Get Started Implementing the Care Transitions Intervention® in Your Community

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

April 2013
Version 2.1

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

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Rebecca Sandall
June 4, 2013

Washington Stat Department of Socia & Health Services
ALTSA Aging and Long-Tern Support Administration

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Objectives

- Identify resources in the Tool Kit for building and maintaining partnerships in your community
- Learn how to use the Tool Kit to promote coach success in the field
- Review outcome metrics that can show your Care Transitions Intervention® (CTI®) Program is making a difference

What the Tool Kit Is

- It provides tools to support implementation of CTI® in your community
- It allows you to build on what already exists rather than “re-inventing the wheel”
- It is an interactive PDF with web links and guidelines
- It contains a zip-file of modifiable forms and tools

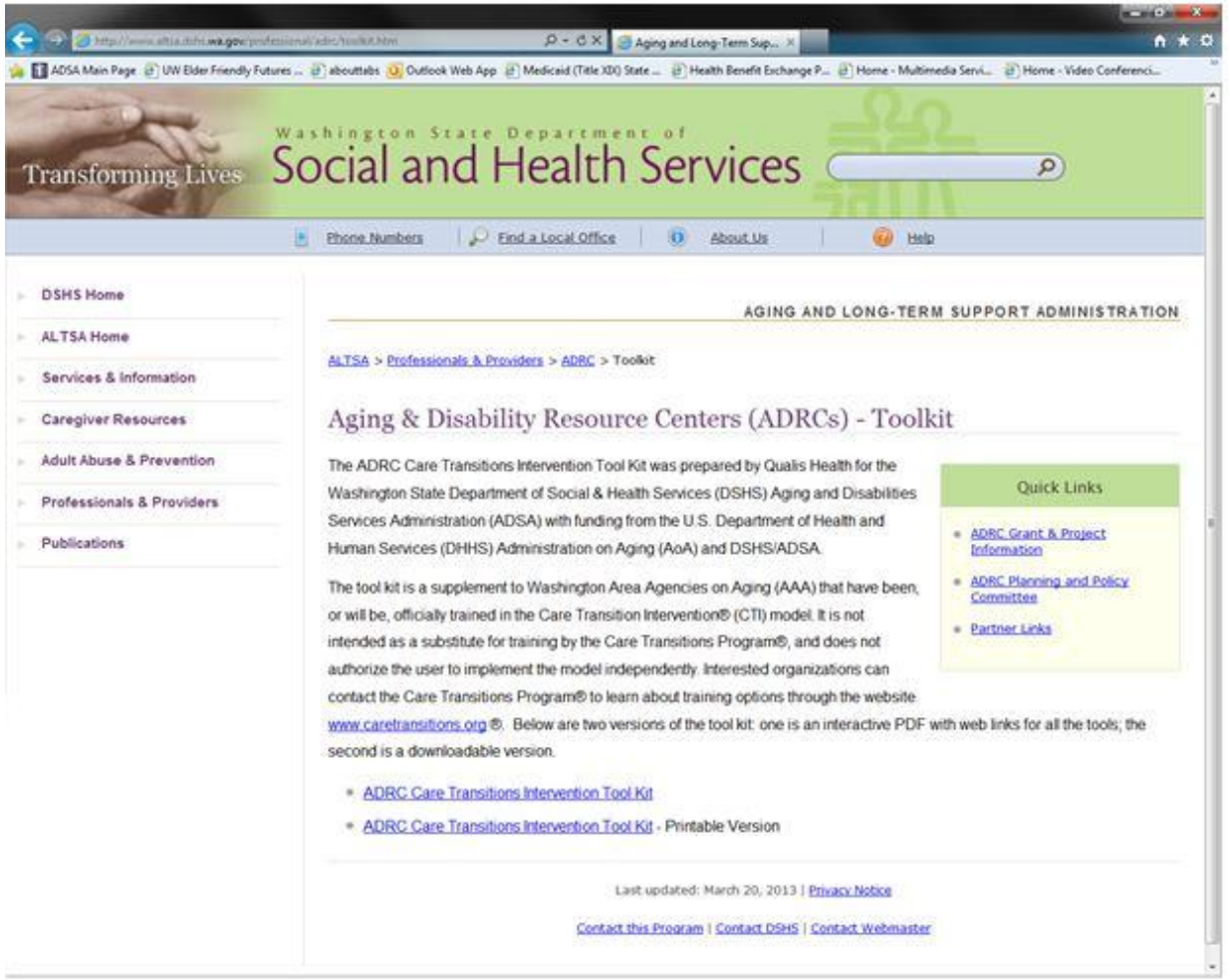
What the Tool Kit Is Not

- It is not intended as a substitute for training in CTI® by the Care Transitions Program® *
- It does not authorize the user to implement CTI® independently
- It is not managed by a webmaster, so content is current as of the date released or revised

* *Parties interested in learning about training options may contact the Care Transitions Program® at www.caretransitions.org*

Getting to the Tool Kit

http://www.altsa.dshs.wa.gov/professional/adrc/toolkit.htm



Navigating the Tool Kit

Get Started Implementing the Care Transitions Intervention® in Your Community: A Tool Kit for Washington State's Area Agencies on Aging

Section 1:
Learn about the CTI® Model

- Describes “Why CTI®” and contains verbiage that can be used in presentations
- Links from www.caretransitions.org can be used as or handouts or talking points with potential partners:
  - CTI® Summary
  - Four Pillars Table

Section 2: Train with the Care Transitions Program®

- **CTI® Program Design**
- **CTI® Training with the Care Transitions Program®**

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.

Section 3: Identify, Orient and Mentor Your Coaches

- Coach selection and support in the field are essential to the success of your CTI® Program
- Attrition is a factor: reference this section when filling any coach position, even if you plan to fill the position internally

Section 3: Identify, Orient and Mentor your Coaches

Tools

- **Transitions Coach® Qualifications**
- **Transitions Coach® Position Description**
- **Transitions Coach® Interview Questions**

Section 3 – Identify, Orient and Mentor Your Coaches

Section 1 Learn about the CTI® Model

Section 2 Train with the Care Transitions Program®

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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

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CTI® Program Design | page 6 of 18

Section 3: Identify, Orient and Mentor Your Coaches

Tools

- Transitions Coach® Orientation Checklist
- Field Orientation Guidelines
- Transitions Coach® Debrief Form
- Home Visit Log

Section 4:
Generate Patient Referrals

- Teach coaches how to pitch your program to various audiences.
- With existing programs, you must get in front of facility audiences again and again. Once is not enough!
- Have a consistent presence on the units, and get to know staff.
- If your program is static, approach new partners.

Section 4:
Generate Patient Referrals

Tools

- Transition Coach Referral Criteria-Example
- Emergency Department Referral Criteria-Example
- CTI® Talking Points for Front Line Staff
- Sample Scripts
- Physicians Need To Know About Coaches
- SJH Care Transition Coach Program® Handout
- NWRC CTI® Postcard

Section 5:
Coach Your Patients

Tools

CTI Phone Call Guidelines

Transition Coach® Troubleshooting Guide

- Scenario: Patient to be discharged Friday afternoon
  - Cue patient to consider how they will get medications
  - Coach patient to have med orders faxed or called to pharmacy
  - Patient needs to know how to respond to red flags after hours

Section 5:
Coach Your Patients

Tools

Helpful Websites and Links-Examples

- National Library of Medicine Medical Search Engine “Medline Plus”
- Interactive Tutorials

Section 5:
Coach Your Patients

Tools

- Teach Back Presentation
- Teach Back Cards
- Personal Health Record
- Shared Care Plan

Section 6:
Document Your Work

Contains

- Links to Care Transitions Program® website tools
- Tools developed during the successful Medicare-funded Stepping Stones Project of Whatcom County
- Documents required by ADSA for AoA grant-funded care transitions work in specific regions
- References tools developed and licensed by Insignia Health www.insigniahealth.com

Section 7:
Collect Data

- Coaching documentation is distilled into data that are reported to internal and external stakeholders.
- Coaching activity metrics (productivity)
- Patient/Client Outcomes

Section 8:
Evaluate and Improve Your Program

An example from a successful program in Washington State:

- The Option D: ADRC Evidence Based Care Transitions Grantees Evaluation Plan

Section 8:
Evaluate and Improve Your Program

- Measuring your processes and outcomes is essential, and allows you to continuously adapt the CTI coaching program for success within a specific community.
- The Plan-Do-Study-Act (PDSA) Cycle is a method for implementing and testing small changes within your organization to see if they lead to better outcomes and quality improvement.
  http://www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx

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When Might You Use the Tool Kit?

Outreach:

- A coach is establishing a relationship with the SWs/RNs at the hospital for referrals.
- A coach is developing hand-outs for meet and greet in the hospital.
  - Section 1 has a Four Pillars table that can be given as a hand-out. Section 4 has referral criteria for ED and general hospital floors and **CTI Talking Points for Frontline Staff**.

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 SM is to empower the patient/caregiver to:

- Assert a more active role during care transitions and
- Develop lasting self-management skills.

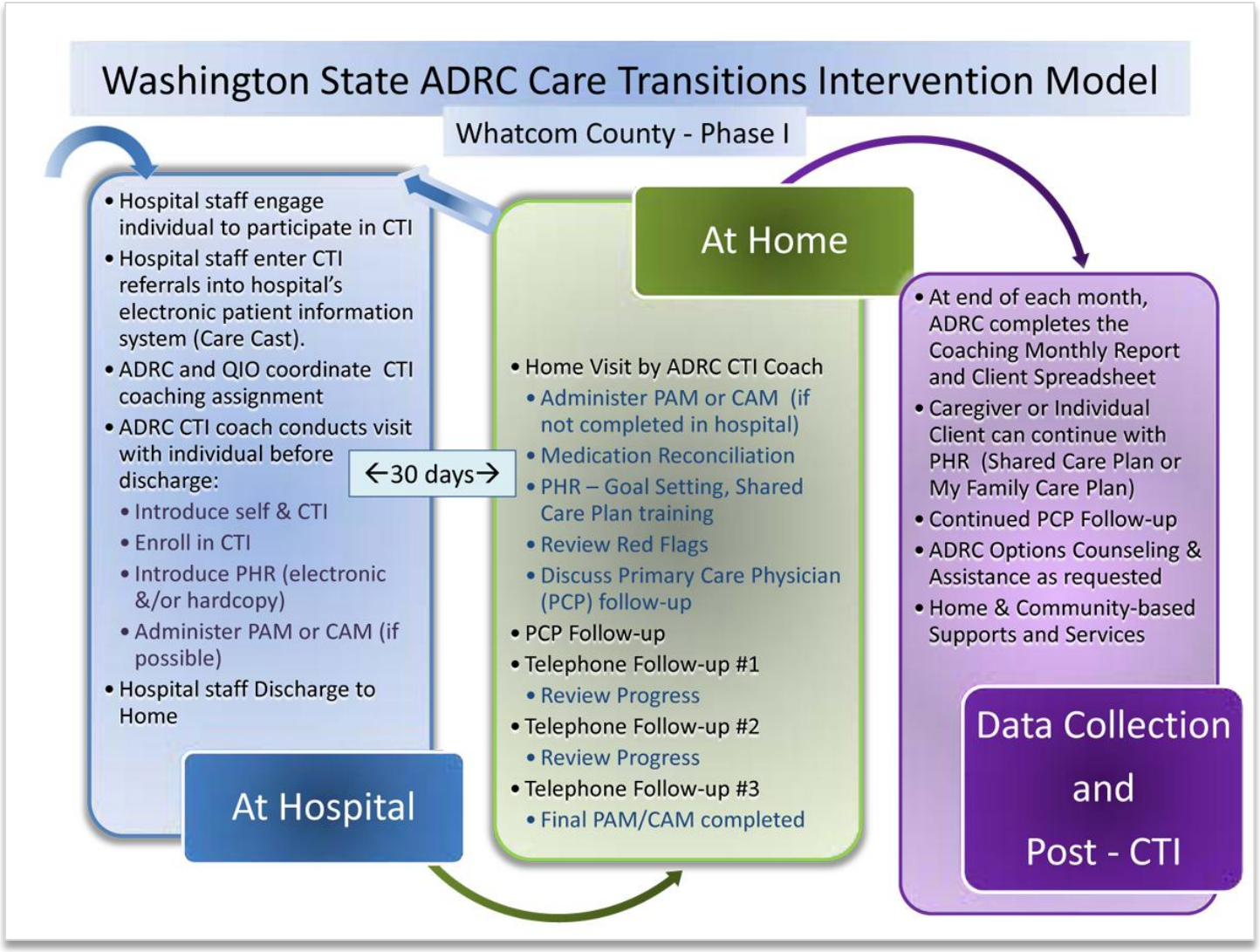
Quality Insights

Quality Insights of Pennsylvania

This material was prepared by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization for Pennsylvania, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication No.93OW-PA-CART-09.40 App.4/09

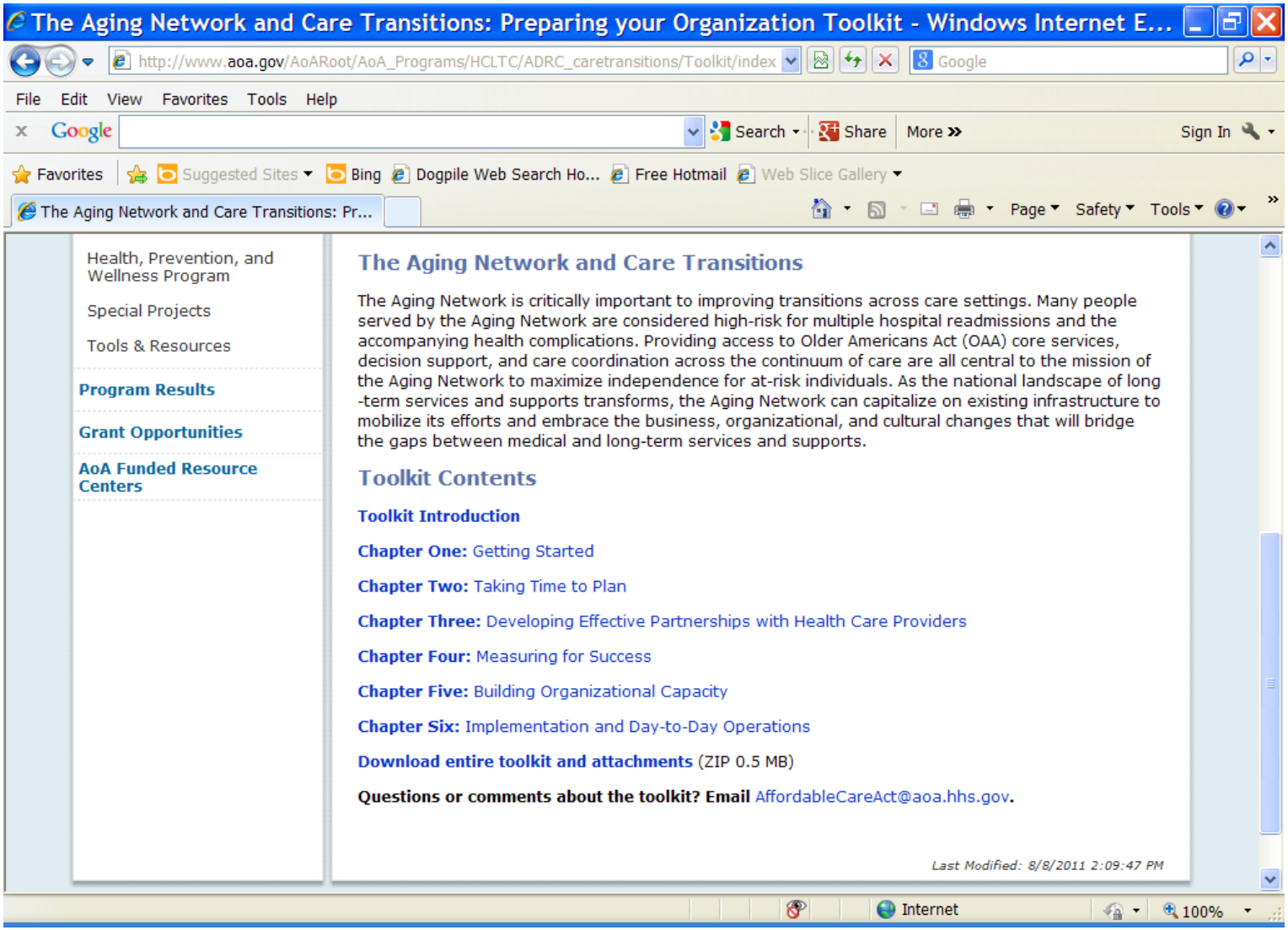
When Might You Use the Tool Kit?

- A supervisor needs to make a CTI® presentation
  - Sections 4 and 8 have ready-made and modifiable hand-outs
  - Consider using a slide deck from the AoA Tool Kit found in section 6
  - Bring one of the front-line coaches to:
    - Tell de-identified stories from the field and create enthusiasm
    - Learn how to present on CTI to various audiences


Washington State ADRC Care Transitions Intervention Model
Whatcom County - Phase I
• 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
At Hospital
←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
• 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
Data Collection and Post - CTI

When Might You Use the Tool Kit?

- Potential partners are struggling with how CTI fits into their care transition strategies.
  - Sections 1 and 5 have ideas and materials, as does the **Helpful Websites and Links** tool in Section 5 such as the CFMC and AoA Tool Kits which provide a national context for Care Transitions in general and CTI specifically.


The Aging Network and Care Transitions: Preparing your Organization Toolkit - Windows Internet E...
http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_caretransitions/Toolkit/index
File Edit View Favorites Tools Help
Favorites
The Aging Network and Care Transitions: Pr...
Health, Prevention, and Wellness Program
Special Projects
Tools & Resources
Program Results
Grant Opportunities
AoA Funded Resource Centers
The Aging Network and Care Transitions
The Aging Network is critically important to improving transitions across care settings. Many people served by the Aging Network are considered high-risk for multiple hospital readmissions and the accompanying health complications. Providing access to Older Americans Act (OAA) core services, decision support, and care coordination across the continuum of care are all central to the mission of the Aging Network to maximize independence for at-risk individuals. As the national landscape of long-term services and supports transforms, the Aging Network can capitalize on existing infrastructure to mobilize its efforts and embrace the business, organizational, and cultural changes that will bridge the gaps between medical and long-term services and supports.
Toolkit Contents
Toolkit Introduction
Chapter One: Getting Started
Chapter Two: Taking Time to Plan
Chapter Three: Developing Effective Partnerships with Health Care Providers
Chapter Four: Measuring for Success
Chapter Five: Building Organizational Capacity
Chapter Six: Implementation and Day-to-Day Operations
Download entire toolkit and attachments (ZIP 0.5 MB)
Questions or comments about the toolkit? Email AffordableCareAct@aoa.hhs.gov.
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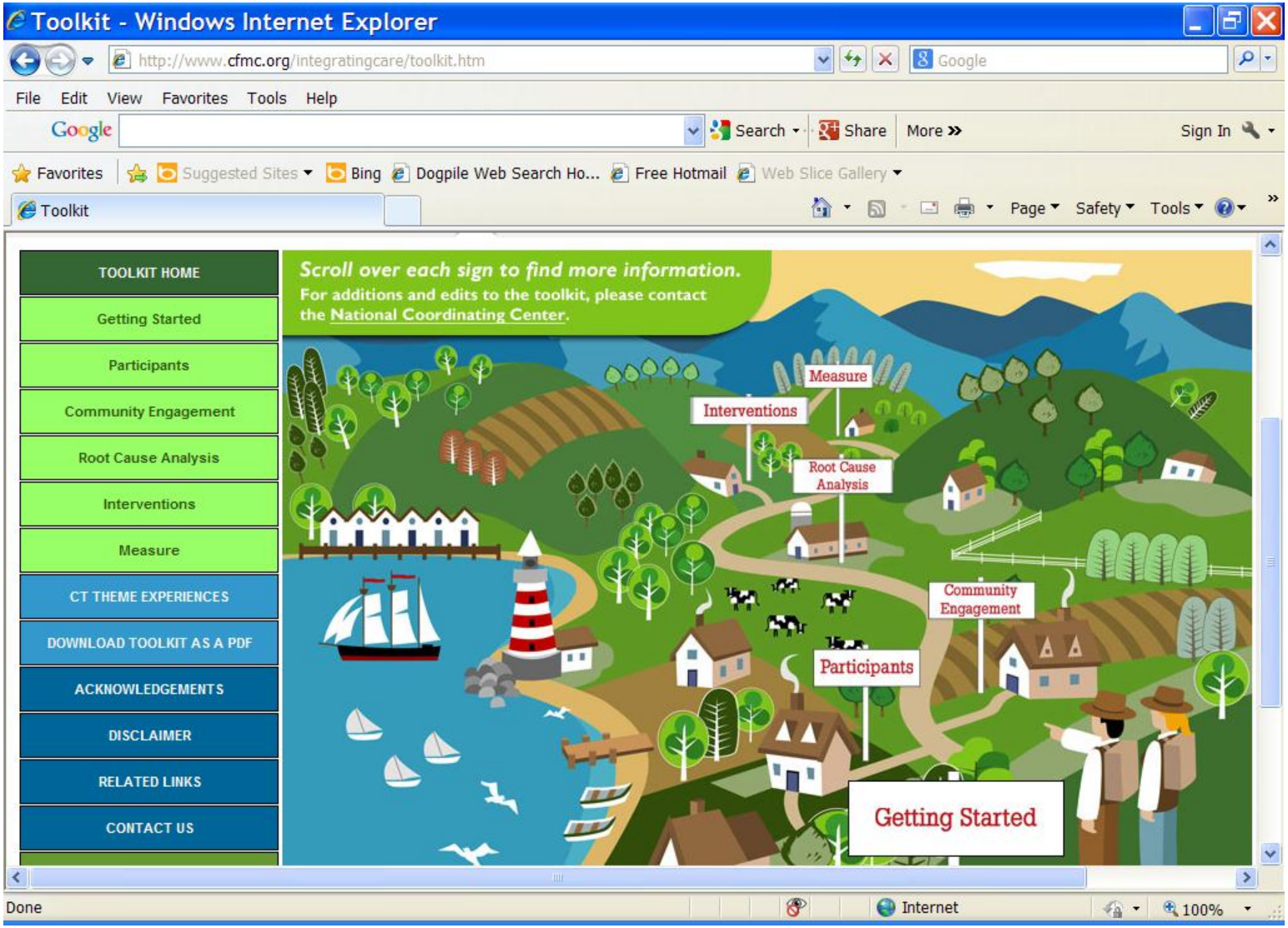
Toolkit - Windows Internet Explorer
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More
Sign In
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Free Hotmail
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Toolkit
Page
Safety
Tools
TOOLKIT HOME
Getting Started
Participants
Community Engagement
Root Cause Analysis
Interventions
Measure
CT THEME EXPERIENCES
DOWNLOAD TOOLKIT AS A PDF
ACKNOWLEDGEMENTS
DISCLAIMER
RELATED LINKS
CONTACT US
Scroll over each sign to find more information.
For additions and edits to the toolkit, please contact the National Coordinating Center.
Measure
Interventions
Root Cause Analysis
Community Engagement
Participants
Getting Started
Done
Internet
100%

When Might You Use the Tool Kit?

- Supervisor Jane just had a coach submit his resignation.
  - Jane can check Section 3 for tips on coach selection, and Section 2 to learn about training options.
  - Why did the coach resign? Jane may need to look at the structure of her CTI® program or her staffing model. Section 8 describes program evaluation and improvement methods.

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

When Might You Use the Tool Kit?

- A coach is struggling with medication reconciliation skill transfer.
  - Refer to the description of the medication reconciliation process in the **Multi-Event Medication Discrepancy Tool® Guidelines** found in Section 6.
- A coach is running into challenging situations on many fronts.
  - The **CTI® Trouble-shooting Guide** in Section 5 offers practical suggestions from real-life coaching experiences.

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

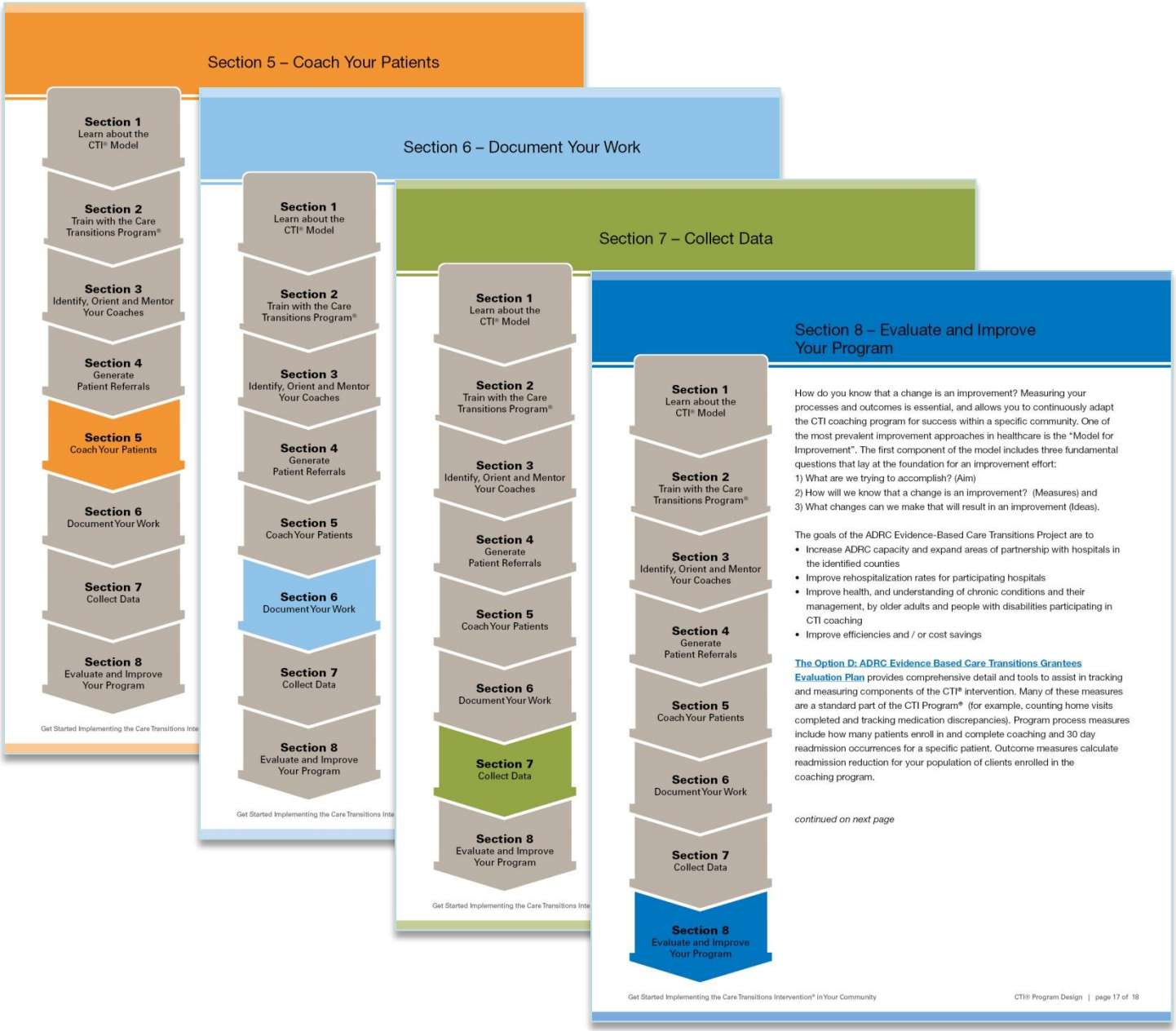
- The patient is asked to gather up all their medications in a single place for review by the patient, any actively involved caregiver and the Transition Coach®. (It can save time if, during the call to set-up or confirm the home visit date/time, the Transition Coach® asks the patient/caregiver to have 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.

When Might You Use the Tool Kit?

- Funders or partners require outcome data as part of your contract or agreement.
  - Check Section 7 for activity and outcome metrics that meet those requirements as well as for tools and spreadsheets to aid in tracking and reporting data.
  - Refer to the **Option D: ADRC Evidence Based Care Transitions Grantees Evaluation Plan** in Section 8 to see how other programs in the State collected and reported data.

When Might You Use the Tool Kit?

- An administrator or supervisor must create a report on their CTI® program.
  - Sections 6,7 and 8 have many resources for documenting, reporting and evaluating. Consider providing stories from the field


Section 5 – Coach Your Patients
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How do you know that a change is an improvement? Measuring your processes and outcomes is essential, and allows you to continuously adapt the CTI coaching program for success within a specific community. One of the most prevalent improvement approaches in healthcare is the "Model for Improvement". The first component of the model includes three fundamental questions that lay at the foundation for an improvement effort:
1) What are we trying to accomplish? (Aim)
2) How will we know that a change is an improvement? (Measures) and
3) What changes can we make that will result in an improvement (Ideas).
The goals of the ADRC Evidence-Based Care Transitions Project are to
• Increase ADRC capacity and expand areas of partnership with hospitals in the identified counties
• Improve rehospitalization rates for participating hospitals
• Improve health, and understanding of chronic conditions and their management, by older adults and people with disabilities participating in CTI coaching
• Improve efficiencies and / or cost savings
The Option D: ADRC Evidence Based Care Transitions Grantees Evaluation Plan provides comprehensive detail and tools to assist in tracking and measuring components of the CTI® intervention. Many of these measures are a standard part of the CTI Program® (for example, counting home visits completed and tracking medication discrepancies). Program process measures include how many patients enroll in and complete coaching and 30 day readmission occurrences for a specific patient. Outcome measures calculate readmission reduction for your population of clients enrolled in the coaching program.
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CTI® Program Design | page 17 of 18

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Transitions Coach® Patient Report Form

Visit Date: _____
Facility: _____

Blue Font: Essential data elements

Black Font: optional data elements completed as applicable

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

- ☐ 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:

Red Flags
Improvement Opportunities

- ☐ 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:

Follow-up, After Care
Improvement Opportunities

- ☐ Unclear what services were set up
- ☐ No contact info for service provider: HHA, DME, OP Svcs (PT/OT/SLP, sleep study, cardiac rehab, counseling,...) PCP, Specialist, Labs, Imaging, Home Care, other:
- ☐ F/U appts not made, or
- ☐ F/U appt instructions unclear
- ☐ Issue with pending test results
- ☐ Unsure which provider is managing what condition
- ☐ Declined SNF: no home health referral
- ☐ Other:

DC Teaching
Improvement Opportunities

- ☐ 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:

Social Needs
Improvement Opportunities

- ☐ 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®]

When Might You Use the Tool Kit?

- A coach feels burned out/stuck.
  - Spend some time in Section 5 reviewing the Phone Call and Trouble-Shooting Guidelines. Learn about conditions and procedures in the interactive tutorials found in the Helpful Websites. Attend the monthly national and State coach support calls.

When Might You Use the Tool Kit?

- Your agency is seeking new or additional CTI® funding.
  - Go to Section 8-Evaluate and Improve your Program, and also use **The Option D: ADRC Evidence Based Care Transitions Grantees Evaluation Plan** as a template
- A coach needs to measure whether CTI® coaching is making a difference with their clients.
  - Check out Section 7

Questions?