Preferred
Care at Home®

Smooth TRANSITION CARE

Better Communication for Better Care

Improving Readmission Rates in the Elderly

When 73-year-old Alice Trimble* checked out of the hospital, where she was being treated for congestive heart failure, she returned to her three-bedroom home of 40 years. It was the type of house where memories seeped from the walls. This was where Mrs. Trimble and her husband raised their two daughters, and where Mr. Trimble passed away two years ago.

Mrs. Trimble's daughter Amy took her home and stayed with her for the weekend. But with work and a family of her own a plane ride away, Amy had to leave before she wanted—and before Mrs. Trimble was ready for her to.

Depressed, weak and drained, Mrs. Trimble missed her first doctor's appointment. She couldn't keep her medication straight—so many pills. Within a month, Mrs. Trimble was back in the hospital with another episode.

On average, if you discharge five Medicare patients from a hospital today, at least one will check back in within a month. Thirty-four percent will be back within 90 days. Most of these readmissions are preventable, so Medicare has announced it will start financially penalizing hospitals that have high readmission rates.

The health-care industry has been working to identify causes of readmission at hospitals and other acute-care facilities, and to put systems in place to thwart them. But solving

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** Fictional patient used to demonstrate a typical case.*

the problem isn't as simple as it may sound. In part, that's because not all the causes happen at the facility. Many happen during the transition and at home.

Nonetheless, leaders in the senior-care industry are beginning to find solutions.

Preventing Senior Readmissions: A Specialized Problem

Hospitals and other health-care facilities are experimenting with a variety of techniques to improve their readmission rates. But there's a catch: Seniors, who make up a large portion of readmissions, are a special group, and what works for most people may not work for them.

Usually, when someone is discharged from an acute-care facility, families are expected to take on many of the recovery responsibilities. Parents help children rehabilitate. Spouses help partners shower, get to doctor appointments and remember medication.

Older people are less likely to have that strong family support. Adult children have their own busy lives; they may not even live in town. Spouses are often impaired or deceased. Compounding all this, seniors may be depressed because they're in a weakened, vulnerable state. It's no wonder many elderly people end up back in the hospital.

Seniors need a constant—someone to walk them through discharge, help them get home and encourage them through the recovery process. They also need help with organization—a storage tool for instructions, appointments and medication information.

Today, some seniors are getting all that from experts trained in transition care.

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Transition Coaching: Helping Reduce Readmission Rates and Increase Quality of Life

To help elderly people recover more successfully, a new service is emerging: transition coaching.

A transition coach is a specially trained expert who helps the senior from the last day in the acute-care facility to the following weeks at home. The coach empowers and encourages the patient to take a proactive role in his or her recovery—to stay out of the hospital and on an upward slope.

The coach meets the patient in the facility and helps improve communication with the staff, patient and family. The coach also helps make organized records about things like medication and follow-up appointments.

After the patient is discharged, the coach becomes an encourager and accountability partner. Through check-ins—phone calls or visits—the coach ensures that practical matters are addressed. Does the senior have transportation to follow-up appointments? Is he taking his medication? Does she need a depression evaluation? The coach provides a listening ear, an encouraging word, and practical advice.

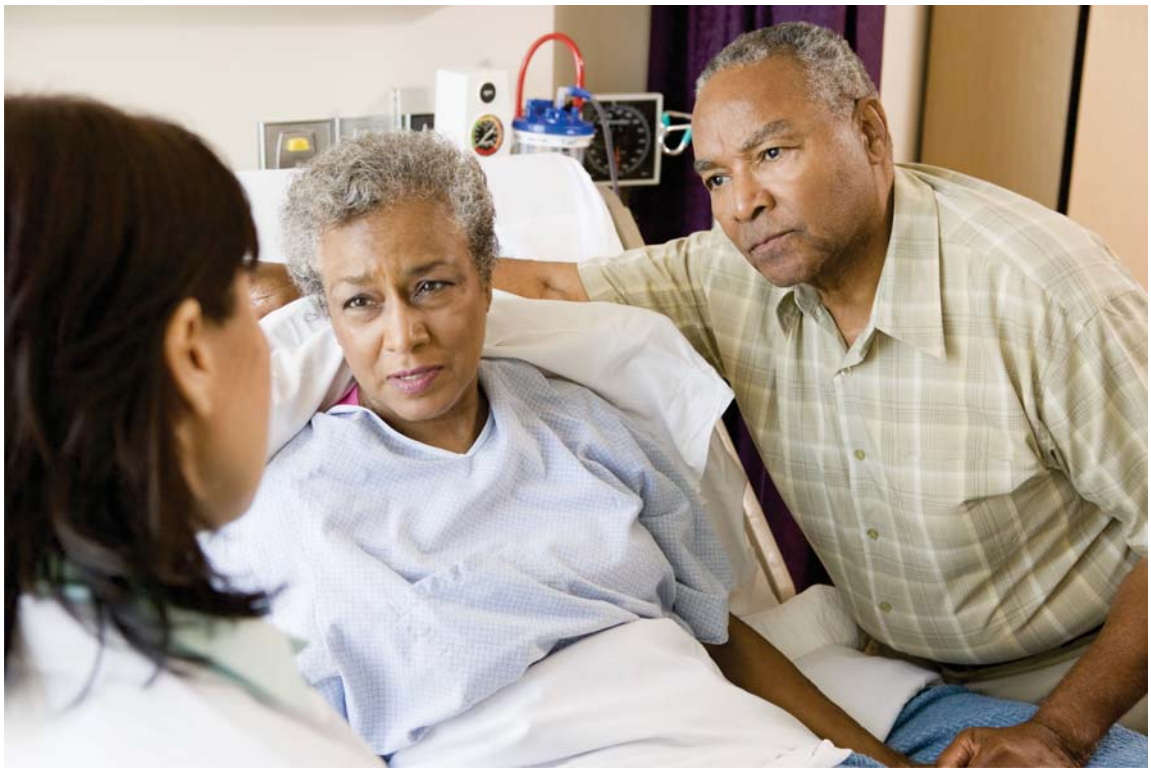
Where to Find Transition Coaching

Agencies that offer transition coaching are on the leading edge of the senior-care industry. Programs still aren't available everywhere.

Most in-home care agencies still only provide traditional forms of care—things like transportation and meal preparation. If they offer so-called "transition care," it's often limited to printed educational information.

Traditional services are important, but they don't provide that continuity of care needed to reduce readmission rates. Offering transportation, for example, doesn't help seniors organize and plan for appointments.

Preferred Care at Home is among the first in the senior-care industry to develop a transition-coaching service.



At Preferred Care at Home, we are among the first in the senior-care industry to develop a transition-coaching service. After all, as an in-home care agency, we've experienced the readmission problem first-hand. We feel a responsibility not to sit on the sidelines but to become part of the solution.

So we delved into the research. We identified what was causing readmissions. And we looked at burgeoning transition programs that have been working in different areas of the country.

Finally, we developed our evidence-based transition program. We call it Smooth-Transition Care.

What Is Smooth-Transition Care?

Smooth-Transition Care combines compassionate transition coaching with an in-depth organization tool called the *Personal Health Record*. Our goal is to educate, empower and encourage seniors to recover proactively and optimally.

What we found in the literature is that seniors need a constant. With all the commotion of different providers coming at them during discharge, then the flurry of follow-up appointments and medication changes, things get confusing. Even personal caregivers—family or hired—come in and out of the picture. Seniors need someone anchoring all this activity and translating when things get confusing.

Patients also need a central place to store all that information—a tool that's easy to navigate and access. Otherwise, complicated care instructions get forgotten, medications get confusing and follow-up appointments get missed.

But the tool shouldn't just be for the patient. Health-care providers and family members need access to up-to-date information as well. Relatives often serve as caregivers. They need to double-check instructions and appointment dates. And providers need to easily view current medication lists, scheduled appointments and pending tests.

So we developed the Preferred Care at Home *Personal Health Record*, and then we decided to offer it for free.

The *Personal Health Record:* A Free Tool Kit to Improve Recovery

Preferred Care at Home's *Personal Health Record* is a health-history tool, an educational manual and a care playbook wrapped into one. We think of this in-depth, 15-piece tool kit as our clients' health-care bible.

> Seniors and their families can download the *Personal Health Record* for free at our website, www.PreferHome.com.

Perhaps most important, **Smooth-Transition Care clients can also store their records online in a secure database**. Family members, caregivers and health-care providers can access the most up-to-date information anytime with a special code. This aspect is essential to reducing readmission rates, according to the National Transitions of Care Coalition, which says communication between everyone involved in the recovery process must be improved.

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How the *Personal Health Record* Improves Communication to Reduce Readmissions

Patients forget up to 80 percent of what health-care providers tell them–and what they do remember is wrong almost half of the time.

In 2003, 50 to 70 percent of hospitalized Medicare patients saw an average of 10 or more doctors—during a single hospital stay—according to the National Transitions of Care Coalition, which is dedicated to improving transition care. People with chronic conditions see up to 16 doctors every year.

In a September 2010 report, the coalition wrote:

> The U.S. health care system often fails to meet the needs of patients during transitions because care is rushed and responsibility is fragmented, with little communication across care settings and multiple providers. … Poor communication during transitions from one care setting to another can lead to confusion about the patient's condition and appropriate care, duplicative tests, inconsistent patient monitoring, medication errors, delays in diagnosis and lack of follow through on referrals.

Starting in the acute-care facility itself, the *Personal Health Record* and guidance from the Smooth-Transition coach help streamline communication. The *Record* tells patients what questions to ask before discharge—and gives them a place to write it down. After all, patients forget up to 80 percent of what health-care providers tell them—and what they do remember is wrong almost half the time, according to a 2003 study in the *Journal of the Royal Society of Medicine*. Older people especially have trouble remembering, the study found.

The patient then takes the *Personal Health Record* home and inputs any further instructions from other providers, along with dates for follow-up appointments, medication prescriptions, pending tests, and other essential information. With the patient's permission, all information is continually added to the secure online database.

Clients either bring their *Personal Health Record* to health-care appointments or give the online-access code to their providers. Either way, **the provider gets access to the most up-to-date information on all aspects of the patient's care**.

Four More Readmission Risks
How the *Personal Health Record* Helps

Improving health-care communication is a broad goal. At Preferred Care at Home, we wanted to hone in on more-specific problems as well. We found that studies reveal four main causes of readmission:

1. **Poor medication management**
2. **Missed follow-up appointments**
3. **Falls**
4. **Lack of education about chronic-illnesses care**

So we structured much of the *Personal Health Record* around these topics.

Readmission Risk 1:
Poor Medication Management

Transition-care experts agree that poor medication management is one of the top readmission causes. The most common complication after a hospital discharge is an adverse drug event, according to the Agency for Healthcare Research and Quality.

Even before a hospital stay, seniors are at risk for medication errors. Half of elderly people who take medicine four times a day don't take it as prescribed, according to *Pharmacy Times*, a journal for pharmacists. And in a small 2010 study, 64 percent of older people receiving home care made medication errors.

A stay in a care facility complicates things further. The senior goes home with new prescriptions and instructions. If he or she forgot to mention a current medicine or two to the doctor, interactions can occur.

The *Personal Health Record* and Smooth-Transition coach address these problems by encouraging:

- **Clear instructions.** The medications section includes not just the list of drugs but also details: what the pills look like, dosages, when to take them, what they're for, and the start and stop dates. Potential side effects are also listed. Sometimes, patients have adverse events but don't realize a medication could be the cause.

- **Medication reconciliation.** The Smooth-Transition coach will recommend medication reconciliation if the senior has been recently discharged, there's been a change in the drug regimen, or four or more medications have been prescribed. With the contact list in the Personal Health Record, it's easy to get in touch with the appropriate provider. The coach will even volunteer to make the appointment and arrange transportation if needed.

- **Accountability.** Sometimes, seniors delay starting medications. The Smooth-Transition coach helps make sure prescriptions get filled immediately.

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Readmission Risk 2:
Missed Follow-Up Appointments

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Patients miss appointments for many reasons. They forget; they don't have transportation; they don't know which doctor to follow up with. The *Personal Health Record* helps with these problems through organization and communication.

The *Record* features a section for detailed appointment information, including transportation plans (which the Smooth-Transition coach can help arrange). Through the online database, family members, who may be helping with transportation or reminders, can double-check appointment dates and times. The Smooth-Transition coach can also make reminder phone calls if needed.

Readmission Risk 3:
Falls

What lands older people in the hospital more than any other cause of trauma? Falls. According to the Centers for Disease Control and Prevention, one in three people 65 and older falls each year.

A stay at an acute-care facility puts seniors particularly at risk. When they get home, they may be confused or weakened. Basic fall-prevention steps need to be taken, but most people don't know what those steps are.

The *Personal Health Record* educates patients about four simple ways to reduce their risk of falling:

1. **Exercise**.
   After recovery, activity that improves balance and coordination (such as tai chi) is best. During recovery, if the senior is working with a Smooth-Transition coach, the coach will encourage the patient to follow physical-therapy prescriptions, set goals and stay motivated.

2. **Medication evaluation**.
   The *Record* urges the senior to have a doctor or pharmacist evaluate current medicines for risky side effects.

3. **Regular eye exams**.
   You may be wearing the wrong glasses or have a condition such as glaucoma or cataracts that limits your vision. Poor vision can increase your chance of falling.

4. **Home-safety evaluation**.
   Suggestions include removing trip hazards, installing grab bars and improving lighting.

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Readmission Risk 4:
Lack of Education About Chronic-Illness Care

About 80 percent of older people have a chronic illness, according to the CDC. Half have at least two. Yet many don't fully understand their symptoms and what to do when they have a problem. **Instead of calling a health-care provider, they often go straight to the emergency room**—for problems that aren't emergencies.

The *Personal Health Record* devotes its final section to the "Emergency Plan." Detailed, easy-to-follow charts tell when to call a health-care provider and when to call 911. These charts can help decrease unnecessary hospital visits by empowering the patient and family caregivers with knowledge.

Smooth-Transition Care: Helping Reduce Readmissions and Improve Outcomes

In a randomized, controlled trial of a program from the University of Colorado, Denver, that was similar to Smooth-Transition Care, **patients in the program had a 30-percent lower rehospitalization rate** at 30 days than those who had no transition care.

By 180 days, 38 percent fewer patients had been readmitted for the same diagnosis they were originally hospitalized for. The study was published in *Archives of Internal Medicine* in 2006.

At Preferred Care at Home, we want to partner with you to improve senior care. Together, as leaders in the care industry, we'll set a new transition standard. **Please give us a call at (866) 690-7733 anytime.** We're eager to share ideas on how we can work together to make patients' lives better.

If you would like to suggest our services to your patients, we'd love to talk with them about their needs as well—and offer them a free download of the *Personal Health Record*. We look forward to creating compassionate, affordable, effective, evidence-based transition solutions with you.

At Preferred Care at Home, we want to partner with you to improve senior care. Together, as leaders in the care industry, we'll set a new transition standard.

Preferred Care at Home is pleased to offer the *Personal Health Record* to your patients for free. They can download it anytime at www.PreferHome.com. A printed version is included in the Smooth-Transition Care program. This in-depth, 15-piece tool kit includes the following sections:

1. **General Information**:
   identification, emergency contacts, health-insurance information, health history, lifestyle.

2. **Advance Directives**:
   health-care proxy, living-will location, power of attorney.

3. **Health Events**:
   hospitalizations, surgeries, emergency-room visits.

4. **Going-Home Checklist**:
   discharge necessities.

5. **Health-Care Team**:
   contact information for doctors, case managers, therapists and other providers.

6. **Medications**:
   pharmacy information, medication reconciliation, allergies, immunizations, over-the-counter medicines, prescriptions.

7. **Tests & Results**
   (including pending tests).

8. **Limitations, Restrictions & Special Instructions**
   for diet, activity.

9. **Home-Care Services**:
   Medicaid, Medicare, private home-care information.

10. **Fall Prevention**:
    questions about exercise, medication, eye exams, home safety.

11. **Medical Equipment**:
    equipment list, ordering information.

12. **Follow-Up Appointments**:
    location, date, time, reason, telephone number, transportation plan, notes.

13. **What to Take to Appointments**:
    questions to ask, reminder to bring your *Personal Health Record* or key code.

14. **Goals**:
    a plan for accomplishment.

15. **Emergency Plan**:
    when to call a health-care provider and when to call 911.

Frequently Asked Questions

Q. Since Preferred Care at Home also offers in-home care, do patients have to sign up for that in order to get the Smooth-Transition Care?

A. No. The Smooth-Transition program is flexible and customizable. It's a stand-alone service, but it can be paired with in-home care. For some patients, the coach may even be able to serve as the home-care aide.

Q. How often does the Smooth-Transition coach meet with the patient?

A. The coach initially meets the patient at the acute-care facility. They get to know each other, and the coach guides the patient through the discharge process. After that, the meeting frequency is customized according to the patient's needs. Some need weekly meetings, while others may need monthly or quarterly ones. The meetings can be done in person or by phone. In addition to scheduled meetings, the coach is available by phone for questions or concerns that may come up.

Q. How much does the Smooth-Transition program cost?

A. We are committed to keeping our services affordable. Each locally owned franchisee prices services for that area. Please contact your representative for details. Medicare or Medicaid may cover the services under certain circumstances.

Q. How do my patients get the *Personal Health Record*?

A. It's free! Your patients can simply log on to the Preferred Care at Home website, www.PreferHome.com, and download the forms. Or they can give us a call, (866) 690-7733, for a printed version at a small cost.

Q. How do my patients hire a Smooth-Transition coach?

A. They can call us at (866) 690-7733. We'll answer their questions and get them started on a personalized plan.

Preferred Care at Home is a national senior home-care franchise whose number-one goal is to keep clients safe and sound in the comfort and security of where they prefer to be—home.

A wide range of services are provided, including: companionship, housekeeping, meal preparation, personal care, skilled care, medication reminders, accompanying to health-care appointments and much more. Preferred Care at Home's mission is to improve quality of life so much that independence and dignity is restored.

But besides these important services, Preferred Care at Home is also a connector for clients—connecting them with better-organized and easily accessible personal health information for the entire health-care team. The ultimate goal is to minimize hospital readmissions, given that almost one-fifth of people on Medicare may be readmitted within 30 days after they leave, and up to 76 percent of those readmissions may be preventable.

Preferred Care at Home is committed to helping improve client outcomes by facilitating better communications for better care. Give us a call today at (866) 690-7733, and see how we can help be part of the solution.

Preferred Care at Home®

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