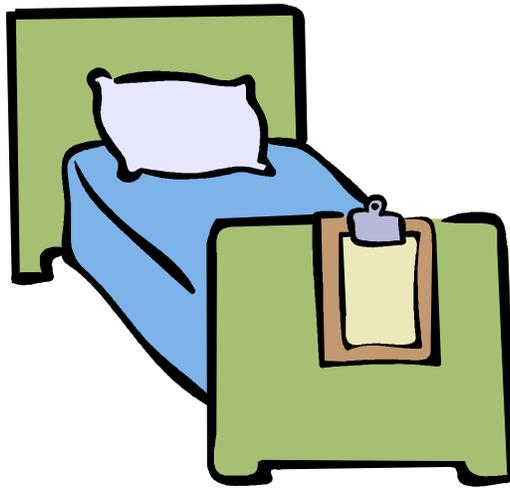


# Transitions of Care Toolkit



Transitions of Care (TOC) Toolkit for the 2012 Quality Improvement Project (QIP) and 2013 Performance Improvement Project: Improving Transitions Post-hospitalization for Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), and Special Needs BasicCare (SNBC) Members.

Provided by:



## Transitions of Care Toolkit

This health plan project focuses on improving transitions of care from hospitals.

- This project was implemented in 2013 and strives to decrease the rate of Minnesota Senior Health Options (MSHO), MSC+ and SNBC hospitalized members who are readmitted within 30 days of discharge by enhancing care coordinator tools and resources for their interactions with members after discharge.

### ***Importance of effective transitions of care***

Based on research about preventable hospital readmissions, Medicare implemented a program in October 2012 that financially penalizes hospitals with excessive readmissions within 30 days of discharge. Research determined that inadequate discharge planning is one factor that contributes to readmissions. In response to the potential Medicare penalty, many Minnesota hospitals joined the statewide Reducing Avoidable Readmissions Effectively (RARE) campaign and implemented discharge programs that improve transitions and thereby, reduce the risk of readmission. RARE provided training to hospitals on three evidence-based discharge programs: Care Transitions Intervention<sup>®</sup>, Project RED and Safe Transitions. These programs encompass the same basic components of effective transition but have variation in structure and emphasis. The following links provide additional information about the RARE campaign and two of the three discharge programs.

<http://www.rarereadmissions.org/>

<http://www.caretransitions.org/>

<https://www.bu.edu/fammed/projectred/>

Eric Coleman, MD, is a geriatrician and researcher who developed the Care Transitions Intervention<sup>®</sup>. The primary program goal is to engage and empower individuals and their caregivers to manage their own care. Program components of effective transition are labeled the Four Pillars.

- Medication self-management; this requires accurate medication reconciliation.
- Timely primary care or specialist follow-up.
- Knowledge of red flags, i.e. knowledge of the warning signs that indicate the condition is worsening and how to respond.
- Use of a personal health record that the individual or caregiver manages.

Research by Brian Jack, MD, the developer of Project RED, shows that the following factors place individuals at greater risk of readmission.

- Elderly
- Length of stay
- More than one condition
- Frequent hospitalizations (>2 in 6 months)
- Low health literacy
- Depression
- Limited or lack of patient activation
- Male
- Substance abuse

## ***Resource topics***

This toolkit offers tools and information that can help you better identify and address some of the identified risk factors for readmission, such as limited patient activation, low health literacy, depression and substance abuse; as well as other important topics that can play a role in optimal recovery, i.e. falls, cognitive impairment, pain. Several links provide screening tools and scoring instructions.

### ***Personal health record***

Developing and maintaining a personal health record is one of the four pillars of Dr Coleman's Care Transition Intervention® and is recommended by several national organizations that encourage self management. Use of a personal health record reflects the individual's or caregiver's basic understanding of his or her medical condition/s and treatment as well as the motivation to manage his or her own care. Personal health records typically encompass information about current treating practitioners (including pharmacy and ancillary support services) and their contact information, current conditions, warning signs (or red flags) that warrant taking action, and current medications with instructions for use. Some personal health records may also include space for allergies, immunizations, medical appointments, questions for healthcare practitioners, notes and personal goals. Suggested personal health record templates are available at the following links.

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

<http://www.champ-program.org/static/Personal Health Record for BPIP.pdf>

### ***Health literacy***

Nearly one in two Americans has difficulty understanding and using health information. The Minnesota Health Literacy Partnership offers information and training on health literacy on their website. In particular, the teach-back method is a straightforward method to assess an individual's understanding of health information. We encourage you to view the training on the teach-back method if you have not already done so. The teach-back method is recommended by the RARE campaign.

<http://healthliteracymn.org/resources/presentations-and-training>

### ***Depression***

Depression is a common mental illness and often co-occurs with chronic medical conditions such as diabetes and heart disease. It can be difficult to identify when the individual has other conditions that have similar symptoms; for example, fatigue or loss of appetite. Two studies determined that the presence of depression or depressive symptoms doubled or tripled the risk of readmission within 90 days of hospital discharge.

#### **Depression screening questionnaires**

The **Patient Health Questionnaire-9 (PHQ-9)** is a nine-item self-report questionnaire that is used by many medical care systems and mental health clinics in Minnesota to screen for and monitor treatment of depression. The questionnaire was developed in the 1990s, and the questions reflect the primary symptoms of depression. The score (0-27) provides an indication of the presence of depression as well as an estimate of severity. It can be administered on paper or orally and is available in many languages. Pfizer holds the copyright but allows use at no charge.

<http://www.phqscreeners.com/> (page 109)

The **Geriatric Depression Scale (GDS)** was developed in 1982 because it was thought that yes/no questions would be easier for elderly people to answer. There are 30-item and 15-item forms. It can be used with healthy, physically ill or mildly cognitively impaired elderly people. The questionnaire is not copyrighted.

<http://www.stanford.edu/~yesavage/GDS.html>

[https://www.icsi.org/guidelines\\_more/catalog\\_guidelines\\_and\\_more/catalog\\_guidelines/catalog\\_behavioral\\_health\\_guidelines/depression/](https://www.icsi.org/guidelines_more/catalog_guidelines_and_more/catalog_guidelines/catalog_behavioral_health_guidelines/depression/) (page 116)

### ***Substance abuse***

Substance abuse is another important risk factor for hospital readmission. Alcohol or illicit drug abuse can interact with or reduce the benefits of prescription medication. Alcohol or drug abuse can also inhibit the individual's motivation or ability to follow through on recommendations for self care. Of particular concern may be abuse of prescription pain medication.

#### **Substance abuse screening questionnaires**

The **Alcohol Use Disorders Identification Test-C (AUDIT-C)** is a three-item self-report alcohol abuse screening questionnaire. It consists of the first three consumption questions of the ten-item AUDIT developed by the World Health Organization in the 1980s. The score (0-8) indicates the level of severity of alcohol abuse. The questionnaire is not copyrighted.

<http://www.hiv.va.gov/provider/manual-primary-care/alcohol-misuse-tool1.asp>

The **CAGE-AID** is a four-item self-report questionnaire that can assist in detecting alcohol or drug use disorders. The alcohol-only version (CAGE) was developed in the 1970s and is probably the best known screening questionnaire in primary care. The score (0-4) detects the likelihood of the presence of an alcohol or drug disorder but cannot detect risky use.

<http://www.partnersagainstpain.com/printouts/A7012DA4.pdf>

<http://lib.adai.washington.edu/dbtw->

[wpd/exec/dbtwpub.dll?BU=http%3A//lib.adai.washington.edu/instrumentsearch.htm&TN=Instruments&CS=0&QY=find%20%28AccessNo%20ct%20321%29&RF=Full&DF=Full&MR=&NP=3&RL=0&DL=0&XC=&ID=&AC=QBE\\_QUERY](http://lib.adai.washington.edu/instrumentsearch.htm&TN=Instruments&CS=0&QY=find%20%28AccessNo%20ct%20321%29&RF=Full&DF=Full&MR=&NP=3&RL=0&DL=0&XC=&ID=&AC=QBE_QUERY)

### ***Falls prevention***

Minnesota has the fifth highest fall death rate in the United States. Adults age 65 and older account for 86% of deaths due to falls. Many elderly adults are at greater risk for falls after hospitalization. The Minnesota Falls Prevention website has materials for individuals and health care providers on screening and prevention.

<http://www.mnfallsprevention.org/>

### ***Cognitive screening***

Related to the issue of low health literacy is the issue of cognitive impairment. The **Short Portable Mental Status Questionnaire (SPMSQ)** was developed in 1975 to assist clinicians in screening elderly people for organic brain deficits.

<http://www.healthcare.uiowa.edu/igec/tools/cognitive/SPMSQ.pdf>

### ***Pain screening***

Acute and/or chronic pain reduces the ability to think clearly and function optimally. The website offers screening tools and information about pain management.

<http://www.geriatricpain.org/Content/Assessment/Intact/Pages/default.aspx>