AN INTERDISCIPLINARY TEAM APPROACH TO IMPROVING TRANSITIONS ACROSS SITES OF GERIATRIC CARE

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Introduction:

Bridging the Gap

To implement a management plan, not only do patients have to be ready for it, believe it is in their best interest, and believe that they can accomplish it; they also have to do it. The more complex and behaviorally demanding a management plan, the greater the challenge for the patient who must integrate it into the demands of day-to-day living.

~Principles of Ambulatory Medicine, 5th Ed.

Older patients with chronic illness often require care from a variety of practitioners in multiple settings. For example, in a given month, an individual with chronic illness may receive care from his or her primary care physician or a specialist in the ambulatory care setting. That same person may then receive care from a hospitalist physician and nursing team during an inpatient admission, a different physician and nursing team during a brief stay in a skilled nursing facility (SNF), and finally, from a visiting nurse in the home. Yet during times when they are most vulnerable and their informal caregivers are often overwhelmed, systems of care fail patients by not ensuring that: (1) the critical elements of the care plan developed in one setting are transferred to the next; and (2) the essential steps that need to take place before and after transfer are executed. By default, facilitation of successful care transitions becomes the responsibility of patients and their caregivers, who often do not possess the necessary health care self-management skills or confidence to assume this role.

Although not all episodes of care have a discrete beginning, bridging the gap for this intervention starts with an older person's admission to the hospital. This allows the focus on care transitions between hospital and nursing home, or hospital and home.

The goal of improving care transitions across these multiple sites can be achieved through a patient-centered interdisciplinary team model that is comprised of four components:

1) A patient-centered record that consists of the essential care elements for facilitating productive interdisciplinary communication during the care transition
2) A structured checklist of critical activities designed to empower patients to enlist interdisciplinary collaboration throughout the transition
3) Nurse Transition Coach facilitated patient activation and self-management sessions designed to help patients and their caregivers understand and apply the first two elements, and assert their role in managing transitions
4) Nurse Transition Coach follow-up visit(s) in the skilled nursing facility and/or in the home with accompanying phone calls designed to sustain the first three components and provide continuity across the transition.

CHAPTER 1

Intervention Structure

Then into the New Wing! We'll see Dr. Spreckles, who does the Three F's – Footsies, Fungus, and Freckles. Nextly, we'll drop in on young Dr. Ginns, our A & S Man who does Antrums and Shins, and of course, he'll refer us to Drs. McGrew, McGuire, and McPherson & Blinn & Ballew & Timpkins & Tempkins & Diller & Drew, Fitzsimmons, Fitzgerald, and Fitzpatrick, too, all of whom will prescribe a prescription for you.
~Dr. Seuss, You're Only Old Once

OVERVIEW

The overriding goal of the Transition Coach is to improve care transitions by providing patients with tools and support that promote knowledge and self-management of their transition as they move from hospital to home.

1.1: The Four Pillars

The Transition Coach collaborates with patients and caregivers in four conceptual areas, or "pillars":

1. **Medication self-management:** Patient is knowledgeable about medications and has a medication management system.
2. **Use of a patient-centered record:** Patient understands and utilizes the Personal Health Record (PHR) to facilitate communication and ensure continuity of care plan across providers and settings. The PHR is managed by the patient or by the informal caregiver.

3. **Primary Care and Specialist Follow-Up:** Patient schedules and completes follow-up visit with the primary care physician or specialist physician and is prepared to be an active participant in these interactions.
4. **Knowledge of Red Flags:** Patient is knowledgeable about indicators that suggest his or her condition is worsening and how to respond.

1.2: Structure and Components of the Intervention

The structure of the intervention is described in detail in: Parry, C., Coleman, E., Smith, J., Frank, J., and Kramer, A. (2003) "The Care Transitions Intervention: A Patient-Centered Approach to Ensuring Effective Transfers Between Sites of Geriatric Care", *Home Health Services Quarterly*, Volume 22 (3): 1-17.

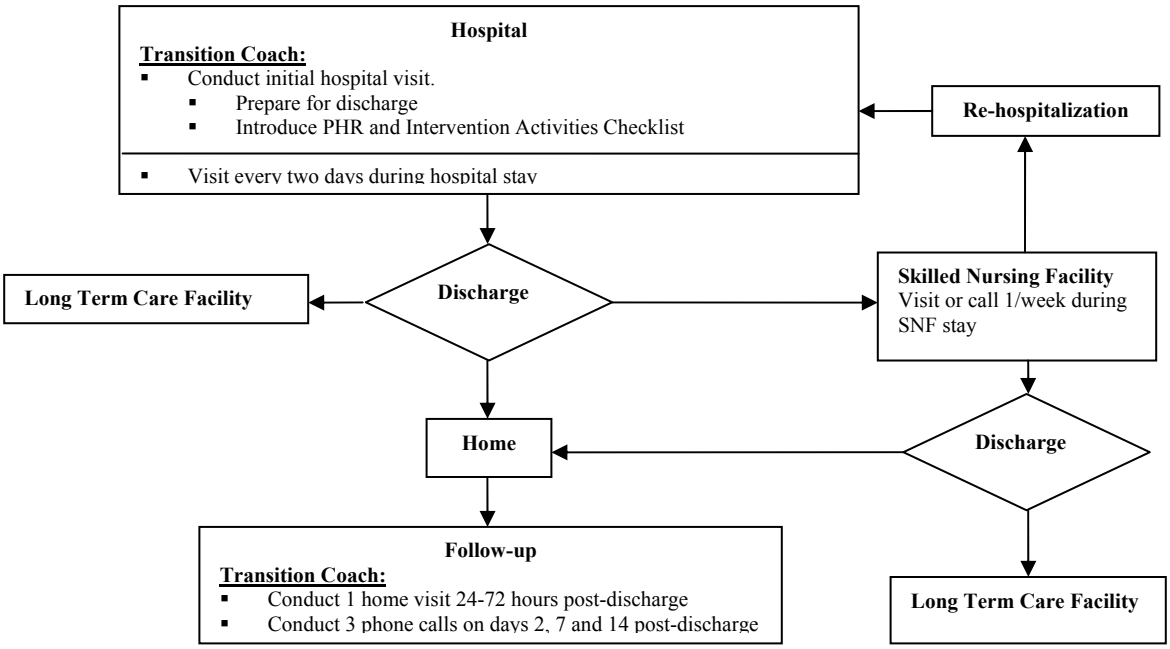
As noted in that publication, the four pillars are operationalized through two mechanisms, a Personal Health Record (PHR) and a series of structured visits and follow-up phone calls with the Transition Coach. The PHR is a dynamic record that includes the patient's demographic information and medical history, the Primary Care Physician and Caregiver contact information, Advance Directives, medications and allergies, a list of warning signs (red flags), a structured checklist of activities that should precede discharge and aid in the follow-up at home (such as instructions and dates of follow-up appointments), and a place for patients to write questions for their care practitioners. The PHR is owned and maintained by that patient. The PHR is discussed in detail in section 1.3 of this chapter.

The Transition Coach functions as a facilitator of interdisciplinary collaboration and care continuity across care settings, coaching the older patient and caregiver/s to play an active and informed role in care plan execution. The Transition Coach first interacts with patients upon hospital admission to ensure a smooth transition home. The coach's role is not to be a service broker or care manager, but rather, to provide information and support for the patient in identifying concerns and problems and building relationships with practitioners. The role of the Transition Coach is described in greater detail in section 1.4 of this chapter.

The structure of the intervention is outlined in Figure 1. The hospital visit is designed to help prepare patients and caregivers for discharge by introducing the intervention and

the Transition Coach, providing them with the Personal Health Record and Intervention Activities Checklist, and addressing concerns. Follow-up visits in the Skilled Nursing Facility and/or home, along with follow-up calls, are intended to empower patients to adopt a more active role in their care by expanding upon the information provided in the initial (hospital) visit and assuring that care needs and concerns are addressed as the transition is accomplished. Specific detail about the content of the visits and phone calls is provided in chapters 2-6 of this manual.

Figure 1: Structure of the Care Transitions Intervention



The patient and Transition Coach review the content area of the four pillars during each contact with the Transition Coach, but the specific focus varies by patient and by visit. Because the Transition Coach tailors the content from the Four Pillars to the needs and priorities of the patient during each intervention contact point, the patient's readiness and ability to increase his/her involvement within the Four Pillars will dictate the most appropriate timing to focus on specific content. For instance, during the home visit, the coach may find that the patient's medications are in order, but his/her condition is worsening and requires a follow-up appointment (or more immediate attention). In this case, the focus of the visit would be on recognition of red flags (warning signs) and

establishing follow-up care. An abbreviated sample list of intervention activities is provided in Table 1 and a list of specific tools and coaching support addressing each pillar are listed below in Table 1 (Parry, et al, 2003).

Table 1: Care Transitions Intervention Activities by Pillar and Stage of Intervention

Pillar	Medication self-management	Patient-centered record	Follow-up	Red Flags
Goal	Patient is knowledgeable about medications and has a medication management system.	Patient understands and utilizes a Personal Health Record (PHR) to facilitate communication and ensure continuity of care plan across providers and settings. The patient manages the PHR.	Patient schedules and completes follow-up visit with Primary Care Practitioner/Specialist and is empowered to be an active participant in these interactions	Patient is knowledgeable about indicators that condition is worsening and how to respond.
Hospital Visit	Discuss importance of knowing medications and having a system in place	Explain PHR and its components	Recommend Primary Care Practitioner follow-up visit	Discuss symptoms and drug reactions
Home Visit	Reconcile pre- and post-hospitalization medication regimens Identify and correct any discrepancies	Review and update PHR Review discharge summary Encourage patient to update and share the PHR with Primary Care Practitioner and/or Specialist at follow-up visits	Emphasize importance of the follow-up visit and need to provide Primary Care Practitioner with recent hospitalization information Practice and role-play questions for Primary Care Practitioner	Assess condition Discuss symptoms and side effects of medications
Follow-Up Calls	Answer any remaining medication questions	Remind patient to share PHR with Primary Care Practitioner/Specialist Discuss outcome of visit with Primary Care Practitioner or Specialist	Provide advice in getting prompt appointment, if necessary	Reinforce when/if Primary Care Practitioner should be called

The Transition Coach functions as a facilitator of interdisciplinary collaboration across the care transition, coaching the older patient and caregiver to assert a more central role in their care. The focus of this model is to coordinate these setting-specific practitioners during the transition, expanding the purview of the traditional team. The older patient, caregiver, and Transition Coach work together to maximize the

involvement of interdisciplinary expertise. This ensures that the appropriate professionals are involved, the correct issues are addressed, and that the care plan and treatment goals are understood. The information provided within this manual is designed to provide an aspiring transition coach with the conceptual and practical information needed to perform this role effectively.

The following is a list of the tools and support for each of the four pillars:

1. Medication self-management:
    - Tools include an up-to-date Medication List, having reconciled the pre and post hospital regimens, to be clarified by the patient with the Primary Care Practitioner.
    - Support includes education based on patient's needs, review of new medications, side effects, adverse drug reactions, and guidance in developing a patient-oriented medication management system.
2. Use of a patient-centered record:
    - Tools include a patient-specific Personal Health Record (PHR) prepared by the patient or Transition Coach, but managed by the patient/caregiver, to facilitate cross-site communication and ensure continuity of care across different practitioners and settings.
    - Support includes teaching the patient how to manage the PHR, its components, how to update the data, and the value of taking it everywhere.
3. Primary Care and Specialist follow-up:
    - Tools include use of the PHR as a guide for preparation of an effective and productive follow-up visit with the Primary Care Practitioner or Specialist.
    - Support includes discussion involving the patient's concerns, topics to be discussed with physician, future health care plan, and health maintenance issues.

4. Knowledge of Red Flags:
    - Tools include information sheets explaining self-management of chronic illnesses (causes, signs, symptoms and care), and medication information sheets explaining the purpose, use, warning signs, side effects, and storage tips for each medication.
    - Support includes explanations of above and education based on the patient's diagnoses, history, level of understanding, and ability to assimilate the information.

Click here to view use of the PHR in the intervention

1.3: Personal Health Record (PHR)

A printer-friendly version of the Personal Health Record can be found by going to http://www.caretransitions.org and then selecting "Intervention Design and Tools" and "Patient-Centered Record" from the menus.

The PHR is a dynamic tool prepared by the patient and the Transition Coach to enable the patient to take control of his or her own health care issues, and to facilitate communication of essential information across settings.

Components of the PHR include:

1. Demographic information
    - Personal, hospitalization, and caregiver information
2. Medical History
    - Chronic conditions and other diagnoses
3. List of activities before leaving the care facility
    - Know medications, what they're for, when and how to take
    - Set-up home support, what caregivers need to know
    - Schedule follow-up appointment with Primary Care Practitioner
    - Get questions answered by physicians and nurses
    - Call PCP/Specialist for any Red Flags (listed)

4. Medication Record
    - Name of medication (both generic and brand names)
    - Dosage, frequency, and timing
    - Reasons for taking, special instructions
5. Tips on managing health and medications
    - Take PHR to all health care encounters
    - Share medication list and clarify all medications with PCP/Specialist
    - Update Medication Record with any changes
6. Designated space for follow-up questions for each practitioner
    - PCP, Specialist, Home Health Nurse, PT, OT, Case Manager

Transition Follow-up Plan includes:

- Explanation of Transition Coach role, what to expect from coach or next setting
- Timing of anticipated phone calls, home visit
- Instructions to call when discharged, Transition Coach phone/pager number

Calendar and Contact info for Transition Coach:

- Two week calendar to track follow-up appointments
- Transition Coach name, phone/pager number
- Instructions to call with any questions or concerns

1.4: Roles and Functions of the Transition Coach

The Transition Coach is key to ensuring safe and effective transfers in the movement of patients across the care continuum. The Transition Coach serves as the bridge between the professional staff in a care setting (e.g. hospital) and the patient and/or family. In his/her role as a patient educator-advocate, and patient empowerment facilitator, the Transition Coach provides information and guidance to the patient and/or family for an effective care transition, improved self-management skills and enhanced patient-practitioner communication.

An important distinction between the Transition Coach role and a traditional nurse role is that the coach should be a guide for the patient, addressing critical issues and self-management tasks rather than directly taking over and providing care. Strong nursing judgment and critical thinking skills are essential to appropriately evaluate aspects of each patient's condition, diagnoses, and medications to formulate an individualized plan. Identifying the patient's strengths is a vital component of building trust and setting the stage for increased patient self-management activities. In other words, the Transition Coach may need to table what s/he feels is a critical pillar to address, in order to listen to the patient's major concern and assist him/her in dealing with it. Once the patient has experienced this type of support from the Transition Coach, s/he will be more willing to listen to the issues raised in discussing content within the Four Pillars.

Whenever possible, the Transition Coach encourages the patient or caregiver to engage with the health delivery system to ensure that his/her needs are met. It can be challenging for a directive professional to become comfortable in the coaching role: providing support and encouragement, promoting self-activation on the part of the patient/caregiver. Guidance on how to approach and accomplish this coaching role is provided below:

Clinical role of the Transition Coach

Requires collaboration with interdisciplinary team.

- The Transition Coach makes a thorough assessment of the patient's psychological, social, emotional, physical, and financial needs.
- The Transition Coach may guide the activities, nursing treatments, and interventions of other practitioners.
- The Transition Coach monitors the patient's response to treatment and works with the patient's team to analyze and deal with the unanticipated developments.

Includes responsibility for coordination of care during the course of illness.

- Care is managed by planning the nursing treatment modalities and interventions necessary for meeting the needs of the patient and family.
- Goals of treatment are set at admission, and follow up plan is established.

CHAPTER 2

Transition Coaching In the Hospital

OVERVIEW

The Transition Coach first engages with the patient upon admission to the hospital. S/he works closely with patients and caregivers to ensure a smooth transition from hospital to home following an acute episode requiring hospitalization. While the Transition Coach may interact with other service practitioners, the Transition Coach's role is not that of a service broker or care manager. Rather, the Transition Coach is a source of information and support for the patient, assisting the patient in identifying key questions or concerns and empowering the patient to make contact with health care practitioners as necessary.

During the hospital visit, the Transition Coach introduces herself to the patient and conducts the initial session aimed at imparting skills for greater self-management. The hospital visit is designed to help patients and their caregivers understand and use the PHR, to prepare patients and caregivers for discharge, and to empower patients to play a more active and informed role in managing their care during upcoming transitions.

2.1: Guiding Principles & Applying the Four Pillars in the Hospital

Guiding Principles:

- The hospital is the crucial place to meet and establish a good working relationship with patients and caregivers. If the hospital visit goes well, patients usually look forward to future contact and are more open to Transition Coach support.

- Encourage the patient to take charge of his/her care – increase awareness, readiness and capacity for self-management while recognizing the extent to which the patient's current illness state may limit his/her interest and ability to do so.
- Set the stage for future contacts and reinforce how the intervention may be valuable to the patient and caregivers.
    - Talk about the support to be provided after the transition home.
        - Having someone who understands what s/he may be feeling helps to validate patient anxiety about the impending discharge.
        - Reassuring the patient that s/he will not be alone during this transition can alleviate fears and feelings of abandonment.
        - An offer to visit the patient at home the next day can provide a sense of relief and safety.
- Ask patient to call the Transition Coach when s/he gets discharged.
    - Give timid patients a script, "Hi, it's _____. I was discharged today."
        - Creates two-way communication.
        - Imparts a skill that can be applied during future hospitalizations and relationships with patient's Care Manager.

2.2: Hospital Process and Content

Tips and Protocol for Coaching in the Hospital

A priority goal of the hospital visit is to relate the four pillars to patient needs and priorities. All patient contact is based on the four pillars: Medication self-management, the Personal Health Record, the Primary Care Physician or Specialist follow-up, and review of Red Flags.

Click here to view a brief video clip of the Hospital visit.

The Four Pillars in the Hospital Visit:

1) Medication Management:

- Reinforce importance of knowing each medication: why, when and how to take what is prescribed.

- Encourage patient to ask the nurses and/or discharge planners to review the list of medications one by one, to write down any extra instructions or details, and to ask questions such as:
    - "What is this medication for?"
    - "How often do I need to take it?"
    - "For how long?"
    - "Will this interact with any of the medications I'm taking at home?"
- Introduce new medications
- Review status of pre-hospital medications (determine whether necessary to continue to take, adjust dosage, or discontinue)
- Review Side Effects/Adverse Drug Reactions (ADRs)
- Reiterate importance of adherence to a regimen
- Identify possible problems with refilling prescriptions (e.g. transportation, cost, etc.)

2) Personal Health Record (PHR)

- Use the PHR (especially the Discharge Checklist section) to guide the conversation in the hospital.
- Explain the PHR has information about the patient and her/his health care that every health care practitioner needs to know.
- Work with patients in developing and writing down (on the PHR) patient-specific questions to ask hospital doctors, nurses and discharge planners such as "What is my plan?" and "Where am I going?"
- Encourage patient to:
    - Bring the PHR everywhere, (doctor visits, Emergency Department, vacation, etc.) and share it with all practitioners (e.g., therapy, PCP, Specialists, home health care nurses).
    - Use the PHR as a mechanism for getting important questions answered.

3) PCP or Specialist follow-up:

- Enlist patient's involvement in scheduling an appointment with the PCP or Specialist as soon as possible after discharge:
  - to discuss the reasons that brought the patient to the hospital in the first place
  - to discuss any new medications or old medications that have been added, discontinued, or dosages changed
  - to discuss any change in health status or adverse events since hospital discharge
  - to discuss the patient's future health care and maintenance plan (e.g., how the patient can be proactive in preventing a recurrence of the problem)
  - to refer the patient to additional services or specialty care as needed
- Assist in empowering patient to maintain collaborative partnership with PCP and/or Specialist.

4) Red Flags:

- Alert patient to disease-specific warning signs and symptoms
- Instruct patient how to access health care system, including nights and weekends: "Call your Dr.'s office immediately if any of the following occur: fever, bleeding, confusion, uncontrollable pain, increased tiredness."

Other Tips:

- Conversation tools and probes to build rapport and elicit information:
  - "What concerns you most about going home?"
  - "How can I help you get home successfully?"
  - "What do you think contributed to this hospital stay?"
  - "How comfortable are you in talking with your doctor?"
- Review discharge form and instruct the patient to look it over carefully, assuring it is complete and accurate and that s/he understands everything before leaving the hospital.

Common Challenges:

- Interruptions are common. Patience pays off – waiting for a good time to meet is beneficial for both parties.
- When engaging disinterested or distracted patients, shift the focus from the four pillars to the patient's agenda. In most circumstances, the four pillars can be woven in when addressing the patient-specific needs and concerns.
- Practice and experience helps to make the most of these contacts.

CHAPTER 3

Transition Coaching In the Skilled Nursing Facility

3.1: Guiding Principles & Applying the Four Pillars in the Skilled Nursing Facility

Guiding Principles:

- Before admission to the SNF and/or immediately following, explain what patients can and should expect from their SNF stay, thereby limiting the number of surprises and disappointments, as well as maximizing their participation in their rehabilitation plan.
- While some patients may welcome a brief SNF stay before resuming self-care at home, others may see it as a setback. Watch for symptoms of depression and try to address anxiety with concrete explanations of the reasons this level of care is in the patient's best interests.

3.2: Skilled Nursing Facility Visit Process and Content

Tips and Protocol for Coaching in the Skilled Nursing Facility

The Transition Coach visits or contacts the patient by telephone within 5 days of SNF transfer.

The Four Pillars in the Skilled Nursing or Rehabilitation Facility:

1) PHR:

- Work with patients in developing and writing down patient-specific questions to ask SNF doctors, nurse practitioners, nurses, social workers, discharge planners and therapists such as:
  - "What is the plan for me while I am here?"
  - "How long until I can return home?"
  - "What arrangements will I need to have in place when I'm discharged home?"
  - "What does my family need to help me care for myself?"
- Encourage the patient to share the PHR with SNF care practitioners.

2) Medication Management:

- Encourage the patient to know his/her medications: why and how to take what is prescribed. Have the patient compare the meds given in the SNF to what is in the PHR and update/correct as necessary.
- Introduce new medications
- Review status of pre-hospital medications (continue to take?, dosage adjustment?, dosage changes?)
- Discuss side effects/Adverse Drug Reactions (ADRs)
- Reinforce importance of adherence to a regimen
- Identify possible filling and/or refill problems that may arise after discharge
- Encourage the patient to ask the nurses and/or discharge planners to review the list of medications one by one and write down any extra instructions or details and to ask questions like:
  - "What is this one for?"
  - "How often do I need to take it?"
  - "For how long?"
  - "Will this interact with any of the medications I'm taking at home?"

3) PCP or Specialist follow-up:

- Enlist patient's involvement in scheduling an appointment with the PCP or Specialist as soon as possible after discharge:
    - to discuss the reasons that brought the patient to the hospital in the first place
    - to discuss any new medications or old medications that have been added, discontinued, or dosages changed
    - to discuss any change in health status or adverse events since hospital discharge
    - to discuss the patient's future health care and maintenance plan (e.g. how the patient can be proactive in preventing a recurrence of the problem)
    - to refer the patient to additional services or specialty care as needed
- Assist in empowering patient to maintain collaborative partnership with PCP and/or Specialist.

4) Red Flags:

- Alert patient to disease-specific warning signs and symptoms
- Instruct patient how to access health care system, including nights and weekends: "Call your Dr.'s office immediately if any of the following occur: fever, bleeding, confusion, uncontrollable pain, increased tiredness."

Other Tips:

- Conversation tools and probes to build rapport and elicit information:
    - "What concerns you most about going home?"
    - "How can I help you get home successfully?"
    - "What do you think contributed to this hospital stay?"
    - "How comfortable are you in talking with your doctor?"

- Review discharge form and instruct the patient to look it over carefully, assuring it is complete and accurate and that s/he understands everything before leaving the hospital.

- Facilitate patient communication with SNF staff regarding goals, pain, and maintenance of the care plan after discharge.
- As is helpful, communicate with the SNF staff to inquire about changes to the patient care and discharge plans.
- Again, positive reinforcement is essential for successful empowerment. The patients/caregivers need to hear what they're doing is OK. Reinforce what they are doing well, what is going well for them and relate it to their goal/s as much as possible.

Common Challenges:

- Just as in the hospital, the environment of the SNF provides few opportunities for patients to assume a more active role in their care.
- It may be difficult to maintain solid relationships with patients admitted to a SNF, especially if the prospect of a long stay is high. Circumvent this challenge by being diligent in making weekly contacts and supporting the patient and caregiver with preparations for discharge home, always keeping the patient's goal/s in mind. Encourage two-way communication/dialogue on patient's status, plan of care, etc. This may serve as a primer for the patient/caregiver for further interactions with other health care professionals in the interdisciplinary team.

CHAPTER 4

Transition Coaching In the Home

OVERVIEW

The home visit is an opportunity for patient assessment, education and activation in self-management skills. The Home Visit is a critical feature of the intervention and should be scheduled for a minimum of one hour. The context of the patient's home provides important information on the patient's functional abilities, social support, environmental challenges and self-management capabilities and needs.

Follow-up home visits should be conducted as soon as possible after the patient arrives home. Typically, the home visit is scheduled within two days of discharge.

4.1: Guiding Principles & Applying the Four Pillars in the Home

Guiding Principles:

- Conduct the home visit as soon as possible after the patient is discharged home to provide the best continuity of care and quickly target any immediate post-hospital. (i.e. within 48 hours).
- The home visit facilitates relationship building. During the hospital stay, patients see many different care practitioners in addition to the Transition Coach. The home visit facilitates a deeper level of connection and comfort for the patient/caregiver and the Transition Coach.

- For most patients, a thorough review of all medications is the first and most important order of business during the home visit. Information is gathered that is vital and most often can't be done over the phone (i.e. identification of pre-hospital medications, duplications, missing medications, refills needed, etc.) The Transition Coach can observe the patient's medication management system to see if the patient understands its function and purpose.
- Preparing for the patient's PCP or Specialist follow-up visit is often the second order of business.
- Home visits provide the opportunity to observe what additional struggles (nutrition, transportation, non-working appliances, etc.) and assets (support systems, existing self-management style, and activities) exist for each patient and caregiver. This is an appropriate time to assess and intervene if the patient requires referral to a Care Manager for longitudinal support.

Click here for to view patient comments about Home Visit

4.2: Home Visit Process and Content

Tips and Protocol for Coaching in the Home

While the hospital setting is the initial place to introduce the PHR and begin patient activation activities, the home visit provides an opportunity to build on this momentum by emphasizing medication self-management and PCP/Specialist follow-up.

The Four Pillars in the Home Visit:

1) Medication Management and the PHR:

- Focus on the Medication Record section of the PHR.
- Review and update every medication on the Medication Record, cross-referencing with all medications in the home and integration into the patient's medication management systems (or addressing the lack thereof).
- Encourage the disposal of expired or non-essential medications.
- Quiz the patient: "What is this one for?" "When do you take it? How much do you take?" "For how long?"
- Discuss side effects/Adverse Drug Reactions (ADRs)

- Reinforce importance of adherence to a regimen
- Address filling problems/refills (e.g. cost, transportation)
- Encourage or establish use of a Medication Planner (such as a plastic pill organizer)
- Encourage patient to:
    - "Show your Medication Record to all your practitioners (e.g. therapy, PCP, Specialists, home health care nurses) and discuss any problems."
    - "Take your PHR/Medication Record wherever you go" (doctor visits, ER, vacation, etc.)

Click here to view example of medication management component of home visit

2) PCP or Specialist follow-up and PHR:

- Enlist patient's involvement in scheduling an appointment with the PCP or Specialist as soon as possible after discharge:
    - to discuss the reasons that brought the patient to the hospital in the first place
    - to discuss any new medications or old medications that have been added, discontinued, or dosages changed
    - to discuss any change in health status or adverse events since hospital discharge
    - to discuss the patient's future health care and maintenance plan (e.g., how the patient can be proactive in preventing a recurrence of the problem)
    - to refer the patient to additional services or specialty care as needed
    - Encourage the patient and caregiver to view their relationship with their PCP or Specialist as a collaborative partnership. Co-create questions for the patient to ask his/her PCP or Specialist during their follow-up visit and write them on the PHR.
        - Remind and encourage patient to ***take*** the PHR to their follow-up visit and ***ask*** the questions s/he wrote in his/her PHR.
- Role-play possible patient/PCP or patient/Specialist interactions including:
    - Asking the questions written on the PHR.

- Asserting the need to get adequate answers.
- Demonstrating how to deal with a doctor who has a different agenda or is not very receptive or open to the patient's role.
- Sharing information about the patient's hospitalization, including complications.
- Reviewing the patient's discharge instructions.
- Addressing the patient's pain concerns.
- Asking for explanations about any changes in the treatment or care plan.

- Some PCPs or Specialists won't think it's necessary for a particular patient to come in for a follow-up visit:
  - For a patient whom the Transition Coach believes a follow-up appointment is imperative, support the patient in scheduling an appointment.
  - For a patient who does not need follow-up, emphasize identifying and reacting appropriately to red flags.
  - The issue of the patient and his/her caregiver being the only constant member of his/her health care team is never more apparent than when coordinating care plans and communicating care issues between practitioner and setting. This is the perfect opportunity to emphasize the patient's central role on her or his health care team. The PHR is the tool to communicate with various members of the health care team and provide critical information to each member. Role play with the patient the challenges of showing up at busy care practitioner's offices, and being the only person who truly understands their current situation and has the most current information that needs to be shared.

Click here to view example of coaching for the Primary Care Physician follow-up visit

Click here to view Practitioner responding to a patient using the PHR

3) Red Flags

- Alert patient to disease-specific warning signs and symptoms
- Instruct patient how to access health care system, including nights and weekends: "Call your Dr.'s office immediately if any of the following occur: fever, bleeding, confusion, uncontrollable pain, increased tiredness."
- Quiz patients about identifying and responding to red flags. If the patient can't recall the red flags for and/or how to respond to them, have the patient write them down on the PHR.

Other Tips:

- Conversation tools and probes to build rapport and elicit information:
  - "What has been going well since our last call/visit?"
  - "Since the last time we talked, has anything changed? (with your medications, health care plan…)"
  - "How confident are you about…?"
  - "When I visit/call you again, let's make sure we talk about…"
  - "Let's review the specific things you are going to do within the next couple of days/weeks."

- Some patients who experienced a significant loss of function may require more support from the Transition Coach. They may need the Transition Coach to assume a greater role. Be more directive with these patients – explain things more explicitly – e.g. actually write down their questions for their PCP/Specialist follow-up visit, make referral to Care Manager, update their PHR/medications.

- Address patient-specific disease management issues/provide patient with materials that foster self-management.

- Positive reinforcement is an important underpinning in creating the confidence patients/caregivers need to make the changes necessary for successful empowerment. The patient/caregivers need validation that what they're doing is correct. Reinforce what they are doing well, what is going well for them and relate it to their goal/s.

- Be creative in addressing patient/caregiver needs. Organize the disease processes and medication management issues in an easy to follow style, providing information sheets on areas of influence (diagnoses, medications) for reference. Explain in laymen's terms what the issues are and how to ask the physician questions about how to handle them. This will give patients first-hand knowledge about the complexity of their condition/s, and a starting point for the PCP/Specialist to evaluate and formulate a tailored health care plan incorporating specialist recommendations and personal patient insight.

Click here to view summary of home visit:

Common Challenges:

- It is difficult to empower someone to become more involved in their health care when they are disempowered in their everyday life. In these situations, it's best to focus on the patient's agenda and provide assistance regarding broader life issues and support related changes.

4.3: Identifying Post-Acute Medication Discrepancies

The Need for a New Taxonomy

Despite significant national awareness for the problem of medication safety, there has been relatively little attention paid to problems faced by older patients receiving care across multiple settings. Attention has primarily focused on errors occurring in specific settings. Older adults with complex acute and chronic care needs often require care in multiple settings. As a consequence, they receive prescriptions from multiple practitioners. Due to lack of coordination and communication between institutions, these prescribers may unknowingly contribute to duplicative and potentially harmful medication regimens.

Traditionally, the definitions and tools used to identify medication errors have been developed for individual settings, have primarily addressed the problem from the perspective of the system or practitioner, and have relied on the presence of a "gold

standard" for what the appropriate regimen should entail. A taxonomy developed to capture medication-related problems experienced by older adults receiving care across multiple settings needs to include the perspective of the patient and caregiver and incorporate the fact that there often is not a single "gold standard" when multiple prescribers are involved. The Medication Discrepancy Tool (MDT) was developed to fill this current gap in identifying transition-related medication problems and characterize accompanying action steps at either the patient or system level.

Creation of the Medication Discrepancy Tool (MDT)

A series of "guiding principles" informed the development of the MDT:

- Patient-centered
- Application across a variety of health care settings
- Account for intentional and non-intentional patient non-adherence
- Account for performance deficits attributable to physical or cognitive function
- Account for knowledge deficits due to education or health status
- Representation of patient- and system-level contributing factors
- Actionable items that could be incorporated into continuous quality improvement initiatives
- Meaningful to patients, caregivers, practitioners, health care systems, and payers

Errors Versus Discrepancies

When considering medication safety, it is important to differentiate between the terms error and discrepancy. Traditionally, the definitions and tools used to describe medication errors have applied to the inpatient setting and were either provider-based or setting-specific. To suggest that a medication "error" has occurred for patients receiving care across settings is to suggest that a gold standard for the correct medication regimen exists and is readily available for confirmation. For example, a hospital discharge summary may not account for the patient's pre-hospital medication regimen or may not be available to practitioners in the next setting in a timely manner. In the absence of such a gold standard, use of the term discrepancy may provide a more practical approach for

capturing the events that occur for patients in transition between acute and post-acute care settings.

Components of the Medication Discrepancy Tool

Problems found in post-acute medications regimens are generally not uni-dimensional and any new taxonomy needs to account for the multitude of reasons for which discrepancies may arise. For the MDT, the rater is given a variety of potential reasons for discrepancies and asked to check all that apply. The MDT is divided into patient level and system level causes and contributing factors.

Patient Level Discrepancy: This section is intended to assess the patient's role in managing their medication regimen. An important focus of this section is the differentiation between intentional non-adherence and non-intentional non-adherence. The former infers that a patient knows the regimen and chooses not to adhere, while the latter infers that a patient was not aware that they were not adhering.

System Level Discrepancy: This section is intended to assess the role of practitioners working within health care systems for ensuring safe and effective medication regimens for patients transitioning across settings. An example of a system level discrepancy is when a patient's discharge instructions are either incomplete, illegible or has inaccuracies.

Resolution: This section is intended to capture what potential action(s) could be taken to correct the identified discrepancies.

- Patient was taking Lisinopril 10 mg once daily prior to hospitalization. This drug was discontinued while patient was in the hospital and stated so on discharge instructions. At home visit, patient was taking "Lisinopril 10 mg once daily".
- Patient was discharged from the hospital on several new medications. During the home visit, it was discovered that two drugs were missing. Patient had already completed a follow-up appointment with her primary care physicians who did not recognize that these two prescriptions were missing.

- During a home visit, a patient stated that she did not receive any discharge instructions from the skilled nursing facility. She did, however, have the leftover medications from the skilled nursing facility that had been sealed in blister pack. The blister-packed medications did not match her pre-hospital medication regimen. The patient could not read the labels on the blister-packed medications. The patient was very confused about what she should be taking.

Medication Review

With respect to the Care Transitions Intervention, medication review requires a detailed assessment of medications prescribed pre and post hospitalization in order to construct an accurate medication list. A comprehensive review of the discharge instructions with the patient at the home visit allows the patient time to ask questions and voice concerns. Early identification of inconsistencies is essential and follow-up can be critical to the patient's wellness. (e. g. after being hospitalized for dehydration, a patient may go home with a new prescription for Furosemide 20 mg. and think she should also continue taking her pre-hospital medicine Lasix 40 mg., not realizing they are the same medication). The Transition Coach encourages patients to collect all medications (prescription and non-prescription) for review during the home visit. At this time, the patient and Transition Coach review all medications, identify discrepancies, follow up with practitioners for clarification/correction as needed, and update the Medication list in the PHR, as needed.

CHAPTER 5

Post-Hospital Follow-Up Phone Calls

OVERVIEW

The aim of the follow-up calls is to reinforce the Four Pillars, review patients' interim health encounters and problem-solve challenging areas. With each contact the patient will feel supported in his or her own efforts to promote good health and the understanding that s/he can and will successfully manage his/her personalized health plan.

5.1: Guiding Principles & Applying the Four Pillars into the Post-Hospital Follow-Up Phone Calls

Guiding Principles:

- Follow-up calls are designed to touch on areas of concern identified during the prior contact. Skillful charting enables the Transition Coach to keep track of the progress of events and concerns. (See Sample Charting in Appendix)
- Patients often welcome the Transition Coach's call. Patients often have questions, but haven't been encouraged to call or they experience systems/barriers that make it difficult for the patient to reach a practitioner via the phone system.

- Two-day call:
  - Used to engage the patient to become more involved in the management of his/her health care and take an active role in his/her recovery.
  - Schedule Home Visit
  - Address any immediate concerns/issues/problems

- Seven day call:
  - Often used to remind patient to arrange and prepare for follow-up appointment. Cue patient on key points to ask the doctor particularly if the patient is apprehensive.
  - Inquire about the patient's progress since last contact.

- Fourteen-day call:
  - Emphasizes future sustained use of self-management skills and tools for future transitions.

5.2: Post-Hospital Follow-Up Phone Call Process and Content

Tips and Protocol for Coaching Post-Hospital Follow-Up Phone Calls

The follow-up phone calls are typically tailored to on-going self-management issues, patient-PCP, patient-Specialist communication and other loose ends identified by the patient and/or Transition Coach. The follow-up calls are intended to address specific areas of concern to each individual patient. In so doing, each patient's follow-up call will be tailored to the needs of that patient and the events that have transpired since the last contact.

The Four Pillars:

1) Medication Management:

- Inquire about side effects or adverse drug reactions.
- Ask if the patient is using the medication management system.
- Reinforce importance of adherence to a regimen.
- Follow-up on any problems, re-filling medications.

2) PHR:

- Remind and encourage patient to "take your PHR wherever you go" (doctor visits, ER, vacation, etc.).
- Reinforce the importance of updating the PHR after each health care encounter.

3) Red Flags:

- Quiz patients about identifying and responding to red flags.
- Instruct patient how to access health care system, including nights and weekends: "Call your Dr.'s office immediately if any of the following occur: fever, bleeding, confusion, uncontrollable pain, increased tiredness."

4) PCP and Specialist follow-up:

- Review importance of scheduling and completing follow-up visit
- Ascertain whether visit has been scheduled/completed
    - Encourage patient to prepare questions and write them down in the PHR
    - Remind patient to take PHR with Medication Record to visit
- If visit has been completed:
    - Ask if patient reviewed Medication List with PCP/Specialist and clarified any discrepancies
    - Ask patient about any changes to the plan of care
    - Encourage patient to keep track of updates in PHR

Other tips:

- Conversation tools and probes to build rapport and elicit information:
    - "What has been going well since our last call/visit?"
    - "Since the last time we talked, has anything changed? (with your medications, health care plan…)"
    - "How confident are you about…?"
    - "When I visit/call you again, let's make sure we talk about…" (for calls 2 and 7 and the home visit).

- "Let's review the specific things you are going to do within the next couple of days/weeks."
- Provide positive reinforcement. The patients/caregivers need to hear what they're doing well.
- Be creative in addressing patient/caregiver needs [see previous comments]

Common challenges:

- It is difficult to reach some patients. Persistence is key.

Appendices

A. Personal Health Record:

http://www.caretransitions.org/documents/phr.pdf

B. Care Transitions Measure:

http://www.caretransitions.org/measures.htm

C. Sample Transition Coach Charting Form

http://www.caretransitions.org/documents/Intervention-Pillars.pdf

D. Medication Discrepancy Tool

http://www.caretransitions.org/documents/MDT.v3.pdf