALL names)
  - What to do when symptoms worsen
  - Weight monitoring

Nurse Quick Reference for National Quality Indicators

ACUTE MYOCARDIAL INFARCTION

- ASA on arrival and discharge / or contraindication documented
- BB on discharge / or contraindication documented
- Documentation of LV function (EF)
- ACE inhibitor / ARB for EF < 40% / or contraindication documented
- Thrombolytics within 30 minutes of arrival if appropriate
- PCI within 90 minutes of arrival
- Documentation of smoking cessation counseling

Nurse Quick Reference for National Quality Indicators

ACUTE MYOCARDIAL INFARCTION

- ASA on arrival and discharge / or contraindication documented
- BB on discharge / or contraindication documented
- Documentation of LV function (EF)
- ACE inhibitor / ARB for EF < 40% / or contraindication documented
- Thrombolytics within 30 minutes of arrival if appropriate
- PCI within 90 minutes of arrival
- Documentation of smoking cessation counseling

Nurse Quick Reference for National Quality Indicators

ACUTE MYOCARDIAL INFARCTION

- ASA on arrival and discharge / or contraindication documented
- BB on discharge / or contraindication documented
- Documentation of LV function (EF)
- ACE inhibitor / ARB for EF < 40% / or contraindication documented
- Thrombolytics within 30 minutes of arrival if appropriate
- PCI within 90 minutes of arrival
- Documentation of smoking cessation counseling

CORE CARD

ACUTE MYOCARDIAL INFARCTION

- ASA within 24 hours of arrival (if not, document reason)
- Fibrinolytics within 30 minutes of arrival (if not, document reason for delay)
- PCI within 90 minutes of arrival (if not, document reason for delay)
- LVF assessment (document if prior, during stay or if planned after discharge)
- ASA Rx at discharge (if not, document reason)
- Beta-blocker at discharge (if not, document reason)
- ACEI / ARB Rx for LVSD: EF < 40%, mod-severe LVSF (if not, document reason)
- Smoking cessation advice / counseling

CORE CARD

ACUTE MYOCARDIAL INFARCTION

- ASA within 24 hours of arrival (if not, document reason)
- Fibrinolytics within 30 minutes of arrival (if not, document reason for delay)
- PCI within 90 minutes of arrival (if not, document reason for delay)
- LVF assessment (document if prior, during stay or if planned after discharge)
- ASA Rx at discharge (if not, document reason)
- Beta-blocker at discharge (if not, document reason)
- ACEI / ARB Rx for LVSD: EF < 40%, mod-severe LVSF (if not, document reason)
- Smoking cessation advice / counseling

CORE CARD

ACUTE MYOCARDIAL INFARCTION

- ASA within 24 hours of arrival (if not, document reason)
- Fibrinolytics within 30 minutes of arrival (if not, document reason for delay)
- PCI within 90 minutes of arrival (if not, document reason for delay)
- LVF assessment (document if prior, during stay or if planned after discharge)
- ASA Rx at discharge (if not, document reason)
- Beta-blocker at discharge (if not, document reason)
- ACEI / ARB Rx for LVSD: EF < 40%, mod-severe LVSF (if not, document reason)
- Smoking cessation advice / counseling

Nurse Quick Reference for
National Quality Indicators

PNEUMONIA

- Blood cultures before 1st antibiotic given
- Initial antibiotics given within 6 hours of arrival
- Appropriate antibiotics given
- Influenza/Pneumococcal Vaccination given or documented
- Documentation of smoking cessation counseling

FRONT

CORE CARD

PNEUMONIA

- Pneumonia pathways in chart
- Blood cultures on transfer to ICU for pneumonia
- Blood cultures drawn prior to 1st antibiotic
- Initial antibiotic administered within 6 hours of arrival
- Influenza vaccination during specified times (if not, document reason)
- Pneumococcal vaccination (if not, document reason)
- Smoking cessation advice / counseling

CORE CARD

PNEUMONIA

- Pneumonia pathways in chart
- Blood cultures on transfer to ICU for pneumonia
- Blood cultures drawn prior to 1st antibiotic
- Initial antibiotic administered within 6 hours of arrival
- Influenza vaccination during specified times (if not, document reason)
- Pneumococcal vaccination (if not, document reason)
- Smoking cessation advice / counseling

CORE CARD

PNEUMONIA

- Pneumonia pathways in chart
- Blood cultures on transfer to ICU for pneumonia
- Blood cultures drawn prior to 1st antibiotic
- Initial antibiotic administered within 6 hours of arrival
- Influenza vaccination during specified times (if not, document reason)
- Pneumococcal vaccination (if not, document reason)
- Smoking cessation advice / counseling

ACE-INHIBITORS

GENERIC	BRAND NAME
Benazepril	Lortensin
Captopril	Capoten
Enalapril	Vasotec
Fosinopril	Monopril
Lisinopril	Prinivil, Zestril
Moexipril	Univasc
Perindopril	Aceon
Quinapril	Accupril
Ramipril	Altace
Trandolapril	Mavik

COMBINATIONS

Accuretic	Quinapril / HCTZ
Captozide	Captopril / HCTZ
Lotrel	Benazepril / amlodipine
Prinizide	Lisinopril / HCTZ
Tarka	Trandolapril / verapamil
Uniretic	Moexipril / HCTZ

ACE-INHIBITORS

GENERIC	BRAND NAME
Benazepril	Lortensin
Captopril	Capoten
Enalapril	Vasotec
Fosinopril	Monopril
Lisinopril	Prinivil, Zestril
Moexipril	Univasc
Perindopril	Aceon
Quinapril	Accupril
Ramipril	Altace
Trandolapril	Mavik

COMBINATIONS

Accuretic	Quinapril / HCTZ
Captozide	Captopril / HCTZ
Lotrel	Benazepril / amlodipine
Prinizide	Lisinopril / HCTZ
Tarka	Trandolapril / verapamil
Uniretic	Moexipril / HCTZ

ACE-INHIBITORS

GENERIC	BRAND NAME
Benazepril	Lortensin
Captopril	Capoten
Enalapril	Vasotec
Fosinopril	Monopril
Lisinopril	Prinivil, Zestril
Moexipril	Univasc
Perindopril	Aceon
Quinapril	Accupril
Ramipril	Altace
Trandolapril	Mavik

COMBINATIONS

Accuretic	Quinapril / HCTZ
Captozide	Captopril / HCTZ
Lotrel	Benazepril / amlodipine
Prinizide	Lisinopril / HCTZ
Tarka	Trandolapril / verapamil
Uniretic	Moexipril / HCTZ

BETA BLOCKERS

GENERIC	BRAND NAME
Atenolol	Tenormin
Bisoprolol	Zebeta
Carvedilol	Coreg
Labetolol	Normodyne, Trandate
Metoprolol	Lopressor, Toprol XL
Nadolol	Corgard
Pindolol	Visken
Propranolol	Inderal, Innopran XL
Sotalol	Betapace

COMBINATIONS

Inderide	Propranolol / HCTZ
Tenoretic	Atenolol /chlorthalidone
Ziac	Bisoprolol/HCTZ

ARB

GENERIC	BRAND NAME
Candesartan	Atacand
Eprosartan	Tevetan
Irbesartan	Avapro
Losartan	Cozaar
Valsartan	Diovan

BETA BLOCKERS

GENERIC	BRAND NAME
Atenolol	Tenormin
Bisoprolol	Zebeta
Carvedilol	Coreg
Labetolol	Normodyne, Trandate
Metoprolol	Lopressor, Toprol XL
Nadolol	Corgard
Pindolol	Visken
Propranolol	Inderal, Innopran XL
Sotalol	Betapace

COMBINATIONS

Inderide	Propranolol / HCTZ
Tenoretic	Atenolol /chlorthalidone
Ziac	Bisoprolol/HCTZ

ARB

GENERIC	BRAND NAME
Candesartan	Atacand
Eprosartan	Tevetan
Irbesartan	Avapro
Losartan	Cozaar
Valsartan	Diovan

BETA BLOCKERS

GENERIC	BRAND NAME
Atenolol	Tenormin
Bisoprolol	Zebeta
Carvedilol	Coreg
Labetolol	Normodyne, Trandate
Metoprolol	Lopressor, Toprol XL
Nadolol	Corgard
Pindolol	Visken
Propranolol	Inderal, Innopran XL
Sotalol	Betapace

COMBINATIONS

Inderide	Propranolol / HCTZ
Tenoretic	Atenolol /chlorthalidone
Ziac	Bisoprolol/HCTZ

ARB

GENERIC	BRAND NAME
Candesartan	Atacand
Eprosartan	Tevetan
Irbesartan	Avapro
Losartan	Cozaar
Valsartan	Diovan

P H R

Personal Health Record of:

_____

If you have questions or concerns,

contact _____

at (_____) _____ - _____

REMEMBER to take this record
with you to all doctor visits
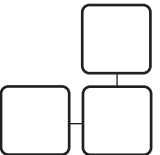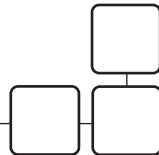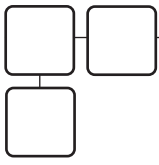
Personal Information

Family Caregiver Information

Name: _____

Relation to Patient: _____

Phone #: _____

Alternate Phone #: _____

In what ways do your caregivers help you manage your conditions?

_____

_____

Advance Directive / Living Will:

☐ NO ☐ YES Where can this be found?

_____

Health Care Provider Information

Primary Care Dr.: _____

Phone #: _____

Pharmacy: _____

Other Providers: _____
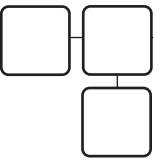
Questions for other Providers:

Pharmacist

Case Manager

Other (list name, specialty, organization)
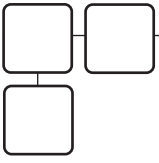
Questions for my Primary Care Doctor:

My Health Conditions

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Red Flags

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____
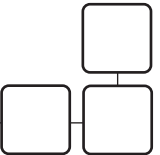
Personal Goal

Notes:

Allergies

Medication Record

Medication & Supplement Record

Name: _____
Date: _____

Name	Dose	How Often?	Reason	New?
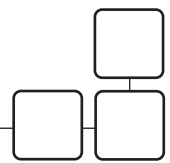
Welcome to Your Shared Care Plan

Shared Care Plan

Manage. Communicate. Relax.

What is the Shared Care Plan?

The Shared Care Plan is a free, online health record that makes it easy to organize, store, and share your health information. Your Shared Care Plan can be reached securely from any computer with internet access. For more information about the Shared Care Plan please visit **www.SharedCarePlan.org** or call (360) 788-6840.

How do I begin?

This is a great way to get you started. You may keep your information in this paper version, but it is easiest to keep it updated online. We encourage you to visit our website at **www.SharedCarePlan.org** for more information.

You may register online and enter the information you gathered on these forms, or bring them to the Shared Care Plan office at 800 E. Chestnut Street, Lower Level 3, Bellingham, WA 98225 or fax them to us at (360) 671-9992 to have a Shared Care Plan staff member assist you in this process.

If you need a new set of paper forms and do not have internet access please contact a Shared Care Plan team member at (360) 788-6840 or (888) 503-6843.

How can I make the most of my Shared Care Plan?

❑ Fill out as much information as you can in your Shared Care Plan. If there are things you don't know, ask your provider for that information.
❑ Bring a copy of your Shared Care Plan with you to all of your health care appointments.
❑ Ask your Care Team members to look at your Shared Care Plan for a current picture of your health.
❑ Work together with your Care Team to define problems, set priorities, establish goals, create treatment plans, and solve problems.

How do I add rows to these tables in Microsoft Word?

In order to prevent accidental reformatting of the tables, we've protected the document. To add rows to the tables, go to the Tools or Review menu and choose Unprotect document. Please note that when you make changes, page headings and the location of information may shift. If you would just like additional copies of certain pages, you can choose File and then Print and under page range, enter the number of the page of which you would like another copy.

How do I put this booklet together?

The paper Shared Care Plan is designed to be printed double-sided and folded like a booklet although you can print it in one-sided sheets as well. Refer to your printer's documentation for specific instructions on how to print double-sided. Generally, you select File and then Print. In the print dialog box, enter 2-13 next to Pages: and choose "odd pages" next to the word "Print." After the pages have printed, flip them over and print the even pages this time. Fold the printed pages in half to form a booklet. If you decide not to print double sided, just print the document as you would any other. Place the coversheet at the back with the printed side facing out, then fold in half.

Care Team

Emergency Contacts
Your Emergency Contact is the person you would like called first should you have an emergency. Your Backup Emergency Contact is the person you would like called if your primary Emergency Contact is unavailable.

Contact	Name	Phone Number	Alternate Phone Number
Emergency Contact			
Backup Emergency Contact			

Care Team Members
Care Team Members are people and/or organizations who help you manage your health. Anyone who you feel has a role in your health care can be part of your Care Team.

Appointments	Name	Contact	Role/Description	Comments

Insurance Providers
Record here any insurance policies you use for your health care.

Type of Insurer	Carrier Name	Policy Number	Group Number	Phone Number	Address
Primary Medical					
Secondary Medical					
Prescription Drug					

CONFIDENTIAL

About Me

I want the person working with me to know...

This section is for you to record important details about your health and life that will help health care professionals understand your needs.

This is the most important information you need to know about me: _____

_____

I have challenges with: □ Vision □ Hearing □ Speech □ Mobility □ Transportation □ Other

My primary language is: □ English □ Español □ Other _____

I need a translator: □ Yes □ No

Comments _____

_____

My blood type is: □ O+ □ O- □ A+ □ A- □ B+ □ B- □ AB+ □ AB-

I have special dietary needs: □ Yes □ No

Comments _____

_____

My religion/spirituality impacts my health care: □ Yes □ No

Comments _____

_____

I have: □ Advance Directives □ POLST □ Power of Attorney

Comments _____

_____

I live: □ Alone □ With a partner/spouse □ With family □ Other
□ With others □ In assisted living □ In a nursing home

Comments _____

_____

I learn best by: □ Reading □ Being spoken to □ Being shown
□ Listening to tapes □ Seeing pictures/videos □ Other

Comments _____

I have access to the Internet: □ Yes □ No

Comments _____

Additional information

_____

_____

_____

CONFIDENTIAL

Shared Care Plan

Diagnoses

My Chronic and Long-Term Diagnoses
This is a list of all the conditions you have been diagnosed with and are managing.

Diagnosis	Description	Date Diagnosed	Diagnosed By	Comments

Next Steps

Where I am – My concerns

This section helps you identify the types of problems or concerns you are currently facing as you manage your health. Sharing your concerns helps your Care Team assist you with Next Steps.

- ☐ My ability to manage my chronic condition(s)
- ☐ Thinking/memory problems
- ☐ Family issues

- ☐ Emotional Issues
- ☐ Financial issues
- ☐ End of life issues

- ☐ Spiritual support
- ☐ Access to health care
- ☐ Other

Details _____

_____

Where I want to be – Life goals

A Life Goal is a motivating reason you are working toward better health.

Completed	Goal Description
☐	
☐	
☐	

How I'm getting there – Next steps

Next Steps are small, short-term steps that you are ready and willing to take towards obtaining your life goals.

Completed	Date	Description
☐		**Step:**
☐		Action:
☐		Action:
☐		**Step:**
☐		Action:
☐		Action:
☐		**Step:**
☐		Action:
☐		Action:

Be sure to reward yourself along the way!

CONFIDENTIAL

Shared Care Plan

Health Log

Health Indicators

This is the place to record health indicators such as blood pressure, cholesterol and weight, the goal values that you want to reach or maintain and to monitor them over time.

Indicator:		Goal:		Comments:		
Date	**Value**	**Comments**	**Date**	**Value**	**Comments**	

Indicator:		Goal:		Comments:		
Date	**Value**	**Comments**	**Date**	**Value**	**Comments**	

Indicator:		Goal:		Comments:		
Date	**Value**	**Comments**	**Date**	**Value**	**Comments**	

Indicator:		Goal:		Comments:		
Date	**Value**	**Comments**	**Date**	**Value**	**Comments**	

CONFIDENTIAL

Medications

Prescribed medications
These are medications that a health care professional has advised you to take, including medications, vitamins and supplements available over-the-counter.

Start Date	Prescribed By	Brand (Generic) Name and Strength	Directions	Use	B	L	D	N
Comments:								
Comments:								
Comments:								
Comments:								
Comments:								
Comments:								
Comments:								
Comments:								
Comments:								
Comments:								

Shared Care Plan

Additional Medications

Add here any other medications that you are taking and that no health care professional has advised you to take, including herbal supplements, vitamins, etc.

Start Date	Prescribed By	Brand (Generic) Name and Strength	Directions	Use	B	L	D	N
Comments:								
Comments:								
Comments:								
Comments:								

Discontinued Medications

This is a list of all medications that you are no longer taking.

Start Date	Stop Date	RX By	Generic (Brand) Name and Strength	Directions	Use	Reason Discontinued
Comments:						
Comments:						
Comments:						
Comments:						
Comments:						

CONFIDENTIAL

Shared Care Plan

Reactions

Allergies/Intolerances
These are substances (drug, food, or otherwise) that cause a bad reaction when you take, inhale or in some way come in contact with them.

Substance	Date Occurred	Type	Documented By	Reaction

Contraindications
These are substances (both drugs and food) that interact badly with your condition or medications that you are already taking.

Substance	Reason	Documented By

CONFIDENTIAL

History

Procedures and Surgeries

Here you can keep track of any procedures and surgeries you have had. These can range from a biopsy to a cat scan to a mammogram.

Description	Date	Comment

![Shared Care Plan logo]

Hospital Visits

Here you can keep track of any hospital visits you have had. Include visits to the emergency room and longer in-patient stays for observation and so forth, but you do not need to duplicate stays listed under surgeries.

Description	Date	Comment

Immunizations

Immunizations are vaccines taken to prevent illness. It is important to keep a record of these in case you are ever exposed to a serious contagious disease.

Vaccine	Dose # in Series	Date	Vaccine	Dose # in Series	Date

![Shared Care Plan logo]

Family Health History

Knowing your family's health history and sharing it with your healthcare professionals can help with diagnosing medical conditions, calculating risk of certain diseases, deciding what medical tests to run, and calculating risk of passing certain conditions on to children. (Include only relatives related by blood.)

Relation:		Name:		Deceased? □ If yes, age at death:
Condition/Disease		**Age Diagnosed**	**Cause of Death?**	**Comments**
			□	
			□	
			□	

Relation:		Name:		Deceased? □ If yes, age at death:
Condition/Disease		**Age Diagnosed**	**Cause of Death?**	**Comments**
			□	
			□	
			□	

Relation:		Name:		Deceased? □ If yes, age at death:
Condition/Disease		**Age Diagnosed**	**Cause of Death?**	**Comments**
			□	
			□	
			□	

Relation:		Name:		Deceased? □ If yes, age at death:
Condition/Disease		**Age Diagnosed**	**Cause of Death?**	**Comments**
			□	
			□	
			□	

Relation:		Name:		Deceased? □ If yes, age at death:
Condition/Disease		**Age Diagnosed**	**Cause of Death?**	**Comments**
			□	
			□	
			□	

Relation:		Name:		Deceased? □ If yes, age at death:
Condition/Disease		**Age Diagnosed**	**Cause of Death?**	**Comments**
			□	
			□	
			□	

CONFIDENTIAL

This paper copy belongs to: _____

Shared Care Plan

SHARED CARE PLAN
800 E. Chestnut St., Ste. LL3
PO Box 5365
Bellingham, WA 98227
(360) 788-6840 • Toll free (888) 503-6843

The Shared Care Plan is continually designed with patients' guidance. It was developed as a part of the Whatcom County Pursuing Perfection Program, a non-profit initiative to improve the safety, efficiency and effectiveness of health care across organizational boundaries.

Section 6 – Document Your Work

Section 1 Learn about the CTI® Model
Section 2 Train with the Care Transitions Program®
Section 3 Identify, Orient and Mentor Your Coaches
Section 4 Generate Patient Referrals
Section 5 Coach Your Patients
Section 6 Document Your Work
Section 7 Collect Data
Section 8 Evaluate and Improve Your Program

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.

continued on next page

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.

continued on next page

Section 6 – Document Your Work

Section 1
Learn about the CTI® Model

Section 2
Train with the Care Transitions Program®

Section 3
Identify, Orient and Mentor Your Coaches

Section 4
Generate Patient Referrals

Section 5
Coach Your Patients

Section 6
Document Your Work

Section 7
Collect Data

Section 8
Evaluate and Improve Your Program

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.

Coaching Abbreviations Key

AAA	Area Agency on Aging
ABA	Activated Behaviors Assessment
Adm	Admission
ADRC	Aging and Disability Resource Center
CAM	Caregiver Activation Measure
CTI®	Care Transitions Intervention®
DC	Discharge
F2F	Face-to-face
Freq	Frequency [refers to medications]
HC	Home Care
HHA	Home Health Agency
Hosp	Hospital
Med	Medication
MSW	Medical Social Worker
NTL	Nursing Team Lead
OT	Occupational Therapist
PAM	Patient Activation Measure
PCP	Primary Care Physician
PHI	Protected Health Information
PII	Personally Identifiable Information
PHR	Personal Health Record (paper patient-centered record)
PT	Physical Therapist
RN	Registered Nurse
SCP	Shared Care Plan (web-based patient-centered record)
SLP	Speech and Language Pathologist (also known as ST)
SNF	Skilled Nursing Facility
ST	Speech therapist (also known as SLP)
TC	Telephone Call

General Medical Abbreviations

(Facilities will have individualized, approved lists)

AAA	Abdominal aortic aneurysm
ac	Before meals
ACS	Acute coronary syndrome
A fib	Atrial fibrillation
AMI	Acute myocardial infarction (heart attack)
BID	Twice a day
CA	Cancer
CAD	Coronary artery disease
CHF	Congestive heart failure (or, HF)
COPD	Chronic obstructive pulmonary disease
CVA	Stroke
DM	Diabetes Mellitus
Gm	Gram
gtt	drop
h / hr	hour
HF	Heart failure (or, CHF)
hs	At bedtime
HTN	Hypertension (or, high blood pressure)
Inh	Inhaled/Inhaler
Inj	Injected
IU	International unit
mcg	micrograms
mg	milligrams
MI	Myocardial infarction (heart attack)
ml	milliliters
pc	After meals
PNE	Pneumonia
PO	By mouth
PR	By rectum
prn	As needed
q	every
QID	Four times a day
SC / Subc / Subq	Subcutaneous injection
TID	Three times a day
top	Topically
TBI	Traumatic brain injury

CTI® Coaching Sheet Guidelines

Purpose:

The coach documents coaching activity with individual patients on the CTI® Coaching Sheet. This de-identified information is then aggregated for reporting purposes. The patient and coach are assigned discrete identification designations.

Process:

Data captured includes:

- Date and patient location of initial contact.
- Admission and Discharge dates.
- Readmission date, if applicable.
- Date case was closed if coach was unable to reach patient after initial contact.
- Date of Home Visit.
- Date of first telephone call.
- Date of second telephone call.
- Date of third telephone call.
- Dates of any unsuccessful attempts to reach patient by phone.
- Patient location at final contact.
- First and second Patient Activation Measure (PAM*) score and level. The first PAM is administered during the home visit and the second is administered with the final patient contact.
- Dates of first and second Caregiver Activation Measure (CAM*). The first CAM is administered during the home visit and the second is administered with the final patient/caregiver contact in cases where there is a caregiver actively involved. If multiple caregivers are actively involved, each can complete the first and second CAM. Care must be taken to label the CAMs by a specific caregiver identifier to avoid confusion.
- First and second Activated Behaviors Assessment (ABA) completion dates. The first ABA is completed by the coach after the home visit and is to be reflective of the systems in place and the activation before any coaching takes place. The second is completed by the coach after the final patient/caregiver contact and is to be reflective of the systems in place and the activation after coaching takes place. The Agency may choose to use the Care Transitions Program® Patient Activation Assessment (PAA) instead of the ABA.
- Whether hospital discharge instructions were received by the patient and if so, whether they were complete.

*Licensed by Insignia

- Whether home health was requested
- Whether SNF discharge instructions received. If the patient did not discharge to a SNF this is left blank.
- Whether there are informal caregivers who check up on client or provide other kinds of care, and if so, to specify the number of caregivers by type: family, friends, neighbors, other.
- Physician name and type, date and time of appointments and whether appointments were kept.
- Whether Teach Back was used.
- Does the patient/caregiver know red flags.
- Whether the Personal Health Record (PHR) was provided and whether the patient/caregiver is using the PHR.
- Whether there were any medication discrepancies.
- Whether the medication discrepancies were resolved by the final patient/caregiver contact.

CTI Coaching Intervention   PT. ID CTI-00 **CTI-10**   Coach ID:**NWRC-23**

Initial Contact Date **5/13/11**   Location   **St. Joseph Hospital**

Admit Date   **5/11/11**   Discharge Date   **5/14/11**

     (Readmitted Date **N/A**)

If unable to reach date case closed: **N/A**

Home Visit **5/16/11**

Call #1   **5/19/11**   Call #2   **5/26/11**   Call #3   **6/2/11**

Attempted Calls   **5/24/11**   **5/31/11**   _____   _____

Patient location at final contact (Home)/ SNF / Hospital / Other_____

1st PAM score **37** / **2**   2nd PAM score **43** / **3**

1st CAM date **5/16/11**   2nd CAM date **6/2/11**

1st ABA date **5/16/11**   2nd ABA date **6/2/11**

Hospital discharge instructions received: (Y) / N   Complete: (Y) / N

Was home health requested: Y / (N)

SNF discharge instructions received: Y / N   Complete: Y / N

Are there informal caregivers who check up on client or provide other kinds of care? (Y)/ N

    Family _____   Friends _____   Neighbors __1__ Other _____

Physician / Type	Appt Date /Time	Appt Kept?	Notes
Dr. Samuel Smith / PCP	**5/18/11 @ 11:00 AM**	(Y)/ N	*Next appt scheduled for in one month.*
Dr. James Jones / Cardiology	**5/21/11 @ 2:00 PM**	(Y)/ N	*Weekly INR labs. Next appt w/MD in 2 wks.*
		Y / N	

Teach Back Used: (Y)/ N   Patient Knows Red Flags: (Y)/ N

PHR Provided: (Y) / N   Are they using PHR: (Y) / N (ask at final contact)

Med Discrepancies: (Y) / N   Med Discrepancies Resolved: (Y)/ N (ask at final contact)

CTI Intervention Coaching Sheet   PT. ID CTI-00_____   Coach ID:_____

Initial Contact Date _____   Location _____

Admit Date _____   Discharge Date _____

      (Readmitted Date _____)

If unable to reach date case closed: _____

Home Visit _____

Call #1_____   Call #2_____   Call #3_____

Attempted Calls _____   _____   _____   _____

Patient location at final contact Home / SNF / Hospital / Other_____

1st PAM score _____ / _____   2nd PAM score _____ / _____

1st CAM date _____   2nd CAM date _____

1st ABA date _____   2nd ABA date _____

Hospital discharge instructions received: Y / N   Complete: Y / N

Was home health requested: Y / N

SNF discharge instructions received: Y / N   Complete: Y / N

Are there informal caregivers who check up on client or provide other kinds of care? Y / N

     Family _____   Friends _____   Neighbors _____   Other _____

Physician / Type	Appt Date /Time	Appt Kept?	Notes
		Y / N	
		Y / N	
		Y / N	

Teach Back Used: Y / N   Patient Knows Red Flags: Y / N

PHR Provided: Y / N   Are they using PHR: Y / N (ask at final contact)

Med Discrepancies: Y / N   Med Discrepancies Resolved: Y / N (ask at final contact)

Q:\CTI\CTI Intervention Coaching Sheet

CTI® Notes Page Guidelines

Purpose:

Documentation of anecdotal information from coaching patient contacts. The Transition Coach® can review previous coaching activity and the progression along the four pillars prior to patient/caregiver contacts, allowing for continuity between coaching encounters.

Process:

- The Transition Coach® documents the dates and details of telephone (TC), face-to-face (F2F) contacts with the patient, caregiver or care team member. If communication takes place via mail, email etc., the coach can capture those exchanges also.
- The intent it not to duplicate documentation. The Transition Coach® may use the notes section of the Activated Behaviors Assessment (ABA) to document the details of the Home visit and/or final coaching contact rather than the Notes Page.

CTI® Notes Page Example

Patient ID: _____CTI-10_____   Coach ID: _____NWRC-23_____

Date: _____5/13/11_____   Contact: _____Patient_____   (F2F)/ TC / Other: _____
Facility visit. Patient lives alone. Good support system in friends. Low vision. Obtained verbal consent. Discussed what concerns her about going home. Discussed her plans for help at home and with transportation, from friends. Explained Coaching and number and sequence of visits/calls. Patient verbalized a list of questions she wants answered by nursing and physicians before discharge. Patient aware of planned discharge date. Scheduled home visit date and time.

Date: _____5/16/11_____   Contact: _____Patient_____   (F2F)/ TC / Other: _____
Home visit. Reviewed mediation management system.
Med Discrepancy: new Med, Coreg, taken daily instead of twice a day. Patient drew large "X" on lid. All other meds daily. Patient made aware of option to have medi-planner set-up by pharmacy. Chose not to do so. Can't read discharge instructions/Heart Failure packet. Aware should weigh herself daily. Teach back of correct method for daily dry weights. Teach back of Red Flags, and what to do if they occur. Unable to read scale. Coach provided number for patient to call Senior I & A for low vision assistive device of talking scale. Explained medical transportation is available through Senior I & A. Declined. Patient chose to only use last page of the PHR, for questions for MDs. No computer/internet. Declined SCP registration. MD appointments scheduled. No barriers to keeping appointments. Friends taking her.

Date: _____5/19/11_____   Contact: _____Patient_____   F2F /(TC)/ Other: _____
TC1. Saw PCP as scheduled. Referred by PCP to Cardiologist for specific medication and diet questions. Confused about diet. Wants to eat cabbage, but afraid to. Difficult to adhere to diet when out with friends. PCP suggested she drink V-8 juice as substitute for vegetables. Coach discussed V-8 high sodium content with patient. Referred to cardiologist or clinic RN with question of drinking V-8. Reviewed and reinforced diet information provided in discharge packet. Suggested asking cardiologist for a session with the advance practice nurse at the cardiology practice to review diet. Suggested asking questions when she goes to anticoagulation clinic for labs.

Date: _____5/26/11_____   Contact: _____Patient_____   F2F /(TC)/ Other: _____
TC2. Saw Cardiologist, who cautioned patient against drinking V-8 juice. Patient had diet instruction from advance practice nurse. More comfortable with diet. Coreg increased. Reviewed dose. Patient felt confident about new dose. Suggested she ask any medication questions of pharmacist or cardiologist.

Date: _____6/2/11_____   Contact: _____Patient_____   F2F /(TC)/ Other: _____
TC3. Talking scale not working. Patient called for new one. No red flags noted. MD appointments scheduled. No barriers to keeping appointments. Reports medication self-management system is working. Reminded patient of option of medi-planner set-up by pharmacist if regimen becomes more complex. Adjusting to new diet. Labs therapeutic. Teach back of whom patient should call with questions, or what to do if red flags noted. Verbalized understanding that this is last call. No readmission.

CTI® Notes Page

Patient ID: _____   Transition Coach® ID: _____

_____

Date: _____   Contact: _____   F2F /TC / Other: _____

_____

Date: _____   Contact: _____   F2F /TC / Other: _____

_____

Date: _____   Contact: _____   F2F /TC / Other: _____

_____

Date: _____   Contact: _____   F2F /TC / Other: _____

_____

Date: _____   Contact: _____   F2F /TC / Other: _____

Activated Behaviors Assessment (ABA) Guidelines

Purpose:
The Activate Behaviors Assessment provides Transition Coaches® with a method of tracking patients' progress in skill transfer and activation along the Four Pillars® during their participation in the Care Transitions Intervention®.

Process:
The first ABA serves as a baseline measure of the patient's activation before having received any coaching. This could either be in the hospital, the skilled nursing facility, or at the beginning of the first home visit.

Throughout the coaching encounters coaches may refer to the ABA to ascertain progress across the Four Pillars®.

The final ABA forms the basis for an overall determination, in the coach's estimation, of activation. If the patient and caregiver are functioning in tandem, consider the ABA as measuring their activation as a "unit."

Timing:
Separate evaluations are to be completed by the coach on the ABA form after the home visit and at the end of the 30 day intervention:
- After the home visit, document how you found the patient/caregiver at the beginning of the home visit, not how you left them after the home visit
- With each telephone contact, refer to the ABA to guide coaching activities
- Complete the second ABA after the final telephone contact

Activated Behaviors Assessment - Home Visit

Patient ID: _____ Coach: _____ Date: _____

PILLAR	RATING					
	N/A	Poor	Fair	Good	Very Good	Excellent
MEDICATION MANAGEMENT						
1. Uses an effective medication management system (e.g., medication system like a medi-set, flow chart of what to take when and how, etc.)						
2. Understands purpose of their medications						
3. Knows when and how to take medications						
4. Knows possible side-effects of medications						
5. Agrees to confirm (or has confirmed) medication list with physician.	YES			NO		
PERSONAL HEALTH RECORD (PHR)						
1. Understands purpose of PHR						
2. Initiates PHR: questions for provider and current med list						
3. Agrees to bring (or has brought) PHR to physician/medical visits	YES			NO		
MEDICAL CARE FOLLOW-UP						
1. Knows how to effectively schedule medical appointments						
2. Keeps medical appointments						
3. Agrees to take (or has taken) written list of questions to physician visits	YES			NO		
RED FLAGS						
1. Knows signs and symptoms to watch for						
2. Knows what to do when signs/symptoms are present						
3. Takes appropriate action when signs/symptoms appear						

Notes

Activated Behaviors Assessment - Telephone Call # 3

Patient ID: _____ Coach: _____ Date: _____

PILLAR	RATING					
	N/A	Poor	Fair	Good	Very Good	Excellent
MEDICATION MANAGEMENT						
1. Uses an effective medication management system (e.g., medication system like a medi-set, flow chart of what to take when and how, etc.)						
2. Understands purpose of their medications						
3. Knows when and how to take medications						
4. Knows possible side-effects of medications						
5. Has confirmed medication list with physician		YES			NO	
PERSONAL HEALTH RECORD (PHR)						
1. Understands purpose of PHR						
2. Keeps PHR, including medication list, up-to-date						
3. Has brought PHR to physician/medical visits		YES			NO	
MEDICAL CARE FOLLOW-UP						
1. Knows how to effectively schedule medical appointments						
2. Keeps medical appointments						
3. Has taken written list of questions to physician visits		YES			NO	
RED FLAGS						
1. Knows signs and symptoms to watch for						
2. Knows what to do when signs/symptoms are present						
3. Takes appropriate action when signs/symptoms appear						

Notes

Multi-Event Medication Discrepancy Tool® Guidelines

PURPOSE

The Medication Discrepancy Tool® (MDT) allows coaches to document, track and trend medication discrepancies that occur or are identified during transitions between care settings, and document corrective action steps taken. Medication discrepancies may be identified at the patient level or at the health practitioner/system level. The MDT® also prompts and allows for documentation of action steps at the patient or system level to correct medication discrepancies. The goal is to promote development of a single, reconciled list of current medications.

PROCESS

Medication discrepancies may be identified during the medication reconciliation process during the home visit. Medication discrepancies are documented on the MDT®, as well as the resolution of medication discrepancies.

MEDICATION RECONCILIATION

- The patient is asked to gather up all their medications in a single place for review by the patient, any actively involved caregiver and the Transition Coach®. (It can save time if, during the call to set-up or confirm the home visit date/time, the Transition Coach® asks the patient/caregiver to have all the medications ready before the visit.)
- Using the Medication & Supplement Record in the Personal Health Record (PHR) the coach prompts the patient/caregiver to make a list of prescription and over-the-counter medications, supplements and herbal remedies they are actually taking. The list will include the name, dose, how often and why they are taking each medication, and whether the medication is new or not. If the caregiver manages the patient's medications, then the caregiver would make the list. The Transition Coach® invites the patient/caregiver to give themselves permission to be completely honest.
- If the patient/caregiver doesn't know why they are taking a medication or questions arise, the Transition Coach® prompts them to document the questions and issues on the Medication & Supplement Record "Notes and Questions for my Primary care Doctor" section or on the last page of the Personal Health Record.
- The Transition Coach® then prompts the patient/caregiver to compare the list with the discharge medication list. The coach imparts the hard skill of comparing each aspect of the lists and identifying any discrepancies. The coach doesn't do the comparison for them. This is an essential skill transfer that takes place during coaching. The patient/caregiver are shown how to reconcile medications independently so they will be able to do so in future transitions of care.

- The Transition Coach® then explores with the patient what might have caused the discrepancy.
- The Transition Coach® strategizes with the patient and/or caregiver on solutions to discrepancies identified. Solutions may include the patient/caregiver calling the doctor's office during the home visit and speaking to the nurse or doctor or leaving a detailed message requesting a call-back within a specific timeframe, calling the pharmacy, setting up a next-day appointment for the doctor to review the accurate medication list created by the patient/caregiver and make any necessary order changes, exploring ways for the patient to get financial assistance for medication cost, addressing transportation barriers to picking up prescriptions, prompting the patient to ask for a cheaper drug in class, etc. The Transition Coach® does not call the doctor's office for the patient/ caregiver, but rather practices with the patient/caregiver the wording and methods for getting their questions asked and answered. The coach may sit by while the patient/caregiver makes the call. This is another essential skill transfer that occurs during coaching. By preparing the patient/ caregiver to make the call themselves they will be able to do so independently when questions or issues arise in the future.
- The Transition Coach® stresses the importance of keeping the accurate medication list updated and current and talks about strategies for doing so. When medication changes come to light during follow-up phone calls the Transition Coach® asks the patient/caregiver what their system is to make sure their medication list is updated, and strategizes with the patient/caregiver as indicated.
- If the patient/caregiver already has a medication list, or they want to use the discharge medication list and change and update it to reflect what they are actually taking, they may do so. The Transition Coach® helps them understand how to do so accurately and safely.

MULTI-EVENT MEDICATION DISCREPANCY TOOL® (MDT)

The Transition Coach® jots down notes during the home visit, and then later completes the MDT. Each medication discrepancy is documented in the top box, and each medication discrepancy is assigned a number.
Example:
1. DC med list has Coumadin 5 mg daily. Patient didn't see dose change. Taking 2.5 mg daily
2. DC med list has Plavix 75 mg daily. Patient not taking due to cost.
3. Patient taking Calcium 500 mg twice a day. Not on med list.
4. DC med list has Lisinopril 10 mg daily. Patient not taking due to side effect: cough.
5. DC Med list has insulin sliding scale. Patient doesn't know how to administer.

The numbers are then documented below next to the appropriate "Causes and Contributing Factors" and "Resolution."

CAUSES AND CONTRIBUTING FACTORS

Number "1" would go next to patient level "G: Non-intentional non-adherence (knowledge deficit)."
Number "2" would go next to patient level "E: Money/financial barriers."
Number "3" would go next to system level "L: Discharge Instructions incomplete/ inaccurate/ illegible."
Number "4" would go next to patient level "A: Adverse Drug Reaction or side effects."
Number "5" would go next to patient level "H: Performance deficit."

Some of the numbers may also fit other causes and contributing factors. Number "1" might also fit system level "J: Conflicting information from different informational sources (discharge information indicates one thing and the pill bottle says another)." Number "5" might fit system level "Q: Cognitive impairment not recognized" and/or "R: No caregiver/need for assistance not identified." Each organization will need to determine whether to list the numbers next to all causes and contributing factors that might apply, or only what is considered to be the primary cause or contributing factor for each.

RESOLUTION

Number "1" could be resolved by the Transition Coach® talking to the patient about how they could take the Coumadin to match what was ordered, such as taking two, 2.5 mg tablets for a total of 5 mg a day. The coach could also encourage the patient/caregiver to call the doctor's office or cal the pharmacist to get the correct dosage on-hand. The number "1" would go next to the appropriate resolutions.

Number "2" might be resolved by the coach providing resource information to facilitate adherence. Or the patient might be able to get samples from their provider.

Number "3" could easily be addressed at the next physician appointment. The physician needs to be made aware of the calcium supplement in order to update the office Med list. Also, the physician may have instructions about how or when to take the Calcium, or whether to take it at all.

Number "4" could be resolved by the Transition Coach® encouraging the pt/cg to call the doctor's office, or next-day physician appointment.

Number "5" would necessitate a patient/caregiver call to the ordering physician's office and possibly a same-day office nurse visit or home health nurse visit to provide the needed instruction.

Example:

Resolution: Place the event number on the line to the left of each resolution that applies.

_____ Discussed potential benefits and harm that may result from non-adherence.

_5__ Encouraged patient to call PCP/specialist about problem.

_3, 4_ Encouraged patient to schedule an appt with PCP/specialist to discuss problem at next visit.

_1__ Encouraged patient to talk to pharmacist about problem.

_1__ Addressed performance/knowledge deficit.

_2__ Provided resource information to facilitate adherence.

_5__ Other: Encouraged patient to call PCP office and request a same-day office nurse visit or home health nurse visit for sliding scale instruction.

Medication Discrepancy information in being tracked on the Coaching Sheet:

Medication Discrepancies: Y /   N

Medication Discrepancies Resolved: Y / N (ask at final contact)

Pt. ID: CTI-10   Coach ID: NWRC-23 Date: 5/16/11

_____3_____ No, Med Discrepancies

MEDICATION DISCREPANCY TOOL (MDT)
The MDT is designed to facilitate reconciliation of medication regimens across settings and prescribers.

Medication Discrepancy Event Description: *Place a number (1…2…etc.) next to each event*

1. Coreg: ordered for twice a day – taking once a day
2. Plavix: Not taking – can't afford co-pay
3. Taking both Coumadin (Brandname) and warfarin (generic)

✓ **Causes and Contributing Factors ::** Place the event number on the line to the left of each factor that applies. :: *Italicized text suggests patient's perspective and/or intended meaning*

Patient Level
A. ____ Adverse Drug Reaction or side effects
B. ____ Intolerance
C. ____ Didn't fill prescription
D. ____ Didn't need prescription
(E.) 2 Money/financial barriers

(F.) 2 Intentional non-adherence
   "I was told to take this but I choose not to."
(G.) 1 Non-intentional non-adherence (ie: Knowledge deficit)
   "I don't understand how to take this medication."
H. ____ Performance deficit
   "Maybe someone showed me, but I can't demonstrate to you that I can."

System Level
I. ____ Prescribed with known allergies/intolerances
J. ____ Conflicting information from different informational sources
   For example, discharge instructions indicate one thing and pill bottle says another.
(K.) 3 Confusion between brand & generic names
L. ____ Discharge instructions incomplete/inaccurate/illegible
   Either the patient cannot make out the hand- writing or the information is not written in lay terms.

M. ____ Duplication.
   Taking multiple drugs with the same action without any rationale.
N. ____ Incorrect dosage
O. ____ Incorrect quantity
P. ____ Incorrect label
Q. ____ Cognitive impairment not recognized
R. ____ No caregiver/need for assistance not recognized
S. ____ Sight/dexterity limitations not recognize

✓ **Resolution ::** Place the event number on the line to the left of each resolution that applies.

_____ Discussed potential benefits and harm that may result from non-adherence
2,3 Encouraged patient to call PCP/specialist about problem *patient called PCP during home visit*
_____ Encouraged patient to schedule an appointment with PCP/specialist to discuss problem at next visit
3 Encouraged patient to talk to pharmacist about problem
1 Addressed performance/knowledge deficit
2 Provided resource information to facilitate adherence *cardiologist billing dept. prescription assistance program application*
_____ Other _____

Pt. ID:_____ Coach ID:_____ Date:_____

_____No Med Discrepancies

MEDICATION DISCREPANCY TOOL (MDT)

The MDT is designed to facilitate reconciliation of medication regimens across settings and prescribers.

✎ **Medication Discrepancy Event Description:** *Place a number (1...2...etc.) next to each event*

```



```

✓ **Causes and Contributing Factors ::** **Place the event number on the line to the left of each factor that applies. ::** *Italicized text suggests patient's perspective and/or intended meaning*

Patient Level ───

A. _____ Adverse Drug Reaction or side effects

B. _____ Intolerance

C. _____ Didn't fill prescription

D. _____ Didn't need prescription

E. _____ Money/financial barriers

F. _____ Intentional non-adherence
   "I was told to take this but I choose not to."

G. _____ Non-intentional non-adherence (ie: Knowledge deficit)
   "I don't understand how to take this medication."

H. _____ Performance deficit
   "Maybe someone showed me, but I can't demonstrate to you that I can."

System Level ───

I. _____Prescribed with known allergies/intolerances

J._____Conflicting information from different informational sources
   For example, discharge instructions indicate one thing and pill bottle says another.

K. _____Confusion between brand & generic names

L. _____Discharge instructions incomplete/inaccurate/ illegible
   Either the patient cannot make out the hand- writing or the information is not written in lay terms.

M. _____Duplication.
   Taking multiple drugs with the same action without any rationale.

N. _____Incorrect dosage

O. _____Incorrect quantity

P. _____Incorrect label

Q. _____Cognitive impairment not recognized

R. _____No caregiver/need for assistance not recognized

S. _____Sight/dexterity limitations not recognize

✓ **Resolution ::** **Place the event number on the line to the left of each resolution that applies.**

_____Discussed potential benefits and harm that may result from non-adherence

_____Encouraged patient to call PCP/specialist about problem

_____Encouraged patient to schedule an appointment with PCP/specialist to discuss problem at next visit

_____Encouraged patient to talk to pharmacist about problem

_____Addressed performance/knowledge deficit

_____Provided resource information to facilitate adherence

_____Other _____

Content is from the Care Transitions Intervention™, a program developed by Eric A. Coleman, MD, MPH.

Transitions Coach® Information and Consent

WHAT IS A TRANSITIONS COACH®?

The goal of Transitions Coaching is to improve the transition from hospital to home. The role of the Transitions Coach® is to help you become good at, and comfortable with, managing your care after hospital discharge. The Transitions Coach® will go over your medications with you and help you get ready for meeting with your doctor. For example, the Transitions Coach® can help you decide if you have questions you need to ask your doctor. The Transitions Coach® will help you review hospital information about how to pick up on worsening symptoms and what to do about it. The Transitions Coach® will also show you how to use a Personal Health Record to write down important medical information that you can share with your doctor, and with others you choose, such as family members.

The Transitions Coach® is not a care giver or a treatment provider. The Transitions Coach® can help you understand your discharge instructions and how you can get any additional information or help you need. The Transitions Coach® does not provide any clinical care or treatment to you, or any advice to your doctor.

WHAT DOES PARTICIPATION IN CARE TRANSITION COACHING INVOLVE?

The Transitions Coach® will meet with you, and with any family members who help with your care, while you are in the hospital. The Transitions Coach® will visit you in your home a few days after you leave the hospital. The Transitions Coach® will call you to arrange this visit, and will also call you three more times during the month following your hospital discharge. Coaching help will end in about one month's time after the third phone call.

During visits or calls, the Transitions Coach® may ask you questions or give you a short written survey to answer, to get your opinion on how prepared you were for leaving the hospital. This will provide feedback for the people and organizations who were involved in your discharge. The questions will also help the Transitions Coach® know how much help you may need to manage your care after leaving the hospital.

WHAT DOES TRANSITION COACHING COST?

Transition Coaching is offered to you at no cost. The Transitions Coach® is being provided by _____to help improve the transition from hospital to home. The program is voluntary, and the decision whether or not to participate will not affect any health care benefits.

ACKNOWLEDGEMENT AND CONSENT:

I acknowledge that I have read (or have been read) the description and limitations of the Transitions Coach® role and would like to participate in Transitions Coaching program, which is about one month in duration. The Transitions Coach® role has been explained to me, and my questions about the role and about the coaching time-frame have been answered. I understand that the Transitions Coach® will not provide medical services to me and that, while the goal of the program is to help people avoid re-hospitalization and improve transitions, the program cannot guarantee any outcomes for me.

Patient (Designee) Signature: _____ Date: _____

Printed Patient Name: _____(Designee Name: _____)

Transitions Coach® Signature: _____ Date: _____

Printed Coach Name: _____

CTI® Coach Referral Form Guidelines

PURPOSE

In instances in which referrals cannot be made electronically, the CTI® Coach Referral Form can be completed by a facility staff member and faxed or scanned to the agency providing Transition Coaching.

PROCESS

The form can be modified and the shaded areas changed to meet the need of the agency providing Transition Coaching®. Sections:

- Top: name of the staff member completing the form, the date completed and the referral source
- Second: assessment and documentation of inclusion criteria and presenting complaint and surgical/diagnostic procedures
- Third: demographics, caregivers, admission and discharge dates, medical and social history, medical providers, disposition at discharge and existing services
- Fourth: consent, whether declined or was deemed inappropriate, facility visit, patient goal
- Fifth: coach and patient CTI® IDs are assigned, and disparity information is captured. If the case is a readmission of a patient currently receiving CTI® Coaching services, the agency can choose whether to close the existing case and open a new one with a new ID number, or whether to continue coaching within the open case.

CTI® Coach Referral Form

Name*: _____ Date*: _____

Source*: ☐ Census   ☐ RN CM   ☐ MSW   ☐ Secure email   ☐ Floor staff

☐ Clinic   ☐ Other _____

Patient has (payer type or meets specific inclusion criteria)*:_____

Patient lives in / is being discharged to (city, state, zip code)*: _____

Presenting Complaint*: ☐ CHF   ☐ MI   ☐ Pneumonia   ☐ Other: _____

Procedures/dates*: _____

☐ Patient is alert & oriented x3   ☐ Patient has a "coachable" caregiver

Patient is being discharged to: ☐ Home   ☐ Caregiver's home   ☐ Short Term SNF Stay

---

Name*: _____ Age*: _____ Rm #*: _____ _____ ____

Address*: _____ Phone #*: _____

Caregiver Name/Rel/#/Address: _____

Admission Date*: _____ Anticipated D/C Date*:_____

Social History: _____

_____

Medical History: _____

_____

Comments:_____

Attending (PCP)*: _____ Specialist*: _____

D/C Disposition*: ☐ Home w/o svcs   ☐ Home Health   ☐ OP Therapy

☐ Hospice   ☐ SNF   ☐ Other: _____

Pre-existing Services: _____

☐ Patient Accepted Program_____/_____/_____

Was facility visit completed at time of consent?   ☐ Yes   ☐ No

☐ Patient Refused Program/Not Appropriate

   Reason: _____

☐ Personal Goal: _____

Coach ID*:_____   Patient ID*:_____

☐ New Case   ☐ Open Case (readmission)

Disparity*: ☐ None   ☐ Low Income   ☐ Dual Eligible   ☐ Homeless
           ☐ African American   ☐ Asian   ☐ Latino/Hispanic   ☐ Native American,
           ☐ Ukrainian   ☐ Other: _____

(All items marked "*"must be completed)

Transition Coach® Patient Report Form Guidelines

PURPOSE
The Transition 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. The form is structured to allow for quantifiable trending of findings and is reflective of processes across departments and disciplines. The findings can also be used in root cause analysis of readmissions.

PROCESS
When there are either positive or negative issues identified during the home visit, the coach completes the form immediately and turns it in to administrative staff to submit to facility designate within a seven-day period. This allows for real-time feedback to staff, units and departments involved with the provision of care to and discharge of that specific patient.

Transitions Coach®
Patient Report Form

QUALIS HEALTH™

Visit Date: _____
Facility: _____

Nursing Unit _____ Pt name: _____ Pt #: _____ Coach #: _____ Admit Date: _____ DC Date: _____
Readmission within the last 30 days? ☐ Yes   ☐ No   If yes, dates of previous admission: Adm: _____   DC: _____
• Was Patient Provided Disease/Procedure-specific Informational Packet? ☐ Yes   ☐ No   ☐ N/A _____
• Was Patient Given Updated Med List at DC?   ☐ Yes   ☐ No   DC Instructions?   ☐ Yes   ☐ No

Medications Improvement Opportunities	Red Flags Improvement Opportunities	Follow-up, After Care Improvement Opportunities	DC Teaching Improvement Opportunities	Social Needs Improvement Opportunities
☐ No instructions(verbal or written) on new meds / PRNs ☐ Not clear if new med(s) "for now" or "forever" ☐ Med Reconciliation list incorrect/unclear ☐ Home meds incorrect/absent on DC Med List ☐ Doesn't understand purpose/ frequency of PRN meds ☐ Unclear what meds are new ☐ Unclear what meds/dosages have changed ☐ Not sure which provider to call with med questions ☐ How meds obtained was not assessed ☐ Delay in obtaining meds ☐ not taking, due to: ☐ Financial barrier: can't afford meds ☐ Transportation barrier: can't pick up meds ☐ Needs new medi-set delivered by local pharmacy ☐ Mail-order pharmacy: orders not faxed ☐ Short-fill not provided/set up ☐ Other:	☐ No Red Flag info provided ☐ Doesn't understand Red Flags ☐ No Red Flag parameters given (high and low BP, heart rate, blood glucose, weight gain or loss, etc.) ☐ Doesn't understand what to do if readings fall outside parameters ☐ Not clear which provider to call for what Red Flag ☐ Not clear how to get appropriate level of care after-hours ☐ Other:	☐	☐ Doesn't understand condition ☐ Unable to perform treatments as instructed ☐ Not clear if new treatment(s) "for now" or "forever" ☐ Doesn't understand lifestyle instructions ☐ Doesn't understand dietary instructions ☐ Supplies not sent home with patient: ☐ Other: **Written Information Given** ☐ Medical abbreviations used ☐ Lang/literacy/sensory barrier ☐ No written instructions on new meds / PRNs ☐ No written instructions on home treatment or home exercise program ☐ Other:	☐ Lives alone ☐ Needs Medicaid/ VA/other application ☐ Needs assistance in home: ☐ Patient is caregiver for another person ☐ New disability ☐ Transportation needs ☐ Basic subsistence needs: housing, food, utilities, etc. ☐ Homeless ☐ Meds: cost / access (see Medications column) ☐ Other:

[Please attach copy of Multi-Medication Discrepancy Tool®]

Visit Date: _____

Facility: _____

| Medications
Best Practices Identified | Red Flags
Best Practices Identified | Follow-up, After Care
Best Practices Identified | DC Teaching
Best Practices Identified | Social Needs
Best Practices Identified |
|---|---|---|---|---|
| | | | | |

- Services put in place by facility staff at Discharge:
  ☐ None ☐ SNF ☐ HH ☐ OP Therapy ☐ Home Care ☐ COPES ☐ Other: _____

- Services already in place:
  ☐ None ☐ HH ☐ OP Therapy ☐ Home Care ☐ COPES ☐ Other: _____

- Service needs identified during Home Visit:
  ☐ None ☐ SNF ☐ HH ☐ OP Therapy ☐ Home Care ☐ COPES ☐ Hospice ☐ Other: _____

- Outcome:

_____

_____

_____

_____

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.

continued on next page

Section 1
Learn about the
CTI® Model

Section 2
Train with the Care
Transitions Program®

Section 3
Identify, Orient and Mentor
Your Coaches

Section 4
Generate
Patient Referrals

Section 5
Coach Your Patients

Section 6
Document Your Work

Section 7
Collect Data

Section 8
Evaluate and Improve
Your Program

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.

QUALIS HEALTH™

CTI® Patient ID Log

Coach	Patient ID	MRN	Last Name	Adm Date	DC Date	Date CTI begun	Notes

Data Guidelines

PURPOSE
Collection of individual coach and aggregate data on patients coached on a monthly basis for reporting purposes.

PROCESS

Coach Tracking Spreadsheet

Coaches may use the Coach Tracking Spreadsheet to track caseload activities. Data tracking and aggregation May be delegated to administrative staff. The header rows describe how to document each data element. Each row represents coaching activities and information on a single patient.

After month end, the Transition Coach® can total that month's coaching activity in the applicable columns for reporting on the Coach Monthly Report Form. See example spreadsheet.

Individual Transition Coach® Monthly Report Definitions

Complete Case: home visit completed.

Incomplete Case: Written or verbal consent, no home visit completed.

Readmission: Admission to inpatient status within 30 days of hospital discharge date.

Cases initiated: Consent/Facility Visit total for month

Cases closed: complete: Cases with Final Encounters of Home Visit or a Telephone Call during month.

Cases closed: incomplete: Cases with consent, and Final Encounter of Facility Visit during month.
No Home Visit completed.

Cases in process: Cases still open at end of month, regardless of month initiated.

30-day readmissions: Readmissions to inpatient status, after Home Visit, in month.
Case also counted above as "closed."

Initial Patient Activation Measures (PAMs): Total, PAM* #1, completed in month.

Final PAMs: Total, PAM #2, completed in month.

Initial Caregiver Activation Measures (CAMs): Total, CAM* #1, completed in month.

Final CAMs: Total, CAM #2, completed in month.

Initial Activated Behavior Assessments (ABAs) or

Patient Activation Assessments (PAAs): Total, Home Visit ABA or PAA, completed in month.

Final ABAs or PAAs: Total, final Telephone Call ABA or PAA, completed in month.
Reflective of final Call regardless of Call #.

 # Med Discrepancies / # cases closed "complete" during month:

Total of Home Visit Med Discrepancies for the cases closed "complete" in month.

[Ex: 5 of the 10 cases closed "complete" had combined total of 15 med discrepancies: 15 / 10]

Cases with Med Discrepancies of total # cases closed "complete":

Total of closed cases with Home Visit Med Discrepancies, of total cases closed "complete" in month.

[Ex: 5 cases of 10 that were closed "complete" during month had med discrepancies: 5 of 10]

*Licensed by Insignia

Individual Transition Coach® Monthly Report

Reporting Month / Year: _____   Date Submitted: _____
Report on spreadsheet data from month ended.   Submit 1st work-day of next month.

Coach Name: _____   Coach Number: _____

Definitions:
Complete Case: home visit completed.
Incomplete Case: Written or verbal consent, no home visit completed.
Readmission: Admission to inpatient status within 30 days of hospital discharge date.

	TOTAL
Cases initiated Consent/Facility Visit total for month	
Cases closed: complete Cases with Final Encounters of Home Visit or a Telephone Call during month.	
Cases closed: incomplete Cases with consent, and Final Encounter of Facility Visit during month. No Home Visit completed.	
Cases in process Cases still open at end of month, regardless of month initiated.	
30-day readmissions Readmissions to inpatient status, after Home Visit, in month. Case also counted above as "closed."	
Initial PAM*s Total, Patient Activation Measure (PAM) #1, completed in month.	
Final PAMs Total, PAM #2, completed in month.	

* Licensed by Insignia

	TOTAL
Initial CAM*s Total, Caregiver Activation Measure (CAM) #1, completed in month.	
Final CAMs Total, CAM #2, completed in month.	
Initial ABAs or PAAs Total, Home Visit Activated Behavior Assessment (ABA)or Patient Activation Assessment (PAA) completed in month..	
Final ABAs Total, final Telephone Call ABA/PAA, completed in month. Reflective of final Call regardless of Call #.	
# Med Discrepancies / # cases closed "complete" during month _____/_____ Total of Home Visit Med Discrepancies for the cases closed "complete" in month. [Ex: 5 of the 10 cases closed "complete" had combined total of 15 med discrepancies: 15 / 10]	
Cases with Med Discrepancies of total # cases closed "complete"_____of_____ Total of closed cases with Home Visit Med Discrepancies, of total cases closed "complete" in month. [Ex: 5 cases of 10 that were closed "complete" during month had med discrepancies: 5 of 10]	

Issues or Concerns (use blank sheet of paper if more space is needed):

PAM dates and scores for closed/complete cases only (reflects change in pt. activation):

Coach#	Patient ID	PAM 1			PAM 2		
		Date	Score	Level	Date	Score	Level

Aggregate Transition Coach® Monthly Report

Submitted by: _____   Month /Year: _____   Date submitted: _____

Coach Number:										TOTALs
Cases initiated										
Cases competed										
Cases closed: incomplete										
Cases in process										
30-day readmits										
Initial PAMs*										
Final PAMs										
Initial CAMs*										
Final CAMs										
Initial ABAs or PAAs										
Final ABAs or PAAs										
Med Discrepancies / # cases closed during month	/	/	/	/	/	/	/	/		/
Closed cases with Med Discrepancies per total # cases closed during month	_of_	_of_	_of_	_of_	_of_	_of_	_of_	_of_		__of__

PAM dates and scores for closed/complete cases only (reflects change in pt. activation):

		PAM 1			PAM 2		
Coach#	Patient ID	Date	Score	Level	Date	Score	Level

* Licensed by Insignia

Transitions Coach® Tracking Spreadsheet

Coach ID	Patient ID #	Disparities: Black=B Hispanic=H Native=N Ukrainian=U Asian=A Low income= LI Dual	Hospital admission date	Hospital discharge date	Chief complaint	Complaint	Reason for readmission within 30 days	30-day readmit date	30-day readmit D/C date	Date coach completed fac visit	PAM #1: score	PAM #1: level	Date of CAM #1	Name of SNF Blank=None
Coach ID	Pt_ID	Disp-arities	Adm_date	DC_date	Chief_complaint	Complaint	30_day_Readm_Dx	Readm_date	Readm_DC	Fac_Visit_[E 1]	PAM_score	PAM_level	CAM_#1	SNF

nsitions Coach® Tracking Spreadsh

Patient ID #	Date coach completed home visit	ABA HV: Yes=Y No=N	Med Discrepancy #	Date that coach completed 1st f/u call	Date that coach completed 2nd f/u call	Date that coach completed 3rd f/u call	ABA TC3: Yes=Y No=N	PAM #2: score	PAM #2: level	Date of CAM #2	Expired Y=Yes Blank= No	Teach Back used: Yes =Y No=N	Knows Red Flags:Yes =Y No=N	MD F/U scheduled during Coaching	MD follow-up occurred during Coaching	MD ordered Skilled Care. Provider: HHA Hospice Kidney Ctr	Comments
Pt_ID	Home_Visit[E2]	ABA HV	#Med_Disc	Call_1_[E3]	Call_2_[E4]	Call_3_[E5]	ABA TC3	PAM_score	PAM_level	CAM_#2	Exp	Teach_Back	Red_Flags	Appt_Sched	Appt_Kept	Skilled_Prov	Notes

Section 8 – Evaluate and Improve Your Program

Section 1
Learn about the CTI® Model

Section 2
Train with the Care Transitions Program®

Section 3
Identify, Orient and Mentor Your Coaches

Section 4
Generate Patient Referrals

Section 5
Coach Your Patients

Section 6
Document Your Work

Section 7
Collect Data

Section 8
Evaluate and Improve Your Program

How do you know that a change is an improvement? Measuring your improvement processes and outcomes is essential to continuously adapting the CTI coaching intervention to be successful 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.

continued on next page

Section 8 – Evaluate and Improve Your Program

Section 1
Learn about the CTI® Model

Section 2
Train with the Care Transitions Program®

Section 3
Identify, Orient and Mentor Your Coaches

Section 4
Generate Patient Referrals

Section 5
Coach Your Patients

Section 6
Document Your Work

Section 7
Collect Data

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.
www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx

Option D: ADRC Evidence Based Care Transition Grantees
Evaluation Plan

WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING & DISABILITY SERVICES ADMINISTRTION

The model below depicts the interventions, and the intervening factors (or control variables) and outcomes that will be measured as part of the evaluation of Washington State's Care Transitions Project, ADRC Care Transitions Coaching Program

Intervention Detail

- CT Model – *Care Transitions Intervention (CTI)*

- Other Interventions – *Patient Activation Measure (PAM) and Caregiver Activation Measure (CAM); the Shared Care Plan, an electronic Personal Health Record (PHR) through the Whatcom County Health Information Network (HInet); options counseling, and follow-up participant and caregiver support as-needed/requested.*

- Participating Hospitals, Location:

  o *St Joseph Hospital ("PeaceHealth"), Bellingham, Washington*

  o *Skagit Valley Hospital, Mount Vernon, Washington*

  o *Yakima Memorial Hospital, Yakima, Washington*

  o *Yakima Regional Hospital, Yakima, Washington*

- Participating ADRCs

  o *Northwest Regional Council (PSA 2) ADRCs in Whatcom and Skagit Counties; and*

  o *SE Washington (PSA 9) ADRC in Yakima County*

- Target population –

  o *Whatcom County: older adults and adults under 60 with disabilities, including Medicare Advantage beneficiaries, Medicaid recipients, Medicare/Medicaid dually eligible, and those with private insurance coverage.*

  Note: the QIO currently serves Medicare Fee for Service individuals in Whatcom County under a CMS grant. Once funding for this project is depleted, the ADRC grant will serve these individuals.

  o *Skagit County: older adults and adults under 60 with disabilities, including Medicare beneficiaries, Medicaid recipients, Medicare/Medicaid dually eligible, and those with private insurance coverage.*

  o *Yakima County: older adults and adults under 60 with disabilities, including Medicare beneficiaries, Medicaid recipients, Medicare/Medicaid dually eligible, and those with private insurance coverage.*

- Evaluation Timeframe – *e.g. October 2011-September 2012*

- Evaluation Budget – No dollars budgeted for evaluation. *Data gathered through CTI coaching data collection process, participant surveys and program narrative reports reflecting ADRC observations and experiences. Compilation and evaluation of data and reports will be conducted by state's ADRC Program Manager with support from state colleagues.*

- Data Sharing Agreements with the Hospitals Obtained?

  o *NWRC ADRC, Whatcom Co and St Joseph Hospital ("PeaceHealth"): YES*

  o *NWRC ACRC , Skagit Co and Skagit Valley Hospital: PENDING*

  o *SE WA ALTC ADRC, Yakima Co and Yakima Memorial Hospital: YES*

  o *SE WA ALTC ADRC, Yakima Co and Yakima Regional Hospital: PENDING*

Evaluator

Susan Shepherd, Washington State DSHS-ADSA- State Unit on Aging

Evaluation methodology

Patient level process measures will include tracking initiated and completed coaching cases at the individual patient level. The PAM assessment completed by the participant and the Activated Behavior Coach Assessment is completed by the coach. Each will be administered to evaluate self management improvement. Hospital readmissions, observation admissions and Emergency Room visits will be tracked for 30 days post hospital discharge. Impact will be measured by comparing medical utilization to appropriate non-intervention groups. In Whatcom County, the ADRC has access to hospital admissions and ER visit data for case management clients. Requests are being made to share aggregate readmission and ER data for target populations. Qualitative and quantitative outcome data will be shared with stakeholders to highlight the role of the ADRC in providing safe transitions and efficient use of healthcare resources. Under health care reform, providers will be financially incentivized to partner with community organizations that can show results.
Internal Quality Control (IQC) goals, thresholds and measures will be reviewed monthly to determine accomplishments, key issues, barriers and improvement strategies. Quarterly meetings will address strategic planning, programmatic progress, timelines and transferable learning. Provider and client satisfaction will be collected periodically.
It is anticipated that procurement of the statewide ADRC information system will be finalized in February 2011 (this month). The client management functionality of the system will assist in tracking the progress and outcomes of individuals served through CTI when implemented in 2011.

Evaluation Challenges Anticipated

- *Washington State is hopeful that Medicare rehospitalization rate data will be made available to the Option D ADRC Evidence-based Care Transitions grantees.*
  As a result of other closely aligned initiatives, the state is actively pursuing access to Medicare Part A, B, and D data through work with the CMS Federal Coordinated Health Care Office. We are also in discussions with the CMS Federal Coordinated Health Care Office to enter into an agreement to pilot access to Medicare Part D pharmacy data. In addition, State staff is currently in the process of negotiated changes to a Coordination of Benefits Agreement (COBA) that will authorize state staff to access Medicare Part A and Part B data. Time estimates for gaining access is unclear.

If we are unable to access Medicare data; it would reduce our ability to compare project participant outcomes against those for control groups.

- *The DSHS Integrated Client Database (ICDB) and the associated Predictive Risk Intelligence SysteM (PRISM) provide Washington State with powerful analytical tools to inform the design, implementation, operation, and evaluation of integrated care interventions for Medicaid-only individuals. The ICDB and PRISM applications are maintained by an in-house team with an extensive background in linking and analyzing data from complex healthcare claims, service encounter, and assessment information systems. The team has extensive experience in developing and implementing claims-driven predictive modeling tools to identify high-risk patients and to support clinical decision making.*

  PRISM is an integrated, information-rich decision support tool actively in use by Washington State Medicaid programs to support care management interventions for high-risk chronically ill Medicaid patients. The PRISM tool combines three key innovations: (1) Identification of clients most in need of comprehensive care coordination based on risk scores developed through predictive modeling, (2) Integration of information from medical, social service, behavioral health, and long term care payment and assessment data systems, and (3) An intuitive and accessible display of client health and demographic data from administrative data sources. The medical risk score contained in PRISM is derived from the state-specific calibration of the Chronic Illness and Disability Payment System (CDPS) and Medicaid-Rx risk groupers developed by Rick Kronick and Todd Gilmer at the University of California, San Diego (Gilmer T., Kronick R., Fishman P., et al. 2001; Kronick, R., Gilmer T., Dreyfus T., et al. 2000).

  It has yet to be determined if and how the ICDB and PRISM tools can be used to support grant evaluation process. Potentially they could be used for predictive modeling and clinical decision support, patient health outcomes, service utilization, and costs.

- *The evaluation will be impacted if coaches are unable to reach patients to conduct the second PAM and CAM. To mitigate this, the coach will leave a message by phone explaining the tool will be mailed out to the participant/caregiver and ask them to complete it and mail it back using a pre-addressed and stamped return envelope.*

- *The ABA is currently being completed by rating the patient and the support system (caregiver) as an aggregate for assessing how they are accomplishing the 4 pillars. There might be some discrepancies in data if this is not done consistently.*

- *We are currently fine-tuning when we are conducting first PAM/CAM. It has been found that it is most accurate when it is conducted at home within one-day of discharge.*

- *One of the hospitals is being encouraged to consider home health nursing services in discharge plans. If this practice increases, we will need to incorporate into the data analysis. If we can track hospital HH referral patterns, we can also show additional hospital community partnering.*

- *Procurement of the statewide ADRC information system will be finalized in February 2011. Piloting will occur in the spring and summer of 2011, with anticipated statewide rollout to occur before 2012. Because of the timeline, we cannot depend on its availability in all counties being served under the grant until 2012.*

- *Hospitals are downsizing staff because public funding decreases. We don't anticipate any disruption to our plan; however we will need to monitor this issue.*

Measures and Indicators Table

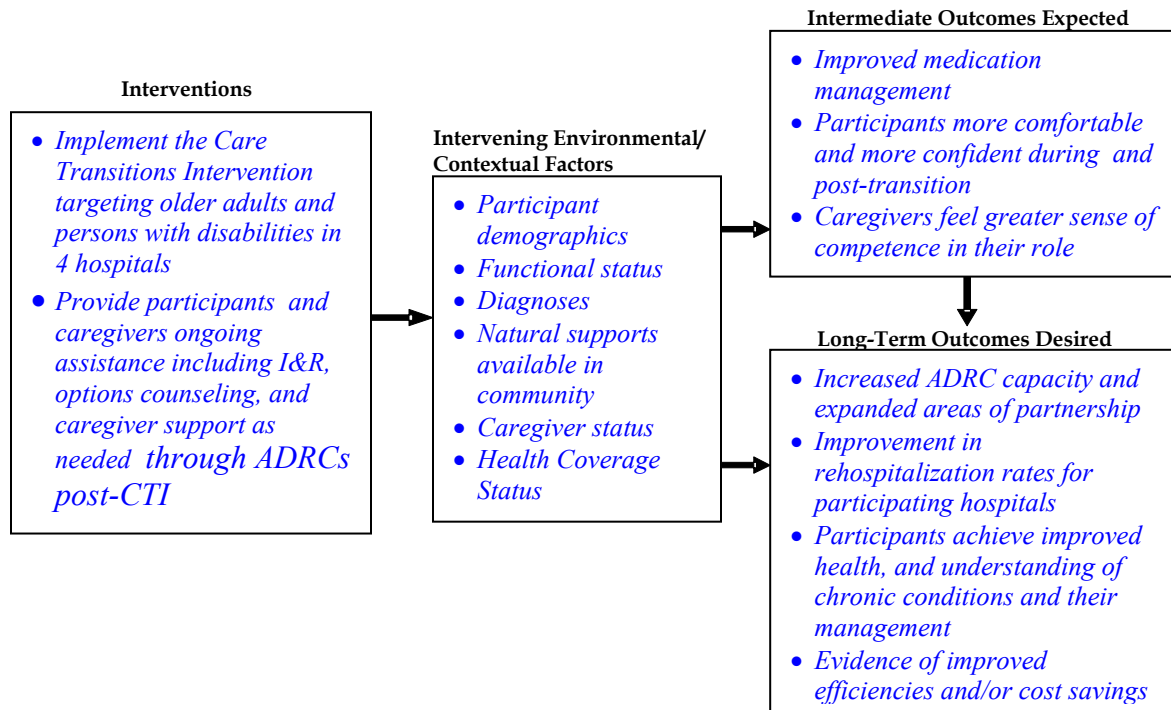| Long-Term Outcome Desired	Grant Activities/ Performance	Measures of Activities (Outputs and Process Indicators)	Measure of Outcomes (Outcome Indicators)
Increased ADRC capacity and expanded areas of partnership with hospitals in the identified counties	o Coordination and execution of partnership agreements with selected hospitals	o # of Partnership Agreements	o Hospital/ADRC CTI partnership agreement? Yes/No
	o Training and mentoring of CTI coaches	o # CTI Trained Coaches in each identified county o 1 CTI trained as a CTI Coach Trainer	o Completed CTI Coach Training/Mentorship? Yes/No o Completed CTI Train the Trainer? Yes/No
	o Deployment of CTI in selected hospitals	o # hospitals where CTI is deployed upon discharge	o CTI deployed at hospital? Yes/No
	o Create CTI Implementation Toolkit for replication of CTI in other areas of state	o Draft CTI Implementation Toolkit for Skagit County o Revise draft toolkit for Yakima County o Finalize CTI Implementation Toolkit	o Initial Draft completed? Yes/No o Revised Draft completed? Yes/No o Final Toolkit completed? Yes/No
Improvement in rehospitalization rates for participating hospitals	o Care Transitions Intervention initiated at hospital pre-discharge	o # participants offered CTI coaching o # participants agreeing to CTI coaching o # participants fully participating in CTI coaching	o Agree to CTI Coaching? Yes/No o Completed CTI coaching? Yes/No/Pending o Readmission within 30 days? Yes/No
	o Comparison of project readmission rates with hospital's average readmission rates	o Obtain and compare hospital readmission rates	o Has comparison data been obtained for hospital readmission rates? Yes/No o Does comparison indicate improvement in rehospitalization rates for project participants? Yes/No

Long-Term Outcome Desired	Grant Activities/ Performance	Measures of Activities (Outputs and Process Indicators)	Measure of Outcomes (Outcome Indicators)
Improved health, and understanding of chronic conditions and their management, by older adults and people with disabilities participating in the CTI coaching	o Participants/Caregivers will be coached in the 4 Pillars.	o # Participants /caregivers coached in PHR/Shared Care Plan. o # Participants coached in red flags o # Participants coached in Medication Discrepancies o # Participants coached in scheduling visit with primary physician	o Uses the PHR/Shared Care Plan? Yes/No o Positive change in Personal Health Record? Yes/No
	o Initial and final PAM/CAM conducted o Initial and final ABA conducted	o # Initial/ Final PAM/CAMs o # Initial/Final ABAs	o PAM/CAM Completed? Yes/No o Positive Changes in PAM/CAM? Yes/No o ABA Completed? Yes/No o Positive Changes in ABA? Yes/No
	o Determine any Medication Discrepancies	o # participants with medication discrepancies	o Medication discrepancies resolved? Yes/No
	o Participant/Caregiver Satisfaction Surveys	o # Surveys mailed o # Surveys returned	o Positive responses to survey questions? Yes/No
Evidence of improved efficiencies and/or cost savings by end of project	o ADRC Monthly Project Narrative Report	o # Monthly Project Narrative Reports Completed	o Increased # Benefits and Successes over time? o Decreased # Challenges over time?
	o Obtain average costs for patients who are rehospitalized compared with those who aren't	o # patients rehospitalized o # patients home for 30 days o Calculate cost variance	o Increased cost savings for CTI participants?
	o Compare health coverage claims data before/ after for project participants and on an on-average basis for hospital or county, depending on availability of data	o # Participants on Medicaid, Medicare FFS* and/or Advantage, Dual Eligible, or private insurance o Ability of grant staff to access data	o Able to access comparison data? Yes/No o Better rehospitalization rates for project participants? Yes/No
	o Consider if possible to compare before/after utilization patterns to less costly home and community-based supports and services (HCBSS) though CTI and ADRC involvement (e.g. home health, OAA services, private pay options)	o Total # Participants o # Participants transitioned to HCBSS o # Participants not transitioned to HCBS o # Participants rehospitalized o # Participants that were transitioned to HCBS that are rehospitalized o Obtain average costs/patient for 2 outcomes	o Utilization patterns obtainable? Yes/No o Average costs obtained? Yes/No o Fewer rehospitalizations for participants transitioned to HCBSS? Yes/No o Estimated costs decreased with HCBSS? Yes/No

* Whatcom County only: Medicare Fee For Service (FFS) participants served by QIO under a CMS grant so will not be included in data collection or grant evaluation

Data Sources Table

Source #	Data Source/Data Collection Instrument	Relevant Data Included/Collected	Collection Intervals	Data Sharing Agreement Status
1	• *ADRC Staff Monthly Narrative Report* • *Sample: Months in project*	**Control variables:** • *N/A – only collected for participants* **Outcome indicators:** • *Increased Benefits/Successes* • *Decreased Challenges*	*Monthly*	*N/A; however, ADSA has data share agreements with all AAAs*

2	• *Stepping Stones Client Spreadsheet:*
	  ▪ *PAM/CAM scores*
	  ▪ *ABA scores*
	  ▪ *Activation Assessment*
	  ▪ *Charting Form*
	  ▪ *Medication Discrepancy Sheet*
	  ▪ *PHR*
	• *Sample size is all participants contacted for care transition coaching*
		Control variables:
		• *N/A – only collected for participants*
		Outcome indicators:
		• *Improved PHR, PAM/CAMs, ABAs,*
		• *Demonstrates 4 pillars*
		• *Home visits, telephone calls over 30 days*
		• *Rehospitalization? Yes/No*
			As each step in CTI occurs and recorded in participant's individual records it is added to the spreadsheet	*N/A. Aggregate data only (no personal health data) will be shared with state; however, ADSA has data share agreements with all AAAs*

3	• *Stepping Stones Aggregate Report* • *Sample size is all participants contacted for care transition coaching*	**Control variables:** • *N/A – only collected for participants* **Outcome indicators:** • *# cases completed compared to those initiated, in process or incomplete* • *Initial and final PAMs/CAMs completed* • *Initial/ final ABAs completed* • *# Medication discrepancies cases closed*	*Monthly*	*N/A. Aggregate data only will be shared with state; however, ADSA has data share agreements with all AAAs*
4	• *ADRC Care Transitions Coaching Survey* • *Sample size is all participants contacted for care transition coaching*	**Control variables:** • *N/A – only collected for participants* **Outcome indicators:** • *# sent out & returned* • *positive survey responses and improved results over time*	*Upon each participant's completion of 30-day Care Transitions Coaching and return of surveys.*	*N/A. Aggregate data only will be shared with state; however, ADSA has data share agreements with all AAAs*
5	• *Pending: average rehosptialization rates of populations in project coverage areas.* • *Sample size will depend on available data*	**Control variables:** • *Average population rehospitalization rates by geography, facility and/or health coverage type* **Outcome indicators:** • *Rehospitalization rate improvement of general population*	*As available*	*Aggregate data only*
6	• *Data Sources: Medicaid, and possibly Medicare, Claims Data*	**Control variables:** • *Before/after outcomes for project participants* • *Project vs. non-project participants* **Outcome indicators:** • *Improved rehospitalization rates and health outcomes for project participants*	*Quarterly or as possible.*	*TXIX: in place Medicare: pending*

Simple Logic Model/Diagram

Interventions

- *Implement the Care Transitions Intervention targeting older adults and persons with disabilities in 4 hospitals*
- *Provide participants and caregivers ongoing assistance including I&R, options counseling, and caregiver support as needed through ADRCs post-CTI*

Intervening Environmental/ Contextual Factors

- *Participant demographics*
- *Functional status*
- *Diagnoses*
- *Natural supports available in community*
- *Caregiver status*
- *Health Coverage Status*

Intermediate Outcomes Expected

- *Improved medication management*
- *Participants more comfortable and more confident during and post-transition*
- *Caregivers feel greater sense of competence in their role*

Long-Term Outcomes Desired

- *Increased ADRC capacity and expanded areas of partnership*
- *Improvement in rehospitalization rates for participating hospitals*
- *Participants achieve improved health, and understanding of chronic conditions and their management*
- *Evidence of improved efficiencies and/or cost savings*

The following documents and data collection instruments are available at http://www.adsa.dshs.wa.gov/professional/adrc/toolkit.htm or via the links below.

- *Care Transitions Intervention (CTI) Personal Health Record (PHR) used in hardcopy form, developed by the Eric Coleman Care Transitions Program team http://www.caretransitions.org/documents/phr.pdf*

- *Care Transitions Intervention (CTI) Discharge Preparation Checklist used in hardcopy form, developed by the Eric Coleman Care Transitions Program team http://www.caretransitions.org/documents/checklist.pdf*

- *Shared Care Plan Personal Health Record (electronic): https://www.sharedcareplan.org/HomePage.aspx*

- *Patient Activation Assessment http://www.caretransitions.org/documents/Activation_Assessment.pdf developed by the Eric Coleman Care Transitions Program team. For instructions on how to use the Patient Activation Assessment please go to: http://www.caretransitions.org/documents/PAA_Tool_Guidelines.pdf*

- *Stepping Stones* Activated Behavior Assessment http://www.adsa.dshs.wa.gov/professional/adrc/toolkit.htm*

- *CTI Medication Discrepancy Tool (MDT) designed to facilitate reconciliation of medication regimens across settings and prescribers. Developed by the Eric Coleman Care Transitions Program team. http://www.caretransitions.org/mdt_main.asp*

- *Insignia Patient Activation Measure (PAM) (pre/post)*
  Some of the sites have chosen to license and use the PAM, CAM and the Goal Action Sheet as part of their CTI program. To learn more about the PAM please visit: http://www.insigniahealth.com

- *Insignia Caregiver Activation Measure (CAM)(pre/post)*
  Some of the sites have chosen to license and use the PAM, CAM and the Goal Action Sheet as part of their CTI program. To learn more about the PAM please visit: http://www.insigniahealth.com

- *Stepping Stones* Client Spreadsheet*
  (http://www.adsa.dshs.wa.gov/professional/adrc/toolkit.htm

- *Stepping Stones* Coaching Aggregate Report*
  http://www.adsa.dshs.wa.gov/professional/adrc/toolkit.htm

- *ADRC Care Transitions Coaching Program Survey*
  http://www.adsa.dshs.wa.gov/professional/adrc/toolkit.htm

- *ADRC Staff Monthly Narrative Report*
  http://www.adsa.dshs.wa.gov/professional/adrc/toolkit.htm

- *Stepping Stones* Coach Patient Report*
  (http://www.adsa.dshs.wa.gov/professional/adrc/toolkit.htm

* Note: *Stepping Stones* is the name of the Qualis Health QIO Care Transitions project in Whatcom County, and some of their forms are being used by the Option D project.

Washington State ADRC Care Transitions Intervention Model

Whatcom County - Phase I

At Hospital

- Hospital staff engage individual to participate in CTI
- Hospital staff enter CTI referrals into hospital's electronic patient information system (Care Cast).
- ADRC and QIO coordinate CTI coaching assignment
- ADRC CTI coach conducts visit with individual before discharge:
  - Introduce self & CTI
  - Enroll in CTI
  - Introduce PHR (electronic &/or hardcopy)
  - Administer PAM or CAM (if possible)
- Hospital staff Discharge to Home

← 30 days →

At Home

- Home Visit by ADRC CTI Coach
  - Administer PAM or CAM (if not completed in hospital)
  - Medication Reconciliation
  - PHR – Goal Setting, Shared Care Plan training
  - Review Red Flags
  - Discuss Primary Care Physician (PCP) follow-up
- PCP Follow-up
- Telephone Follow-up #1
  - Review Progress
- Telephone Follow-up #2
  - Review Progress
- Telephone Follow-up #3
  - Final PAM/CAM completed

Data Collection and Post - CTI

- At end of each month, ADRC completes the Coaching Monthly Report and Client Spreadsheet
- Caregiver or Individual Client can continue with PHR (Shared Care Plan or My Family Care Plan)
- Continued PCP Follow-up
- ADRC Options Counseling & Assistance as requested
- Home & Community-based Supports and Services