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Healthy Seniors

A HEALTHCARE NEWSLETTER FOR NEW YORK SENIORS

FALL/WINTER 2010

SPECIAL CARE TRANSITIONS ISSUE

IPRO

Improving Healthcare for the Common Good®

Helping Patients Transition from One Healthcare Setting to Another:

The Care Transitions Project

As part of IPRO's contract with Centers for Medicare & Medicaid Services (CMS), we are working on a three-year initiative called the Care Transitions Project. The goal of this project is to improve patient and family/caregiver experiences as they move within or between healthcare settings (from one unit to another in a hospital; or from a hospital to another facility or home) and to help patients better manage their care when they return home.

IPRO is working collaboratively with healthcare providers, patients and their families/caregivers and others to improve communications and care coordination across healthcare settings. IPRO is also working directly with healthcare providers to improve the processes by which they keep patients and their family members informed about their conditions and medications in preparation for discharge or transition to another health-care facility or home.

Importance of the Care Transitions Project

Nationally, almost 20% of Medicare beneficiaries are readmitted to the hospital within 30 days of discharge. It is estimated that up to 76% of these re-hospitalizations may be preventable.

Because older patients with chronic illnesses often require care from multiple healthcare professionals in a variety of settings, communication and care coordination among providers, patients and their families/care-givers is critical. If information is not well-communicated or understood, problems such as duplication of services, inappro-priate or conflicting care recommenda-tions, medication errors, and patient and family/caregiver confusion and distress could occur.

All of these issues may ultimately lead to poor health outcomes and higher costs of care due to re-hospital-ization and more frequent use of the Emergency Department.

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Healthy Seniors **is prepared by IPRO, the Medicare Quality Improvement Organi-zation (QIO) for New York State.**

IPRO, a not-for-profit company under contract with the Centers for Medicare & Medicaid Services (CMS), works to improve the quality of healthcare received by Medicare beneficiaries across NYS. More information about IPRO can be found on the last page of this newsletter and by visiting www.ipro.org.

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If I'm going home, how will I get the supplies the doctor recommended?

Who can help me to understand the instructions the hospital staff gave me?

When should I schedule a follow-up appointment to see my doctor?

Will the results of the tests I had in the hospital be sent to my family doctor?

Do I keep taking the new medications I was given while in the hospital?

Awareness is Key

Despite the best intentions of healthcare providers, each healthcare setting tends to operate independently, leaving doctors, nurses and other clinicians unaware of issues in other settings that may impact patient care. During a care transition, it is essential that patients, their families/caregivers and healthcare providers share and understand important patient care information. For example, patients and their families/caregivers might have problems getting their questions answered in the time between discharge from a hospital and their first follow-up appointment with their family doctor. Not having the right information could lead to the patient being hospitalized again; the work being done on behalf of the Care Transitions Project helps to improve processes to reduce the chances of preventable rehospitalizations.

The Care Transitions Project offers free educational materials to help you better communicate with your healthcare providers and manage your chronic illness and medications between visits to your physician and after a discharge from the hospital. These free materials will help you to:

- be better informed about your chronic illness and medications;
- update and share your health information with your doctor and other healthcare professionals;
- become more aware of how you feel, so you can better recognize the signs and symptoms that let you know your health condition is worsening and what to do when you notice a change;
- schedule a follow-up appointment with your doctor; and
- speak up and ask questions when you don't understand what is being said during a visit with your doctor or other healthcare professionals.

These FREE materials can be accessed on the IPRO Care Transitions website at http://caretransitions.ipro.org

Q. What are some of the key issues my family/caregiver and I should focus on in the event I am admitted to the hospital?

A. Below is information including guidelines for you to follow and key questions to ask if you're admitted to the hospital:

Your healthcare team includes you, your family/caregiver, primary care physician, hospital doctor and discharge planner. A discharge planner meets with you before you leave the hospital to review the instructions your hospital doctor has written for you to follow when you go home, and assists in arranging the care you need following your hospital stay.

1. While in the hospital, you or your family/caregiver should follow the guidelines below:
   - Call your primary care physician to let them know that you're in the hospital.
   - Share your doctors' phone numbers and mailing addresses with everyone on your healthcare team.
   - Ask your doctors to:
     - ✔ share your medical information with each other, and
     - ✔ confirm whether they all agree with the care and medications prescribed as part of your discharge plan.

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2. Before leaving the hospital, ask the hospital doctor and discharge planner about medications, red flags, tasks and any of the information in your discharge plan you might not understand.
   - **Medications:** Ask what they are for, how to take them, how they will make you feel, and if there are any potential side effects.
   - **Red Flags:** Ask about signs or symptoms that will tell you if your condition is getting worse, what to do and whom to call.
   - **Tasks:** Ask what tasks you will need to perform at home (e.g., changing bandages, cleaning a wound, etc.) how to do them and why they are important.
   - **Be honest:** Tell the discharge planner if you do not understand the instructions, need help paying for medications or need help with any of the tasks you are asked to perform at home.
3. Before leaving the hospital, ask the hospital discharge planner to help you prepare for your return home by:
   - Arranging for any medical equipment, supplies and home care services, your hospital doctor prescribes.
   - Giving you a list of community organizations you or your family/caregiver can contact to help with transportation or meal delivery.
   - Scheduling a follow-up appointment with your primary care physician within seven days of being discharged. Your primary care physician should be informed when you are admitted to the hospital and again when you are discharged.

Q. Why is it important to go to a follow-up appointment with my primary care physician after being discharged from the hospital?

A. Your primary care physician may not know you have been in the hospital. Many primary care doctors do not see their patients when they are hospitalized; their patients are cared for by a hospitalist (a doctor that ONLY provides care for patients in the hospital).

If you do receive care from a hospitalist, he/she might order tests to be performed or prescribe new medications while you're in the hospital. The results of these tests and names and doses of new or changed medications need to be shared with your primary care physician because he/she will be the one to take care of you when you go home. If you or your family/caregiver are unable to call your primary care physician while you're in the hospital, it is important that you call as soon as you are back home to tell your primary care physician the reason you were hospitalized and to schedule a follow-up appointment. This appointment should be scheduled within seven days of your hospital discharge date. Your doctor will then contact the hospital and get the information and records needed to best care for you. During your follow-up appointment your doctor will examine you, check your response to any medication changes, and if you've had tests, review the results with you. The follow-up appointment is also a great opportunity to ask any questions you might have about your recent hospital experience and future care.

Q. How can I better manage my medications?

A. Managing your medications is very important to controlling your chronic illness and helps to keep you out of the hospital. Read these Golden Rules for better managing your medications and share the rules with your family/caregiver. You should also discuss them with your doctor.

- Keep all of your medications in one place in your home, so you and your family/caregiver can easily find the medications you need.

ASKING QUESTIONS

Each time you talk with a doctor, nurse, or pharmacist ask the following questions to understand why the information is important:

- What is my main problem?
- What do I need to do?
- Why is it important for me to do this?

Source: Partnership for Clear Health Communication; Ask Me 3 Campaign
www.askme3.org

- Prepare a list of the medications you are currently taking and always keep it up-to-date.
- Include the name of all of your medications, the dosage for each and how often you take them. Remember to include all over-the-counter medications, vitamins, minerals, and herbal supplements.
- Bring the medication list with you to all medical appointments and hospital visits.
- Purchase medications from the same pharmacy.
- If you receive medication samples during your physician office visit, notify your pharmacist and check to make sure it does not interact with any of your other medications before you begin taking the medication sample.
- Contact your physician, nurse or pharmacist when you have a question about a medication you are taking or any side effects you are feeling.
- Review your medication list with your doctor or pharmacist at least every six months.

Q. How can I better manage my health conditions?

A. One of the best ways to manage your health conditions and prevent hospital stays is to be able to recognize the signs that your condition is worsening and to have an "action plan" in place so you know how to quickly respond when these symptoms arise.

Think back to how you were feeling before you went into the hospital: What did you notice? What did you do that seemed to help you feel better? What did you do that did not help you to feel better?

- Discuss these symptoms and your action plan with your doctor.
- Find out whom you should call if these symptoms occur.
- It is a good idea to have two action plans: one that you can use during the day (when your doctor's office is open) and another plan to use at night and on the weekends.
- In some cases, you may be eligible for a home visit by a health professional to help you better manage your condition. You should ask the staff at your doctor's office or your health insurance provider if you are eligible for this type of service.

Q. Why are communications and sharing such an important part of any care transition?

A. Patients often report they did not know why they were admitted to the hospital, what to do when they were discharged home from a hospital stay and whom to call with questions about their hospital stay and follow-up care.

At the heart of this issue is the absence of a standardized communication process among healthcare providers, and between healthcare providers and their patients. Poor communication and lack of care coordination can lead to patient safety issues and medication errors, which can endanger lives, waste resources and frustrate healthcare providers, patients, and their families/caregivers. The Care Transitions project works to improve communications among all of those involved.

Q. How can I help make my next transition from one healthcare setting to another go more smoothly?

A. Improving a transition of care from one healthcare setting to another is a team sport and you, your family/caregiver, and your healthcare providers are key members of that team. Being actively involved in the management of your healthcare can help. The Discharge Preparation Checklist shown below was created to help you ask your doctor and nurses key questions about your health conditions, how to take your medications, what to do after discharge from a healthcare facility and whom to call if you have questions.

Discharge Preparation Checklist

Before I leave the care facility, I will ensure that :

- ☐ I have been involved in decisions about what will take place after I leave the facility.
- ☐ I understand where I am going after I leave this facility and what will happen to me once I arrive.
- ☐ I have the name and phone number of a person I should contact if a problem arises during my transfer.
- ☐ I understand what my medications are and how to take them.
- ☐ I understand the potential side effects of my medications and whom I should call if I experience them.
- ☐ I understand what symptoms I need to watch out for and whom to call should I notice them.
- ☐ I understand how to keep my health problems from becoming worse.
- ☐ My doctor or nurse has answered my most important questions prior to leaving the facility.
- ☐ My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- ☐ If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

This tool was developed by Dr. Eric Coleman, UCHSC, HCPR, with funding from the John A. Hartford Foundation and the Robert Wood Johnson Foundation and can be accessed at www.caretransitions.org/transitionskills.asp.

Q. What is a Personal Health Record and why is it important?

A. A Personal Health Record, sometimes called a PHR, is a record of your important health information, stored in one location, written and kept up-to-date by you or your family/caregiver, which you can easily share with your healthcare providers. A copy of a PHR has been included in this issue of *Healthy Seniors* for your use.

A PHR contains information about your medical history, health conditions and all of the names and doses of the medications you are currently taking. It is a good idea to bring your PHR with you to all of your healthcare appointments, along with a list of questions you might have. During your visit you can ask your questions and write down the answers below each of your questions, update any changes to your medication list (including dosing changes) in your Personal Health Record. This way you and your healthcare providers can easily find the information when it's needed. It is a good idea to keep your Personal Health Record where it is readily accessible to you, along with any other important information (e.g., Medicare card, insurance card) you may need in an emergency.

Q. What is the "Next Step In Care"?

A. The United Hospital Fund's *Next Step In Care* is a campaign that provides easy-to-use materials and guides to help patients and their families/caregivers safely plan for their healthcare needs as they transition home or between healthcare settings. The guides, which can be found by visiting the Next Step In Care website at www.nextstepsincare.org, provide clear information about what to expect and questions to ask to make the care transition process as smooth as it can be. Examples of the guides are:

The Next Step in Care: What Do I Need as a Family Caregiver?
Hospital-to-Home Discharge Guide
Family Caregivers' Guide to Medication Management
Going Home: What You Need to Know
A Guide to the ER
When the Next Step Is Home Care: A Family Caregiver's Guide
When the Next Step Is Rehab: A Family Caregiver's Guide
HIPAA: Questions and Answers for Family Caregivers
Your Family Member's Personal Health Record
Medication Management Form
A Family Caregiver's Guide to Advance Directives

Personal Health Record

This Personal Health Record belongs to

_____

If you have questions or concerns, contact

1) _____ ( ) –
Name of Primary Care Physician — Phone Number

I am receiving home care services from

1) _____ ( ) –
Name of Home Health Agency — 24-hour/7-day Phone Number

Other community services I am receiving

2) _____ ( ) –
Name of Service — Phone Number

3) _____ ( ) –
Name of Service — Phone Number

REMEMBER to take this Personal Health Record with you to all your hospital and doctor visits.

A copy of a Personal Health Record has been included in this publication for your use.

To request additional copies, please send an e-mail to CareTransitions@nyqio.sdps.org.

Q. Where can I get more information about community services in my area?

A. • NY Connects links New York State seniors and their families/caregivers with medical and non-medical services in their area. The program is managed by the New York State Office for Aging. Visit NY Connects at http://www.nyconnects.org/ or call your County Office for Aging for more information.

- Dial 211 from your phone to reach 211-New York, which provides access to community services, 24-hours every day, even on holidays. Right now, this number is available to about 75% of the state's residents, which means there are areas where 211 is not yet available. To learn more visit http://www.211ny.org. If you do not have access to 211, call your County Office for Aging NY Connects program. You can find NY Connects contact information for your area by visiting http://www.nyconnects.org/.
- Medicare.gov is the official US Government website for information about Medicare and is the best resource for you and your families/caregivers to get more information about the Medicare program, information on health and drug programs, tips on how to better manage your health, and provides a way to locate other medical and non-medical services to help you to meet your daily health and activity needs.

Q. Who published these materials and why?

A. This issue of *Healthy Seniors* was prepared and distributed by IPRO, the not-for-profit federally funded Medicare Quality Improvement Organization for New York State with support from the Center for Medicare & Medicaid Services (CMS). CMS is the agency of the US Department of Health and Human Services that oversees Medicare. More information about IPRO can be found by visiting www.ipro.org.

This issue of *Healthy Seniors* was released as part of the Care Transitions Project. The goal of this project is to improve patient experiences as they move within or between healthcare settings (from one unit to another in a hospital; or from a hospital to another facility or home); to help patients manage their care when they return home; and to ensure that healthcare professionals, patients and families/caregivers communicate every step of the way. For more information contact CareTransitions@nyqio.sdps.org.

Important Telephone Numbers

Quality of Care Concerns

"Quality of Care" concerns may include, but are not limited to, the following examples: thinking you may have received the wrong medication; believing you received incorrect treatment for a new or old condition; or thinking your health provider or physician did not give you proper care instructions.

Report quality of care concerns to the IPRO Beneficiary Complaint Response Program by calling 1(800) 331-7767.

Hospital Services

If you think you are being discharged from the hospital too soon call 1(888) 880-9976.

Non-Hospital Services

Traditional Medicare

If you receive a Notice of Medicare Provider Non-Coverage, call 1(800) 833-0356 - TTY 1(866) 446-3507 - to ask for an Expedited Determination of your case.

Medicare Advantage

If you receive a Notice of Medicare Non-Coverage, call 1(888) 696-9561 - TTY 1(866) 446-3507 - to ask for a Fast Track appeal. Telephone lines are open seven days a week from 8:30AM to 4:30PM, even on Saturdays, Sundays and holidays.

Other Questions

For answers to general benefit questions or other Medicare inquiries, call 1(800) MEDICARE - 1(800) 633-4227 - TTY/TDD 1(877) 486-2048); or, visit Medicare's website at www.medicare.gov.

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