Improving Care Transitions Between Hospital and Home Health: A Home Health Model of Care Transitions

January 2014

For more information about this model or the additional work of the Alliance for Home Health Quality and Innovation, please visit www.ahhqi.org.
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Purpose and Instructions

Developed by the Alliance for Home Health Quality and Innovation, this document sets forth a home health model for care transitions from hospital to home health. This model and its accompanying tools are meant to cover the care transition from admission to the acute care inpatient hospital to home health care. In light of the growing emphasis on using appropriate care transitions and post-acute care to reduce unnecessary hospital readmissions, the development of this model and accompanying tools has been an initiative to support the home health community’s efforts to improve quality of care.

The model and tools were developed through an Alliance-convened technical advisory panel comprised of clinical experts and leaders in home health organizations. These are clinical leaders who specifically have expertise on providing health care in the home setting. The technical advisory panel members identified the practices and tools set forth in this model of care after reviewing the existing literature. Thus, based on their expertise and a review of existing literature, the model and accompanying tools represent what key clinical experts in home health believe are best practices for hospital to home health care transitions that should facilitate improvements in quality of care.

The model and tools are intended for use by both home health providers and their hospital partners in caring for patients in the context of preparing for, and providing, post-acute care. The Alliance plans to make the model and tools available for public use. Please use these tools as they apply to your setting and needs. In the future, the Alliance intends to make the model and tools the basis of testing and evaluating home health’s impact on patient care outcomes. As evidence is developed over time, the model and tools will be revised as needed.

Finally, the model and tools emphasize care for, and communication with, the patient, but we note that family members and caregivers play critical roles in caring for the patient. Family and caregiver engagement is often key to ensuring quality of care for the patient and such engagement should be considered implicit in the model elements and tools.

The Alliance wishes to thank the members of the technical advisory panel for their considerable contributions of time, energy and expertise, without which the model and tools in this document would not exist.

Feedback and questions on the model and tools can be directed to the Alliance staff at (202) 239-3206.

Sincerely,

Teresa L. Lee
Executive Director
Background and Overview: A Home Health Model of Care Transitions

I. Improving Care Transitions Between Hospital and Home Health

Today, health care providers and policymakers are focused on the goals of improving quality of care and reducing the overall cost of care. More specifically, many—including the Centers for Medicare and Medicaid Services (CMS)—are focusing on accomplishing the “Triple Aim”:

- Better care for individuals, as described by the six dimensions of health care performance listed in the Institute of Medicine’s 2001 report “Crossing the Quality Chasm” (safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity);¹
- Better health for populations, through attacking “the upstream causes of so much of our ill health,” such as poor nutrition, physical inactivity, and substance abuse; and
- Reducing per-capita costs.

In analyzing the opportunities to achieve these goals, many are looking to improve care transitions, as these hand-offs present particularly important junctures of care for patients. One critical transition is from hospital to home and home health providers are often in the key position of helping patients to achieve a smooth and effective transition. Home health providers have teams of skilled health professionals who are ready and able to work closely with hospital staff, patients, and their families and caregivers to facilitate the transition from hospital to home.

Although home health is well positioned to lead and facilitate care transitions, home health is often not sufficiently recognized as being a critical partner in managing care transitions. In part, this stems from the fact that leading edge models to date (such as the Naylor and Coleman models) do not explicitly include home health providers as a member of the care team carrying out transitional care interventions. Many home health providers have appropriately adapted care transitions models to the in-home setting in an effort to improve care transitions and outcomes for their patients; but there has not been a comprehensive effort to identify the steps home health providers should take to improve the patient care experience and health outcomes during transitions from hospital to home health care.

¹ See http://www.nap.edu/openbook.php?isbn=0309072808.
II. Process: Defining a Model and Improving Competencies

In light of the key role home health providers are playing every day in care transitions, the Alliance’s Quality and Innovation Work Group (QIWG) discussed the challenges discussed in Part I above and directed Alliance staff to pursue the possibility of a study to define and establish the effectiveness of a home health model for care transitions. The QIWG also raised key issues related to ensuring adequate “competencies” for carrying out effective care transitions.

In defining the role of home health in care transitions, the Alliance’s Quality and Innovation Work Group recommended three key areas for Alliance work:

1. Define a home health model for care transitions;
2. Pursue a study to develop evidence on the effectiveness of home health providers in leading care transitions from inpatient care facilities to the home; and
3. Improve the overall home health workforce’s ability to manage patient care transitions through training which develops the core competencies required for effective care transitions.

The QIWG emphasized the need to ensure that any study of care transitions utilizing home health would also require home health professionals that have requisite competencies to execute a smooth transition. Furthermore, the QIWG encouraged exploration of avenues to enhance competencies in the home health workforce in the U.S. more broadly, such as working with the credentialing bodies and professional associations for the various health professions involved in home health.

To examine these issues in more detail, the QIWG convened a Technical Advisory Panel comprised of industry leaders who have focused their careers on improving clinical care, improving quality of care, and building a strong research base for clinical practice.

III. The Home Health Model of Care Transitions

The Technical Advisory Panel began its work with a comprehensive review of existing care transitions literature across all settings. The panel identified common elements to each model and selected five core elements that reflected the best practice in transitional care. These five core values are the foundation of the transitional care model and include:

1. Patient-Centered Focus;
2. Medication Management;
3. Communication and Care Coordination;
4. Timely Follow-Up by the Health Care Team (including the primary care physician and home health); and
5. Patient-activated Education and Coaching.
Additionally, the panel identified two global outcomes that it hopes to achieve through the dissemination and practice of the home health model of care transitions:

- High patient satisfaction, as measured by the HHCAHPS reporting tool; and
- Reduction in 30-day avoidable rehospitalizations following an acute care hospital stay.

In order to achieve these outcomes, the model focuses on the 60-day home health episode following the patient’s discharge from the acute care hospital. The model is not intended to be condition-specific, but instead focuses on capturing the clinical best practices necessary to achieve a successful transition from the acute hospital setting to the post-acute care provided in the home.

**Model 1: Home Health Model of Care Transitions Work Flow**

**Home Health Model of Care Transitions Work Flow**

In practice, a home health clinician (a home health nurse, care transition coordinator or coach, or a physical therapist) begins the transitional care at the end of the patient’s care in the acute care setting. The clinician will work with the patient prior to discharge following the best practices outline in the In-Hospital Transitional Care Checklist. For high-risk patients, the
clinician will then meet with the patient in-home within 24 hours of discharge\(^2\) and complete the Home Health Start of Care Visit Checklist. Within 72 hours of discharge, the clinician should meet with the patient again and complete the Home Health Second Visit Checklist.

For moderate-risk patients, the clinician should meet with the patient within 48 hours of hospital discharge\(^3\) and complete the Home Health Start of Care Visit Checklist. The clinician and home health team should then plan a follow up in-person visit or other contact (such as telephone or videoconferencing) within 96 hours of discharge to complete the Home Health Second Visit Checklist.

For both high-risk and moderate-risk patients, the clinician should continue to reach out to the patient and complete the Subsequent Visits Checklist as needed over the 60-day episode.

In addition to the workflow model provided above, and the checklists included in this packet to accompany the workflow, the Technical Advisory Panel identified a series of core components and example tools to assist clinicians in completing the checklists. These tools and lists of core components for particular tools are included in this document.

III. Next Steps

Like many innovations, this model of care transitions is in development and will be refined through piloting and practices. The Alliance continues to seek your feedback and suggestions in refining this model of transitional care.

Please feel free to reach out to the Alliance staff at (202) 239-3206 or through the Alliance's website at [http://ahhqi.org/contact](http://ahhqi.org/contact) to provide feedback on this work.

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\(^2\) Medicare program regulations require that the home health initial assessment visit “must be held either within 48 hours of referral, or within 48 hours of the patient’s return home, or on the physician-ordered start of care date.” 42 C.F.R. § 484.55(a)(1). It is the recommendation here that for high risk patients, the initial assessment visit take place within 24 hours of hospital discharge.

\(^3\) As stated in footnote 2 supra, Medicare program regulations require that the home health initial assessment visit “must be held either within 48 hours of referral, or within 48 hours of the patient’s return home, or on the physician-ordered start of care date.” 42 C.F.R. § 484.55(a)(1). For moderate risk patients, it is the recommendation here that the initial assessment visit occur within 48 hours of hospital discharge.
Transitional Care Checklists
In-Hospital Transitional Care Checklist

After the referral to home health, a home health care/transition coordinator (or coach) ("HHCC") (who is a staff member at the home health provider) sees the patient while the patient is still in the hospital.

The HHCC should complete the following before discharge to home health:

**Patient Assessment**

- Conduct risk assessment to determine the patient’s risk for rehospitalization (see In-Hospital Risk Assessment tools);
- Determine the patient's language interpretation needs (see FAQs: Federal Requirements and Guidance on Interpretation and Translation for Limited English Proficient Individuals); and
- Perform early medication error risk assessment.

**Patient Education**

- Introduce the concept of home health services;
- Explain when a home health (HH) nurse or physical therapist (PT) will make the first home visit;
- Review key information from the hospital chart (e.g., patient demographics, history and physical exams, history of comorbidities, other hospital services received such as therapy and ongoing needs);
- After performing an early medication error risk assessment (below), coach the patient to help them understand their medications prior to hospital discharge (including understanding new or changed prescriptions and emphasizing need to fill those prescriptions);
- Discuss the patient’s personal goals and explain that HH nurse or PT will follow up in home;
- Make sure patient has home health agency phone number for questions 24/7;
- Introduce disease specific red flags (stoplight or zone forms) to the patient and family caregivers (see example Red Flags tools and Red Flags Tools Core Components); and
- Optional: Work with the patient to conduct a Personal Health Assessment (see sample Personal Health Assessment tools).

**Follow-Up Coordination of Health Care Services**

- Identify the patient’s primary care physician (PCP), especially if hospitalist is used, and call the PCP regarding signing the patient's HH orders;
- Clarify whether hospital or HH provider will assume responsibility of supporting the patient’s task to make a follow-up appointment to visit the PCP;
- Coordinate with hospital case management on discharge date; and
- Communicate with HH office to ensure priority admission for high-risk patients (Start of Care should begin within 24 hours of discharge).
Home Health Start of Care (First Visit) Checklist

For high-risk patients, the home health Start of Care (First Visit) begins within 24 hours of hospital discharge. For moderate-risk patients, the home health Start of Care (First Visit) should begin within 48 hours of hospital discharge. A home health (HH) nurse or physical therapist (PT) can start care.

The HH nurse or PT should complete the following at the Start of Care:

**Patient Assessment**

- Conduct a comprehensive assessment (Note: The OASIS assessment, when required, must be completed within 5 days);
- Assess whether barriers to care exist (e.g., environment, supports, transportation, food, drug cost/access), connect the patient with other disciplines (e.g., social work) to further assess, and connect with community resources as needed;
- Assess the patient’s need for other disciplines (e.g., OT, PT, MSW services); and
- Assess the health literacy needs in order to develop HH plan of care, goals and coaching/teaching needs (*see Universal Health Literacy Guidelines guidance and Health Literacy Tools*).

**Patient Education**

- Make sure the patient knows how to reach HH agency during and after hours;
- Review advanced directives with the patient (*see Advance Directives Guidance and “My Health Wishes” in the sample Personal Health Record*);
- Briefly discuss personal health record (PHR) and personal goals, but explain that more discussion will take during Visit 2 (*see sample Personal Health Record and Personal Health Record Core Components*);
- Discuss the plan of care and frequency of visits; and
- Introduce red flags for symptom recognition (*see Red Flags tools and Red Flags Core Components*).

**Follow-Up Coordination of Health Care Services**

- Conduct medication reconciliation with close attention to high risk medications and communication with the PCP and pharmacist, if possible;
- Asks the patient if follow-up appointment with physician(s) have been made (within 7 days for high risk patients, and within 14 days for moderate risk patients);
- Send the Start of Care report to HH office; and
- Send the admission to home care summary to the PCP. Use the SBAR case conference worksheet (*see Admission to Home Care Summary for PCP tool*) when calling the patient’s PCP.
Home Health Second Visit Checklist

For high-risk patients, the HH nurse or PT makes a second visit within 72 hours of hospital discharge. For moderate-risk patients, the clinician and home health team should plan a follow-up visit or contact (such as telephone or videoconferencing) within 96 hours of hospital discharge to complete the Home Health Second Visit Checklist.

The HH nurse or PT should complete the following during the second visit:

Patient Assessment

☐ Continue medication reconciliation.

Patient Education

☐ Discuss the patient’s PHR and personal goals with patient in greater depth;
☐ Coach or teach the patient about diet, disease process, and medications using materials that are easy to understand and are appropriate to the health literacy of the patient/family, and using teach back method;
☐ Tie coaching and teaching to the patient’s personal goals to motivate behavior change (e.g., smoking, behavior change);
☐ Coach the patient on medication adherence;
☐ Discuss red flags/symptoms in greater depth and when to call the agency, physician (or even 911); and
☐ Coach the patient on how to use modified SBAR when calling the physician office so that critical info is shared with physician and physician's staff (see Admission to Home Care Summary for PCP tool).

Follow-Up Coordination of Health Care Services

☐ Begin planning for transition to the community, including what community resources and other services will be needed upon HH discharge;
☐ If physician appointment is not made by Start of Care, HH staff ensure follow-up appointments for the patient have been made;
☐ Discuss telephone calls to be made by HH team between home visits (including frequency and preferred time of day); and
☐ Schedule additional HH visits using the same clinicians, when possible.
Subsequent Visits Per Plan of Care Checklist

After the second home visit, the home health nurse or the physical therapist should complete the following at each visit:

- Promote patient engagement, self-management and support to encourage patient to continue communication with physician after home health discharge (transition to the community);
- Keep communication open between patient and PCP to ensure appropriate patient support;
- Ensure patient has access to any needed community and caregiving services;
- Conduct ongoing and continual medication reconciliation;
- Continue to coach the patient on medication adherence; and
- Optional: Conduct a final a Personal Health Assessment (see Personal Health Assessment tools).
Key Elements for Care Transitions Tools:
Core Components Lists
Core Components: Personal Health Record (PHR)

- Large fonts and large section for patient input
- Identification of the patient’s personal health goals using clear language (e.g., “My goal is…”)
  - Consider posting the patient’s goals in a prominent place in their home and/or making the goals page a detachable document from the PHR
- Advance directives (if any)
- Medications List
- Allergies
- Space for notes from each doctor’s appointment (e.g., list of patients’ questions and concerns to raise with the doctor; change in medications; date of next appointment)
- Grid for patient’s vital signs and tests (including the date, weight, blood pressure, heart rate, blood sugar, misc.)
- Lined page for extra notes
- Information on where to get additional PHR booklets

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4 There are separate tools outside of the PHR to help patients prepare to call the doctor and to prepare the patient for the actual doctor’s appointment. Please see the SBAR Tool for Case Conferences within the AHHQI Care Transitions Packet.
Core Components: Medication List

- Identifies the name of each pharmaceutical drug, over-the-counter medicine, or herbal supplement that the patient is taking;
- Identifies prescribing doctor, where applicable;
- Identifies what each medicine is used for;
- Describes how the patient should take the medicine;
- Identifies how much medicine (dosage) the patient should take at particular times of the day (Morning Dose, Noon Dose, Evening Dose, Bedtime Dose, As Needed Dose);
- Includes medication allergies;
- Includes pharmacy name(s) and phone number(s);
- Optional: Lists medications that the patient does not take anymore, including:
  - Date Stopped
  - Medicine Name and Strength/Dosage
  - Why the Patient Stopped Taking the Medicine
  - Prescribing Doctor, if applicable
- Optional: Include pictures of the medication and pictures for each time of day to help teach the patient how to take their medication.
Core Components: “Red Flags” Symptoms Exacerbation
Tools

- Utilizes principles of Universal Health Literacy
- Patient name
- Color coded zones to indicate that the whether the treatment is working:
  - “Green Zone” indicating that the patient is managing their disease without difficulty;
  - “Yellow Zone” indicating that the patient should reach out to a care provider but is not having an emergency; and
  - “Red Zone” indicating that the patient should seek emergency treatment.
- Phone numbers for the patient’s care team which correspond with each zone:
  - “Green Zone” and “Yellow Zone”: include the phone numbers for the patient’s home health provider and primary care physician;
  - “Red Zone”, include phone numbers for the patient’s home health provider, primary care physician and, where appropriate, 9-1-1.
  - Put phone numbers in a prominent place that corresponds with each zone
- Plain language list of patient symptoms and characteristics that indicate medication and treatment are working in the “Green” Zone
- Plain language list of patient symptoms and characteristics that indicate the patient should seek medical treatment from the home health provider or primary care physician in the “Yellow” Zone
- Plain language list of patient symptoms and characteristics that indicate the patient should seek immediate, emergency care in the “Red” Zone
- Tools available for each major patient disease
Transitional Care Guidance
Advance Directives Guidance

Questions for the Patient:

1. Do you have a legal document that tells your treating or attending physician who can make health care decisions for you if you cannot make them yourself? This document is often called a “durable power of attorney”, a “medical power of attorney”, or a “healthcare surrogate.” If Yes, please provide a copy of all applicable documents.

   • Yes
   • If no, please refer the patient to a Medical Social Worker or to one of the following resources:

2. Do you have a legal document that tells your treating or attending physician what kind of medical treatment you want if you are very sick and cannot make decisions for yourself? This document is often called a “living will.” If Yes, please provide a copy of all applicable documents.

   • Yes
   • If no, please refer the patient to a Medical Social Worker or to one of the following resources:

LEGAL DISCLAIMER:
This question and the recommended resources are intended only as means to discern whether the patient has the appropriate advance directives to identify who has the power to make health decisions. You should not use these resources without first confirming that they comply with any required federal, state, or local laws and regulations governing your care transitions work or healthcare practice.
Universal Health Literacy Guidelines

Evaluating and creating accessible health materials

Background

The Institute of Medicine defines health literacy as a person’s ability to obtain, process and understand basic health information and services needed to make appropriate health decisions. Yet according to a study at the Harvard School of Public Health, most health materials are written at a level that exceeds the reading skills of the average high school graduate.

Making sure that your health materials align with patients’ abilities to understand them is essential. The following excerpts from the AHRQ Health Literacy Universal Precautions Toolkit provide strategies for developing accessible patient materials.

Assess current materials

Use the following guidelines and resources to assess your current patient-facing materials:

Determine reading level

You can assess any text by cutting and pasting it into a readability program like ReadabilityFormulas.com. Note that readability formulas should not be your only evaluation tool because reading level is only one aspect of readability. Documents should be written at the 4th—6th grade level.

Identify complex words and jargon

Words over three syllables are generally considered inaccessible, as are acronyms and medical jargon. Consult the Centers for Disease Control and Prevention’s Plain Language Thesaurus for Health Communications for alternate, plain-language words.

Get patient feedback

Ask patients if the information is clear and easy to understand, or if there is text that is confusing or offensive. When assessing a form, ask whether there is enough room to write responses. Finally, ask whether the information was helpful.
Create content using plain language

Clearly state how to prevent or manage disease without a lot of extra information. When writing and evaluating health education material ask, “Is this information something the patient needs to know or do to stay healthy?”

Chunk the information

Include clearly defined headings and divisions between sections of information allowing for a lot of white space on the page.

Use short, simple sentences

Write at a reading level between 4th—6th grade.

Pay attention to word choice

Limit the use of medical jargon and avoid using words with over two syllables. If using a medical term, be sure to define it in parentheses after the word.

Use visuals and graphics

Visuals and graphics that relate to the text can help patients understand your message.

Format for maximum accessibility

Designing materials with plenty of white space and accessible fonts is as important as using plain language. Following are format considerations:

Use check boxes

Low literate patients often avoid writing answers because of poor spelling, so offering check boxes next to common answers is helpful.

Include “don’t know” options

Give patients the option of checking a “don’t know” box so they don’t feel compelled to check inaccurate information.

Bold key words

This helps draw attention to the main point. Do not use ALL CAPS.

Evaluating and creating accessible health materials is adapted from the Agency for Healthcare Research and Quality (AHRQ) Health Literacy Universal Precautions Toolkit. AHRQ Pub. No. 10-0046-EF The toolkit is free and available for download at: http://www.ahrq.gov/qual/literacy/
FAQs: Federal Requirements and Guidance on Interpretation and Translation for Limited English Proficient (LEP) Individuals

1. Are there specific guidelines for health care providers on providing language translation services to their patients?

Yes. On August 8, 2003, the HHS Office for Civil Rights (OCR) issued guidance for its recipients of federal funds, which include health care providers. This guidance brings together OCR’s policies in overseeing Title VI of the Civil Rights Act, which is the underlying Federal law that gives rise to the requirement that health care providers must offer interpreters to individuals who do not speak English fluently.

2. How does the HHS Office for Civil Rights (OCR) determine if a health care provider is in compliance (i.e., not discriminating)?

OCR looks at the totality of the circumstances in each case. Four factors will be assessed:

i. The number or proportion of LEP individuals eligible to be served or likely to be encountered by the program or grantee;

ii. The frequency with which LEP individuals come in contact with the program;

iii. The nature and importance of the program, activity, or service provided by the program to people's lives; and

iv. The resources available to the grantee/recipient and costs.

According to HHS, after the four factors have been applied, fund recipients can decide what reasonable steps, if any, they should take to ensure meaningful access. Fund recipients may choose to develop a written implementation plan as a means of documenting compliance with Title VI.

3. How should a provider offer oral language interpretation services?

The OCR Guidance describes various options available for oral language assistance, including the use of bilingual staff, staff interpreters, contracting for interpreter, using telephone interpreter lines, and using community volunteers. It stresses that interpreters need to be competent, though not necessarily formally certified. The Guidance allows the use of family members and friends as interpreters, but clearly states that an LEP person may not be required

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6 Title VI of the Civil Rights Act was passed by Congress in 1964 and states that “No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” 42 U.S.C. sec. 2000d. See also 45 C.F.R. sec. 80 app. A (listing examples of federal financial assistance, including Medicare, Medicaid, and Child Health grants). The U.S. Department of Health and Human Services (HHS) and the courts have applied this statute to protect national origin minorities who do not speak English well. Thus, the recipients of federal funding must take reasonable steps to ensure that people with limited English proficiency (LEP) have meaningful access to their programs and services.
to use a family member or friend to interpret. Moreover, HHS says that recipients should
make the LEP person aware that he or she has the option of having the recipient provide an
interpreter for him/her without charge.

“Extra caution” should be taken when the LEP person chooses to use a minor to interpret.
Recipients are asked to verify and monitor the competence and appropriateness of using the
family member or friend to interpret, particularly in situations involving life, health, safety or
access to important benefits, or when credibility and accuracy are important to protect the
individual.

4. When should a provider translate written materials?

It depends on the relevant circumstances of each provider based on the factors listed in #2
above. After the four factors have been applied, recipients can decide what reasonable steps, if
any, they should take to ensure meaningful access. Recipients could develop a written
implementation plan as a means of documenting compliance with Title VI. If so, the following
five elements are suggested when designing such a plan.

• Identifying LEP individuals who need language assistance.
• Describing language assistance measures, such as the types of language services
  available, how staff can obtain these services and respond to LEP persons; how
  competency of language services can be ensured.
• Training staff to know about LEP policies and procedures and how to work effectively
  with in-person and telephone interpreters.
• Providing notice to LEP persons through, for example, posting signage, providing
  information in outreach brochures, working with community groups, using a telephone
  voice mail menu, providing notices in local non-English media sources, and making
  presentations in community settings.
• Monitoring and updating the LEP plan, considering changes in demographics, types of
  services, and other factors.

OCR will evaluate a provider’s efforts on a case-by-case basis. For the translation of written
materials, the Guidance designates “safe harbors” that, if met, will provide strong evidence of
compliance.7

Disclaimer: Content provided above is for informational purposes only, and
should not be used as a substitution for professional legal and/or compliance
advice.

7 The safe harbors designate that the recipient provides written translations of “vital” documents (e.g.,
intake forms with the potential for important consequences, consent and complaint forms, eligibility and
service notices) for each eligible LEP language group that constitutes 5% or 1,000, whichever is less, of
the population of persons eligible to be served or likely to be affected or encountered. Translation of
other documents, if needed can be provided orally. Or, if there are fewer than 50 persons in a language
group that reaches the 5% trigger, above, the recipient provides written notice in the primary language of
the LEP language group of the right to receive competent oral interpretation of vital written materials,
free of cost. 68 Fed. Reg. at 47319.
Evidence-Based Care Transitions Tools  
(DO NOT MODIFY)
Risk Assessment: In-Hospital Assessment
OASIS-C1 Question M1033

Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)

☐ 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
☐ 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months
☐ 3 - Multiple hospitalizations (2 or more) in the past 6 months
☐ 4 - Multiple emergency department visits (2 or more) in the past 6 months
☐ 5 - Decline in mental, emotional, or behavioral status in the past 3 months
☐ 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
☐ 7 - Currently taking six or more medications
☐ 8 - Currently reports exhaustion
☐ 9 - Other
☐ 10 – None of the above

Risk Assessment: In-Hospital IHI Risk Stratification Tool

<table>
<thead>
<tr>
<th>High-Risk Pts</th>
<th>Moderate Risk Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Patient has been admitted two or more times in the past year</td>
<td></td>
</tr>
<tr>
<td>b. Patient failed teach back, or the patient or family caregiver has a low degree of confidence to carry out self-care at home</td>
<td></td>
</tr>
<tr>
<td>a. Patient has been admitted once in the past year</td>
<td></td>
</tr>
<tr>
<td>b. Patient or family caregiver has moderate degree of confidence to carry out self-care at home</td>
<td></td>
</tr>
</tbody>
</table>

Health Literacy Assessment: REALM SF Tool

REALM-SF Form
Patient name ___________________ Date of birth _______________ Reading level ____________

Date ________________ Examiner ______________________ Grade completed ___________

Menopause ☐
Antibiotics ☐
Exercise ☐
Jaundice ☐
Rectal ☐
Anemia ☐
Behavior ☐

Instructions for Administering the REALM-SF
1. Give the patient a laminated copy of the REALM-SF form and score answers on an unlaminated copy that is attached to a clipboard. Hold the clipboard at an angle so that the patient is not distracted by your scoring. Say:

   "I want to hear you read as many words as you can from this list. Begin with the first word and read aloud. When you come to a word you cannot read, do the best you can or say, 'blank' and go on to the next word."

2. If the patient takes more than 5 seconds on a word, say "blank" and point to the next word, if necessary, to move the patient along. If the patient begins to miss every word, have him or her pronounce only known words.
Health Literacy Assessment: REALM R Tool

Description of the Test

The REALM-R is a brief screening instrument used to assess an adult patient's ability to read common medical words. It is designed to assist medical professionals in identifying patients at risk for poor literacy skills. The REALM-R is a word recognition test – not a reading comprehension instrument. Adults are asked to de-code or pronounce words. The test takes less than 2 minutes to administer and score.

Preliminary data regarding the REALM-R has been published in the Journal of General Internal Medicine December 2003; 18:1036-1038.

Administration and Scoring:

1. Give the patient the laminated copy of the REALM-R word list. Attach the examiner record form to the clipboard. Hold the clipboard at an angle such that the patient is not distracted by your scoring procedure.

In your own words, introduce the REALM-R to the patient:

    In a research setting or for research purposes:

    “It would be helpful for us to get an idea of what medical words you are familiar with. What I need you to do is look at this list of words, beginning here [point to first word with pencil]. Say all of the words you know. If you come to a word you don't know, you can sound it out or just skip it and go on.”
    If the patient stops, say, “Look down this list [point] and say the other words you know.”

    In a clinical setting:

    “Sometimes in this office, we may use medical words that patients aren’t familiar with. We would like you to take a look at this list of words to help us get an idea of what medical words you are familiar with. It will help us know what kinds of patient education to give you. Start with the first word [point to 1st word with pencil], please say all of the words you know. If you come to a word you do not know, you can sound it out or just skip it and go on.” If patient stops do as above.

**Special Note: Do not use the words “read” and “test” when introducing and administering the REALM-R. These words may make patients feel uncomfortable and unwilling to participate.

“Please say these words for me?”
2. If the patient takes more than 5 seconds on a word, encourage the patient to move along by saying, "Let's try the next word."

If the patient begins to miss every word or appears to be struggling or frustrated, tell the patient, "Just look down the list and say the words you know."

3. Count as an error any word that is not attempted or mispronounced (see "Special Considerations" for pronunciation/scoring guidelines).

4. Scoring options:

1) Place a check mark on the line next to each word the patient pronounces correctly.

OR

2) Place an X on the line next to each word the patient does not attempt or mispronounces.

Scoring should be strict, but take into consideration any problems which could be related to dialect or articulation difficulties. Use the dictionary if in doubt. Count as correct any self-corrected word. In our study we chose to define ‘at risk patients’ as those with a score of six or less.

Special Considerations for Administration and Scoring:

Examiner Sensitivity:

Many low literate patients will attempt to hide their deficiency. Ensure that you approach each patient with respect and compassion. You may need to provide encouragement and reassurance.

A positive, respectful attitude is essential for all examiners. (Remember, many people with low literacy feel ashamed.) Be sensitive.
**Visual Acuity:**

If the patient wears glasses, ask him/her to put them on for this test. The REALM-R is designed to be read by persons with 20/100 vision or better. For vision of 20/100 or better I have used a font size of 18. In my studies we have excluded patients with worse vision. The REALM has a visually impaired version using a font size of 28.

**Pronunciation:**

Dictionary pronunciation is the scoring standard.

**Dialect, Accent or Articulation Problems:**

Count a word as correct if the word is pronounced correctly and no additions or deletions have been made to the beginning or ending of the word. For example: A patient who says “jaundiced” would not receive credit for the word “jaundice”; “directs” would not receive credit for the word “directed”; “colon” would not receive credit for “colitis”. Words pronounced with a dialect or accent should be counted as correct provided there are no additions or deletions to the word. Particular attention should be paid for patients who use English as a second language.
REALM-R Examiner Record

Patient Name/Subject # ____________________________ Date of Birth __________________
Date ________________ Clinic _________________________________ Examiner ________________________________

fat       fatigue       ____
flu       directed       ____
pill       colitis       ____
allergic       constipation       ____
jaundice       osteoporosis       ____
anemia

Fat, Flu, and Pill are not scored. We have previously used a score of 6 or less to identify patients at risk for poor literacy.

Score ______
fat
flu
pill
allergic
jaundice
anemia
fatigue
directed
colitis
constipation
osteoporosis
fat
flu
pill
allergic
jaundice
anemia
fatigue
directed
colitis
constipation
osteoporosis
Health Literacy Assessment:
The Newest Vital Sign Test and Scorecard

The Newest Vital Sign Assessment

<table>
<thead>
<tr>
<th>Nutrition Facts</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Serving Size</td>
<td>½ cup</td>
</tr>
<tr>
<td>Servings per container</td>
<td>4</td>
</tr>
<tr>
<td>Amount per serving</td>
<td></td>
</tr>
<tr>
<td>Calories</td>
<td>250</td>
</tr>
<tr>
<td>Fat Cal</td>
<td>120</td>
</tr>
<tr>
<td>%DV</td>
<td></td>
</tr>
<tr>
<td>Total Fat</td>
<td>13g</td>
</tr>
<tr>
<td>Sat Fat</td>
<td>9g</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>28mg</td>
</tr>
<tr>
<td>Sodium</td>
<td>55mg</td>
</tr>
<tr>
<td>Total Carbohydrate</td>
<td>30g</td>
</tr>
<tr>
<td>Dietary Fiber</td>
<td>2g</td>
</tr>
<tr>
<td>Sugars</td>
<td>23g</td>
</tr>
<tr>
<td>Protein</td>
<td>4g</td>
</tr>
<tr>
<td>%DV</td>
<td>8%</td>
</tr>
</tbody>
</table>

*Percentage Daily Values (DV) are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.


The content for this material was excerpted from The Newest Vital Sign—A Health Literacy Assessment Tool website available at: http://www.newestvitalsign.org/nvs-resources.aspx

The views expressed in these documents, Web sites, or other products do not necessarily reflect the official policies of the U.S. Department of Health and Human Services or the Health Resources and Services Administration, nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.
Score Sheet for the Newest Vital Sign Questions and Answers

READ TO SUBJECT: This information is on the back of a container of a pint of ice cream.

1. If you eat the entire container, how many calories will you eat?
   **Answer:** 1,000 is the only correct answer

2. If you are allowed to eat 60 grams of carbohydrates as a snack, how much ice cream could you have?
   **Answer:** Any of the following is correct: 1 cup (or any amount up to 1 cup), half the container. Note: If patient answers “two servings,” ask “How much ice cream would that be if you were to measure it into a bowl.”

3. Your doctor advises you to reduce the amount of saturated fat in your diet. You usually have 42 g of saturated fat each day, which includes one serving of ice cream. If you stop eating ice cream, how many grams of saturated fat would you be consuming each day?
   **Answer:** 33 is the only correct answer

4. If you usually eat 2500 calories in a day, what percentage of your daily value of calories will you be eating if you eat one serving?
   **Answer:** 10% is the only correct answer

READ TO SUBJECT: Pretend that you are allergic to the following substances: Penicillin, peanuts, latex gloves, and bee stings.

5. Is it safe for you to eat this ice cream?
   **Answer:** No

6. (Ask only if the patient responds “no” to question 5): Why not?
   **Answer:** Because it has peanut oil.

**Interpretation**

<table>
<thead>
<tr>
<th>Number of correct answers:</th>
</tr>
</thead>
</table>

Score of 0-1 suggests high likelihood (50% or more) of limited literacy
Score of 2-3 indicates the possibility of limited literacy.
Score of 4-6 almost always indicates adequate literacy.
Health Literacy Assessment: Single Item Literacy Screener

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

1  □ Never
2  □ Rarely
3  □ Sometimes
4  □ Often
5  □ Always

Scores greater than 2 are considered positive (Sensitivity = 54%, Specificity = 83%).

Patient’s Personal Health Assessment: EQ5D Tool

Case ID Number [Redacted]
FI ID Number [Redacted]
Today’s Date: ___ / ___ / ___

Self-Completion Booklet

Conducted by Research Triangle Institute

On Behalf of
The University of Arizona Center for Health Outcomes and PharmacoEconomic Research

April 2002

Form # 2
### OWN HEALTH QUESTIONS

By placing a checkmark in one box in each group below, please indicate which statements best describe your own health state today.

**Mobility**
- I have no problems in walking about
- I have some problems in walking about
- I am confined to bed

**Self-Care**
- I have no problems with self-care
- I have some problems washing or dressing myself
- I am unable to wash or dress myself

**Usual Activities** (e.g., work, study, housework, family, or leisure activities)
- I have no problems with performing my usual activities
- I have some problems with performing my usual activities
- I am unable to perform my usual activities

**Pain/Discomfort**
- I have no pain or discomfort
- I have moderate pain or discomfort
- I have extreme pain or discomfort

**Anxiety/Depression**
- I am not anxious or depressed
- I am moderately anxious or depressed
- I am extremely anxious or depressed

Please tell your interviewer when you have finished.
CATEGORY RATING THERMOMETER

For Office Use Only

<table>
<thead>
<tr>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
<th>7.</th>
<th>8.</th>
<th>9.</th>
<th>10.</th>
<th>11.</th>
<th>12.</th>
<th>13.</th>
<th>14.</th>
<th>15.</th>
</tr>
</thead>
</table>

Best imaginable health state

Worst imaginable health state

0

100

2
Patient’s Personal Health Assessment: HHCAHPS Tool

In general, how would you rate your overall health?

1. ☐ Excellent
2. ☐ Very good
3. ☐ Good
4. ☐ Fair
5. ☐ Poor

**Home Health-Physician Communication:**
Admission to Home Care Summary for PCP Tool

### Home Health Case Conference Guidelines

<table>
<thead>
<tr>
<th>Case Conference SBAR Documentation Guideline:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Situation</strong></td>
</tr>
<tr>
<td>• Brief</td>
</tr>
<tr>
<td>• Grab the listeners’ attention</td>
</tr>
<tr>
<td>• Convey immediate need</td>
</tr>
<tr>
<td>• Speak clearly</td>
</tr>
<tr>
<td>Patient’s name, age and diagnosis:</td>
</tr>
<tr>
<td>Reason for homecare services:</td>
</tr>
<tr>
<td>SOC date:</td>
</tr>
<tr>
<td>Disciplines in the home:</td>
</tr>
<tr>
<td>Situation, in 1 sentence (poor self-management of disease, pain, symptom control of disease, poor functional capacity, etc.):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Background</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Sets the context</td>
</tr>
<tr>
<td>• Only the relevant circumstances to this situation</td>
</tr>
<tr>
<td>• Prepare details in advance</td>
</tr>
<tr>
<td>Relevant history of disease, symptoms, number of hospitalizations this year, abnormal risk assessments (fall, depression, re-hospitalization):</td>
</tr>
<tr>
<td>Important medications (if relevant), high risk medications, labs:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Assessment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Long term goal and current SMART goal</td>
</tr>
<tr>
<td>• Making progress toward goal?</td>
</tr>
<tr>
<td>• If not, what do you think the problem is?</td>
</tr>
<tr>
<td>• What could cause this patient to go back to the ER/Hospital?</td>
</tr>
<tr>
<td>• Be specific</td>
</tr>
<tr>
<td>Brief assessment of progress toward goals:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Recommendation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• What do you suggest be done that may help the situation?</td>
</tr>
<tr>
<td>• Other disciplines needed?</td>
</tr>
<tr>
<td>• Other services needed?</td>
</tr>
<tr>
<td>• What can prevent an ER visit/hospitalization?</td>
</tr>
<tr>
<td>• Appropriate visit plan?</td>
</tr>
<tr>
<td>• Follow up issues with MD?</td>
</tr>
<tr>
<td>• Safety Issues</td>
</tr>
<tr>
<td>Your suggestion:</td>
</tr>
<tr>
<td>Therapy suggestion:</td>
</tr>
<tr>
<td>Nursing suggestion:</td>
</tr>
<tr>
<td>Social work suggestion:</td>
</tr>
<tr>
<td>Planned action/ who responsible:</td>
</tr>
<tr>
<td>Plan for next visit if different from above</td>
</tr>
</tbody>
</table>

---

## “Red Flags” Symptom Exacerbation: COPD Tool

### Controlling COPD at home

How do I feel today?

<table>
<thead>
<tr>
<th>Green zone</th>
<th>Yellow zone</th>
<th>Red zone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>You are</strong> in control.</td>
<td><strong>Take action today.</strong> Call:</td>
<td><strong>Take action now!</strong> Call:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>How is my cough?</strong></th>
<th><strong>My cough is normal.</strong></th>
<th><strong>My cough is worse than normal.</strong></th>
<th><strong>My cough is not going away.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="cough.png" alt="Cough" /></td>
<td><img src="cough.png" alt="Cough" /></td>
<td><img src="cough.png" alt="Cough" /></td>
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<tr>
<td><img src="mucus.png" alt="Mucus" /></td>
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<tr>
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<td><img src="yellow.png" alt="Yellow" /></td>
<td><img src="yellow.png" alt="Yellow" /></td>
</tr>
<tr>
<td>Change in mucus:</td>
<td>Change in mucus:</td>
<td>Change in mucus:</td>
<td>Change in mucus:</td>
</tr>
<tr>
<td>- More than normal</td>
<td>- Looks yellow, green or gray</td>
<td>- More than normal</td>
<td>- Looks yellow, green or gray</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Is my medicine working?</strong></th>
<th><strong>My normal dose is working.</strong></th>
<th><strong>I need to use my medicine more often than normal.</strong></th>
<th><strong>My medicine is not working.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="medicine.png" alt="Medicine" /></td>
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<td><img src="yellow.png" alt="Yellow" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>How is my breathing?</strong></th>
<th><strong>My breathing is normal.</strong></th>
<th><strong>I have trouble breathing while:</strong></th>
<th><strong>I have more trouble breathing at rest.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="breathing.png" alt="Breathing" /></td>
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<td><img src="breathing.png" alt="Breathing" /></td>
</tr>
<tr>
<td>- Walking or talking</td>
<td>- Eating</td>
<td>- I feelconfused or sleepy.</td>
<td>- My lips or nails are turning gray or blue.</td>
</tr>
<tr>
<td>- Bathing or dressing</td>
<td>- I feel tired or restless.</td>
<td><img src="other.png" alt="Other" /></td>
<td><img src="other.png" alt="Other" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Other:</strong></th>
<th><strong>I have a fever of 101.5 or higher.</strong></th>
<th><strong>I have chest pain or pressure that does not go away.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="other.png" alt="Other" /></td>
<td><img src="other.png" alt="Other" /></td>
<td><img src="other.png" alt="Other" /></td>
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</tbody>
</table>

*Graphics used with permission from the Cecil G. Sheps Center for Health Services Research, Feinberg School of Medicine and the UCSF Center for Vulnerable Populations. Developed by the Sutter Center for Integrated Care, 2013. For permission to reproduce please email centerforic@sutterhealth.org.*
My action plan for controlling COPD at home

**Things I can do:**

- Ask “How do I feel today?”
- Stop smoking
- Take my medicine
  Use my inhaler, oxygen or breathing treatment
- Look for signs of infection:
  - Change in cough or mucus
  - More wheezing or trouble breathing
  - Trouble sleeping or feeling tired
  - Fever
- See my doctor
- Drink plenty of water
  At least 8 cups each day
- Get exercise each day
- Have a plan for getting help
- Other ideas:

**How I will do these things:**

Your care team will work with you to set goals so you can stick to your plan.
“Red Flags” Symptom Exacerbation: Depression Tool

Controlling depression at home

How do I feel today?

<table>
<thead>
<tr>
<th>Green zone</th>
<th>Yellow zone</th>
<th>Red zone</th>
</tr>
</thead>
<tbody>
<tr>
<td>No signs of depression.</td>
<td>Take action today. Call:</td>
<td>Take action now! Call:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How do I feel about doing my normal activities?</th>
<th>I can concentrate.</th>
<th>I feel sad, tired or nervous when I think about doing my normal activities.</th>
<th>I would rather: • Stay in bed • Not socialize • Not eat</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel good about: • Getting up • Facing the day • Socializing</td>
<td>I do not want to: • Get up • Face the day • Socialize</td>
<td>I cannot concentrate.</td>
<td>I do not feel anything.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How have I been sleeping?</th>
<th>No change in sleeping patterns.</th>
<th>My sleeping patterns have changed and now I: • Sleep more or less • Have trouble falling or staying asleep • Stay awake and worry</th>
<th>I worry most of the night.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>I sleep a lot during the day and keep my room dark.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Am I taking my medicine for depression?</th>
<th>I take my medicine and it works for me.</th>
<th>I take less medicine than my doctor prescribed because: • It is more than I need • I do not like the side effects • I worry about being addicted to it</th>
<th>I do not take my medicine because: • It is not helping • I do not need it</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Do I think about hurting myself?</th>
<th>No thoughts of hurting myself.</th>
<th>I sometimes think of hurting myself, but I do not do it because I: • Do not believe in suicide • Am afraid to die</th>
<th>I feel like life is not worth living.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel hopeful.</td>
<td></td>
<td>I have a plan for killing myself.</td>
<td></td>
</tr>
</tbody>
</table>

Developed by the Sutter Center for Integrated Care, 2013. For permission to reproduce please email centerforci@sutterhealth.org.
My plan for controlling depression at home

<table>
<thead>
<tr>
<th>Things I can do to control depression:</th>
<th>How I will do these things:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Ask myself how I feel each day</td>
<td></td>
</tr>
<tr>
<td>□ Reach out to people who support me</td>
<td></td>
</tr>
<tr>
<td>□ Take my medicine</td>
<td></td>
</tr>
<tr>
<td>□ Keep pain under control</td>
<td></td>
</tr>
<tr>
<td>□ Keep anxiety under control</td>
<td></td>
</tr>
<tr>
<td>□ Stay active:</td>
<td></td>
</tr>
<tr>
<td>• Get regular exercise</td>
<td></td>
</tr>
<tr>
<td>• Eat balanced meals</td>
<td></td>
</tr>
<tr>
<td>□ Get a healthy amount of sleep</td>
<td></td>
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<tr>
<td>each night (7 - 9 hours)</td>
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<tr>
<td>□ Do something relaxing each day</td>
<td></td>
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<tr>
<td>□ See my doctor</td>
<td></td>
</tr>
<tr>
<td>□ Tell my care team or doctor if:</td>
<td></td>
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<tr>
<td>• I begin to feel worse</td>
<td></td>
</tr>
<tr>
<td>• I have thoughts about hurting</td>
<td></td>
</tr>
<tr>
<td>myself</td>
<td></td>
</tr>
<tr>
<td>□ Other ideas:</td>
<td></td>
</tr>
</tbody>
</table>

Your care team will work with you to set goals so you can stick to your plan.
“Red Flags” Symptom Exacerbation: Falls Prevention Tool

Preventing falls at home
A fall is when you end up on the ground or at a lower level without meaning to.

<table>
<thead>
<tr>
<th>Green zone</th>
<th>Yellow zone</th>
<th>Red zone</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are in control.</td>
<td>Take action today. Call:</td>
<td>Take action now! Call:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did I lose my balance today?</th>
<th>I have no loss of balance.</th>
<th>I lost my balance and: • Stumbled or staggered • Needed to hold on to something • Fell into my chair</th>
<th>I fell today.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Do I feel dizzy or light-headed?</th>
<th>I do not feel dizzy or light-headed.</th>
<th>I feel dizzy or light-headed when I move.</th>
<th>I feel so dizzy or light-headed that I could faint.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Do I feel weak?</th>
<th>I do not feel weak.</th>
<th>I need more help than normal to: • Get out of bed • Stand up</th>
<th>I am too weak to do anything for myself.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Can I see clearly?</th>
<th>I see clearly.</th>
<th>I do not see as well: • I bump into things • I stopped reading or watching TV • I need lights on to see</th>
<th>I see double.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Am I worried about falling: • At home? • Away from home?</th>
<th>I am not worried about falling.</th>
<th>I am worried so I: • Walk less • Drink less to avoid using the bathroom • Stay at home</th>
<th>I am so worried that I will not get up on my own.</th>
</tr>
</thead>
</table>

Developed by the Sutter Center for Integrated Care, 2013. For permission to reproduce please email centerforc@sutterhealth.org.
My plan for preventing falls at home

<table>
<thead>
<tr>
<th>Things I can do to prevent falling:</th>
<th>How I will do these things:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Take my time and be aware:</td>
<td></td>
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<tr>
<td>□ Stand up slowly</td>
<td></td>
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<tr>
<td>□ Make sure I use my cane or walker correctly</td>
<td></td>
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<tr>
<td>□ Wear good-fitting shoes</td>
<td></td>
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<tr>
<td>• Make my home safe:</td>
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<tr>
<td>□ Remove things on the floor that may cause me to trip</td>
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</tr>
<tr>
<td>□ Light up my path at night</td>
<td></td>
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<tr>
<td>□ Add grab bars and railings</td>
<td></td>
</tr>
<tr>
<td>• Stay healthy:</td>
<td></td>
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<tr>
<td>□ Ask my doctor for an exercise program</td>
<td></td>
</tr>
<tr>
<td>□ Have my eyes and ears checked each year</td>
<td></td>
</tr>
<tr>
<td>□ Eat healthy and drink water</td>
<td></td>
</tr>
<tr>
<td>• Talk to my care team or doctor:</td>
<td></td>
</tr>
<tr>
<td>□ Tell them if I fall or worry about falling</td>
<td></td>
</tr>
<tr>
<td>□ Speak up if my medicine makes me feel dizzy or light-headed</td>
<td></td>
</tr>
<tr>
<td>• Other ideas:</td>
<td></td>
</tr>
<tr>
<td>□ Consider a medical alert system</td>
<td></td>
</tr>
</tbody>
</table>

Your care team will work with you to set goals so you can stick to your plan.
"Red Flags" Symptom Exacerbation: Heart Failure Tool

Controlling heart failure at home

How do I feel today?

<table>
<thead>
<tr>
<th>Green zone</th>
<th>Yellow zone</th>
<th>Red zone</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are in control.</td>
<td>Take action today. Call:</td>
<td>Take action now! Call:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is my weight up?</th>
<th>No change in my weight.</th>
<th>My weight is up: 3 pounds overnight 5 pounds since last week</th>
<th>My weight is up: 5 pounds overnight</th>
</tr>
</thead>
<tbody>
<tr>
<td>My healthy weight:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do I have swelling?</th>
<th>I do not have swelling.</th>
<th>I have swelling in my: Foot, ankle or shin Knee or thigh</th>
<th>I have swelling in my: Belly – feels bloated or pants are tighter Hands or face</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Am I short of breath?</th>
<th>I do not feel short of breath: Breathing is normal Sleep is normal</th>
<th>I feel short of breath or cough while: Walking or talking Eating Bathing or dressing</th>
<th>I feel: Short of breath or wheeze at rest Less alert I need to sleep sitting up to breathe.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>My energy level is normal.</td>
<td>My energy level is normal. I am too tired to do most of my normal activities.</td>
<td>I am so tired that I can hardly do any of my normal activities.</td>
</tr>
</tbody>
</table>

| My other signs of heart failure: | | | |
|---------------------------------|-------------|----------------|
| My energy level is normal. | I am too tired to do most of my normal activities. | I am so tired that I can hardly do any of my normal activities. |

Daily Check-Up used with permission from the Cecil G. Sheps Center for Health Services Research, Fienberg School of Medicine and the UCSF Center for Vulnerable Populations. Developed by the Sutter Center for Integrated Care, 2013. For permission to reproduce please email centerforic@sutterhealth.org.
My action plan for controlling heart failure at home

Things I can do:  How I will do these things:

☐ Ask “How do I feel today?”
  Do I have a problem with weight gain, swelling, breathing or my energy level?

☐ Weigh myself each day
  Weigh first thing in the morning (after I empty my bladder but before I eat or drink).

☐ Take my medicine

☐ See my doctor

☐ Eat a healthy, low-salt diet
  Limit salt to 2,000 mg a day
  Limit liquid to 6 – 8 cups a day
  (1 cup = 8 ounces)

☐ Get exercise each day

☐ Know when to take action

☐ Have a plan for getting help

☐ Other ideas:

Your care team will work with you to set goals so you can stick to your plan.
"Red Flags" Symptom Exacerbation: Pneumonia Tool

Preventing pneumonia at home
How do I feel today?

<table>
<thead>
<tr>
<th></th>
<th>Green zone</th>
<th>Yellow zone</th>
<th>Red zone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Do I have a cough?</strong></td>
<td>No cough or cough is normal.</td>
<td>My cough is worse than normal.</td>
<td>My cough is lasting longer than a normal cold.</td>
</tr>
</tbody>
</table>
|                | If I cough up mucus, it looks white. | I am coughing up mucus that looks:  
  • Yellow  
  • Green  
  • Streaked with blood | Pain in my chest that does not go away. |
| **Do I have a fever?** | No fever. | Fever of 100 – 101.5 | Fever over 101.5 |
| **How is my energy level?** | My energy level is normal. | I am too tired to do most of my normal activities. | I am so tired that I can hardly do any of my normal activities. |
| **Am I short of breath?** | My breathing is normal. | I am short of breath or cough while:  
  • Walking or talking  
  • Eating  
  • Bathing or dressing | I am short of breath at rest.  
  I do not feel alert. |

Graphics used with permission from the Cecil G. Sheps Center for Health Services Research, Feinberg School of Medicine and the UCSF Center for Vulnerable Populations. Developed by the Sutter Center for Integrated Care, 2013. For permission to reproduce please email centerforic@sutterhealth.org.
My plan for preventing pneumonia at home

Things I can do to prevent pneumonia:

- Brush my teeth and use an “antiseptic” mouth wash.
- Wash my hands often using soap and warm water.
- Stay away from people who have coughs or colds.
- Eat healthy foods and drink water.
- Have a plan for getting help when I am in the yellow zone.

Look for signs of infection:

- Change in cough or mucus.
- Trouble breathing or shortness of breath.
- Feeling more tired than normal.
- Fever over 100

Other ideas:

Your care team will work with you to set goals so you can stick to your plan.
Sample Tool - Personal Health Record (PHR)

My Personal Health Record

____________________________________________

Name

Take this record with you to all of your medical appointments.
My Personal Health Goals

How I want to feel:

____________________________________________________________

____________________________________________________________

What I want to be able to do:

____________________________________________________________

____________________________________________________________

____________________________________________________________

How [Insert Home Health Provider Name] will help me meet my goals:

____________________________________________________________

____________________________________________________________

I can reach my home care team at:

____________________________________________________________
About Your Personal Health Record

A Personal Health Record (also known as a PHR) is a tool you can use to collect important information about your health. This record stays with you, so you can control what is in it and who sees it. Sharing this record with your health care team will help keep all those who care for you up to date about your health and about what is important to you.

Keep it up to date.
- Write down any new medicines you are taking.
- Update telephone numbers when they change.

Bring it with you to all medical appointments.

Use this tool to help you plan ahead when you call your doctor:
- How to give your doctor a quick, clear picture of your health problem

Use this tool to help you plan ahead when you see your doctor:
- Talking to Your Healthcare Provider
- Questions for my doctor

Extra forms are available from ________________:
- Visit [INSERT WEBSITE] to print your own forms.
- Call [INSERT PHONE NUMBER] to have forms sent to you by mail.

[FOLDER FLAP FOR PATIENT DOCUMENTS]

Your Personal Health Record (PHR) contains private, personal information about your health. Take steps to make sure your personal health information is secure.
My Personal Information

Name: ______________________________ Phone: ______________________

Address: ____________________________________________________________

Date of Birth: ______________________

Emergency Contacts

1. Name: ______________________Relationship: __________________________
   Phone:___________(home)_______________(work)
   ________________(cell)

2. Name: __________________________Relationship: __________________________
   Phone:___________(home)_______________(work)_____________(cell)

Allergies

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________
# About My Health

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>Do I have this?</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis / OA / RA</td>
<td></td>
<td></td>
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<tr>
<td>Asthma / COPD</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
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<tr>
<td>High Blood Pressure / Hypertension</td>
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<tr>
<td>Stroke / CVA</td>
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<td></td>
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<tr>
<td>HIV / AIDS</td>
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<tr>
<td>Wound</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
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<tr>
<td>Other</td>
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<tr>
<td>Other</td>
<td></td>
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</tr>
</tbody>
</table>
My Health Care Team

My Care Providers

1.

Name:______________________________________________________________
Phone:______________________________________________________________
Address:_________________________________________________________________

I see this provider for: ________________________________________________

2.

Name:______________________________________________________________
Phone:______________________________________________________________
Address:_________________________________________________________________

I see this provider for: ________________________________________________

3.

Name:______________________________________________________________
Phone:______________________________________________________________
Address:_________________________________________________________________


I see this provider for: ________________________________

My Pharmacies

1. Name: ____________________________________________
   Phone: ____________________________________________
   Address: __________________________________________

2. Name: ____________________________________________
   Phone: ____________________________________________
   Address: __________________________________________

Other Providers

Medical Supplies: ________________________________
   Phone: ____________________________________________
   Supplies ordered: ________________________________

Oxygen: ________________________________
   Phone: ____________________________________________
   Supplies ordered: ________________________________
My Health Wishes (Advance Directives)

My health wishes are written down and located at:

- **Advance Directive or Living Will**
  - Tells my treating or attending physician what kind of medical treatment I want if I am very sick and cannot make decisions for myself
  - Located at ________________________________

- **Durable Power of Attorney, Medical Power of Attorney, or Health Care Surrogate**
  - Tells my treating or attending physician who can make health care decisions for me if I cannot make them myself
  - Located at ________________________________

- **Do Not Resuscitate (DNR)**
  - Located at ________________________________

- **Other**
  - Located at ________________________________

My medical treatment wishes:

__________________________________________________________

__________________________________________________________

__________________________________________________________
I want to be an organ or tissue donor:

☐ Yes
☐ No

If yes, pick one:

☐ Any part (e.g., organ, eye, or tissue)
☐ Only the following part(s):
___________________________________________

☐ All parts except:
___________________________________________

My spiritual beliefs and wishes are:

__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________

Disclaimer: For informational purposes only. This document does not replace any formal legal documents that memorialize the patient’s wishes or instructions for health care decisions. Should there be a conflict between this document and a patient’s advance directives (including, but not limited to, living wills, durable power of attorneys, medical power of attorneys, health care surrogates, or Do Not Resuscitate) the legal document, not this document, controls.
<table>
<thead>
<tr>
<th>Dates</th>
<th>Reason</th>
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</table>
## Vital Signs

<table>
<thead>
<tr>
<th>Date</th>
<th>Weight</th>
<th>Blood Pressure</th>
<th>Heart Rate</th>
<th>Blood Sugar</th>
<th>Misc.</th>
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</table>
## My Physician Visits

<table>
<thead>
<tr>
<th>Date</th>
<th>Doctor</th>
<th>Reason</th>
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<tbody>
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</table>
How to Give Your Doctor a Quick, Clear Picture of Your Health Problem Over the Phone

1. Say who you are:
   - Give your name
   - If you are not the patient, say how you know the patient

2. Say what you are being treated for at this time:

   Include:
   - Names of medical problems
   - Home health care services you have now
   - Medical supplies you use (medication, oxygen, walker)

3. Say why you are calling:

   For example:
   - To ask a question
   - To report a problem or a change from normal
   - Because you noticed new signs or symptoms

4. Say what you need:

   For example:
   - To make an appointment
   - Have a test
   - More information

5. End the call by asking how to reach the doctor if you need more help:

   For example:
   - If the problem does not go away
   - If you need more information

Source: Courtesy of Sutter Care at Home. Adapted from the SBAR Communication Technique for Patient and Advocates. An Empowered Patient® Publication, used under license by The Empowered Patient Coalition. Copyright © 2009 Dr. Julia A. Hallisy and Helen W. Haskell. For more information, please visit www.EmpoweredPatientCoalition.org.
Questions for My Health Care Team

Appointment with _________________ Date _______________

I have questions about

☐ My medicine
☐ My test results
☐ My pain
☐ How I feel

Other questions: ________________________________

______________________________________________

Appointment with _________________ Date _______________

I have questions about

☐ My medicine
☐ My test results
☐ My pain
☐ How I feel

Other questions: ________________________________

______________________________________________

Appointment with _________________ Date _______________

I have questions about

☐ My medicine
☐ My test results
☐ My pain
☐ How I feel

Other questions: ________________________________

______________________________________________
Appointment with ________________ Date ________________

I have questions about

☐ My medicine
☐ My test results
☐ My pain
☐ How I feel

Other questions: _______________________________________

_________________________________________________________________

Appointment with ________________ Date ________________

I have questions about

☐ My medicine
☐ My test results
☐ My pain
☐ How I feel

Other questions: _______________________________________

_________________________________________________________________

Appointment with ________________ Date ________________

I have questions about

☐ My medicine
☐ My test results
☐ My pain
☐ How I feel

Other questions: _______________________________________

_________________________________________________________________
Talking with Your Healthcare Provider at the Appointment

When you talk with your healthcare provider during your appointment, it’s important to tell him/her just what’s happening. Use the tips below to talk with your provider. Before making the call, have the following information with you:

- Your personal health record
- List of your medications
- Pharmacy name and telephone number
- Your current problems/illnesses/diagnoses

S – Situation
I am having:
- Pain (explain where pain is felt):
- Unexplained weight gain
- Unexplained weight loss
- Difficulty sleeping
- Nausea
- Vomiting
- Bleeding
- Harder time breathing
- Foul drainage from my wound
- Other (explain):

B – Background
I began to feel this way: ________________ (When did it start?)
What makes it better is: ____________________________
What makes it worse is: ___________________________
How long it lasts: ________________________________
It prevents me from doing my usual activities: _____Yes _____No
My last: Weight ____________________ Blood sugar ____________
Temperature__________________ Blood pressure/pulse ______________

A - Assessment
I think I feel this way because (Include any other possible reasons: emotional, stress, finances, new medication): ____________________________________________________

R – Recommendation (by your doctor)
Write down your doctor’s instructions: ____________________________________
___________________________________________________________________
___________________________________________________________________

Source: This material was prepared by Masspro, the Medicare Quality Improvement Organization for Massachusetts, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily represent CMS policy.
## My Medication List

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<thead>
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<th>Name</th>
<th>Used For</th>
<th>Instructions</th>
<th>Morning</th>
<th>Afternoon</th>
<th>Evening</th>
<th>Night</th>
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Technical Advisory Panel Members

January 2013 - June 2013

Kate Jones, Senior Vice President/Chief Clinical Officer, Amedisys
Martha Stuart Williams, Chief Human Resources Officer, Amedisys
Barbara McCann, Chief Industry Officer, Interim HealthCare
Susan P. Smith, DHA, RN, MSN, Gentiva Health Services, Inc.
Charlotte Weaver, Chief Clinical Officer and Senior Vice President, Gentiva Health Services
Judy Fenton, Director of Clinical Integration, Senior Home Care An Affiliate of Kindred at Home
Beth Hennessey, Executive Director, Integrated Care, Sutter Care at Home
Kathleen McConnell, Vice President of Care Coordination, VNA Health Group
Robert Rosati, Vice President of Clinical Informatics, CenterLight Healthcare

Ex officio members:
Mary St. Pierre, Former Vice President for Regulatory Affairs, NAHC