



TALK About Prescriptions Month October 2013

External Partner Resources You Can Use and Improving Transitions of Care & Reducing Hospital Readmissions

[The Alliance for Rational Use of NSAIDs](#)

The Alliance for Rational Use of NSAIDs is a public health coalition dedicated to educating people about the safe and appropriate use of nonsteroidal anti-inflammatory drugs (NSAIDs). The Alliance mission is to inform and educate health care professionals and the public at-large on the safe and appropriate use of NSAID therapy and to balance benefits and risks when taking NSAIDs and to provide a treatment approach that facilitates an active role for patients as a valuable part of their health care team.

[Alliance for the Prudent Use of Antibiotics](#)

The Alliance for the Prudent Use of Antibiotics (APUA) has been the leading global non-governmental organization fighting to preserve the effectiveness of antimicrobial drugs since 1981. With affiliated chapters in over 66 developed and developing countries, we conduct research, education and advocacy programs to control antimicrobial resistance and ensure access to effective antibiotics for current and future generations.

[Get Smart: Know When Antibiotics Work](#)

The Get Smart campaign includes print materials, radio and TV materials, treatment guidelines for upper respiratory tract infections and **Get Smart About Antibiotics Week** materials.

[Know Your Dose Campaign – Promoting Safe & Acetaminophen Use](#)

The Know Your Dose campaign educates patients and consumers about the safe and effective use of acetaminophen. The campaign is organized by the Acetaminophen Awareness Coalition – a group of consumer organizations, health organizations, and healthcare provider organizations. The campaign informs consumers about the hundreds of medicines that contain acetaminophen, and encourages them to always read and follow labels. This information is spread through a partnership with healthcare providers, pharmacies, health clinics, and others to reach patients and consumers as they are making healthcare decisions.

[National Diabetes Education Program \(NDEP\)](#)

A joint initiative of CDC and NIH, the NDEP provides a number of diabetes education resources and tools designed especially for health care professionals, school personnel, and business and managed care professionals. In addition, there are materials for individuals and families, partners, and other community organizations.

[Partnership to Fight Chronic Disease](#)

The Partnership to Fight Chronic Disease (PFCD) is a coalition of hundreds of patient, provider, community, business and labor groups, and health policy experts, committed to raising awareness of the number one cause of death, disability and rising health care costs: chronic disease. An included [Almanac of Chronic Disease](#) highlights the significant impact of chronic disease to the U.S healthcare system, individuals and the economy as well as the growing movement to counter this epidemic. The digital Almanac includes an interactive display on the prevalence of a variety of chronic conditions and risk factors. The map provides a sense of trends across the country and the dynamic charts allow users to explore real data at a National or State level.

[Screen for Life: National Colorectal Cancer Action Campaign](#)

Screen for Life: National Colorectal Cancer Action Campaign informs men and women aged 50 years or older about the importance of having regular colorectal cancer screening tests. Screen for Life has created a suite of educational campaign materials in English and Spanish for patients and health professionals. Print materials, including fact sheets, brochures, and posters, can be viewed, printed, and ordered online. Television and radio public service announcements can be viewed and heard online; transcripts are also available.

[Script Your Future National Medication Adherence Public Education Campaign](#) Script Your Future is here to help people manage chronic conditions such as diabetes, COPD, asthma, high blood pressure or high cholesterol. Understanding your condition and taking your medicine correctly are important steps toward a longer, healthier life. This campaign can help consumers with tools to manage their medicines and sample questions to help start a conversation with their healthcare providers about their medicine. The National Consumers League (NCL) leads the campaign, which also includes coordinated national communications, paid advertising and targeted outreach in six cities around the nation: Birmingham, AL; Cincinnati, OH; Baltimore, MD; Raleigh-Durham, NC; Sacramento, CA; and Providence, RI.

[Inventory of Multiple Chronic Conditions Activities: Database of Programs, Tools, and Research Initiatives to Address the Needs of Individuals with Multiple Chronic Conditions](#)

In January 2013, HHS expanded its *HHS Inventory of Programs, Activities, and Initiatives Focused on Improving the Health of Individuals with Multiple Chronic Conditions (MCC)* to include MCC-related programs and activities that take place in the public and private sectors.

This inventory is a database of programs, tools, and initiatives that address individuals with multiple chronic conditions. This new database will benefit researchers, providers, and organizations interested in improving the care of individuals with MCC. The inventory database is organized according to the *HHS Strategic Framework on MCC* [[PDF](#) - 245 KB], making it easy to locate programs and activities that address each of the *Framework's* goals and objectives. OASH also developed a companion piece that provides additional detail on a subset of activities that support the goals of the *Framework*. The report titled *Private Sector Activities Focused on Improving the Health of Individuals with Multiple Chronic Conditions: Innovative Profiles* [[PDF](#) - 3.78 MB] features successful activities that make use of an innovation. The profiles present a

new or innovative use of the workforce, a technology, or individuals who themselves have MCC.

Multiple Chronic Conditions: A Strategic Framework - Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions

The vision that drives HHS efforts to address MCCs is Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions. Within the vision's focus on the individual with MCC, development of the framework by HHS elucidated four interdependent domains that benefit the individual: strengthening the health care and public health systems; empowering the individual to use self-care management; equipping care providers with tools, information, and other interventions; and supporting targeted research about individuals with MCC and effective interventions. Accordingly, to achieve its vision, this framework comprises these four overarching goals:

- Goal 1: Foster health care and public health system changes to improve the health of individuals with multiple chronic conditions
- Goal 2: Maximize the use of proven self-care management and other services by individuals with multiple chronic conditions
- Goal 3: Provide better tools and information to health care, public health, and social services workers who deliver care to individuals with multiple chronic conditions
- Goal 4: Facilitate research to fill knowledge gaps about, and interventions and systems to benefit, individuals with multiple chronic conditions

Each of these goals includes several key objectives and strategies that HHS—in conjunction with stakeholders and those who have or care for those with multiple chronic conditions—should use to guide its efforts. These efforts should build on and potentiate HHS programs and resources focused on the MCC population. Although this framework addresses those individuals with MCC, many of the strategies, including the prevention of additional chronic conditions, also apply to persons with only one or those with no chronic condition.

The public and private sectors share responsibility for implementing these activities. HHS is particularly grateful to the numerous stakeholders—including organizations and individuals—that provided input to HHS through the public comments process regarding the framework's goals, objectives, and strategies. HHS looks to build and strengthen partnerships with all interested stakeholders to achieve these important goals for individuals with MCC.

Chronic Conditions Among Medicare Beneficiaries – Chartbook 20123 Edition

The 2012 edition of the chartbook “Chronic Conditions among Medicare Beneficiaries” was published in October 2012. The data used in this report come from the 2010 CMS administrative claims data for 100 percent of Medicare beneficiaries enrolled in the fee-for-service (FFS) program, which are available from the CMS Chronic Condition Data Warehouse (www.ccwdata.org). The chartbook includes four sections:

- Section 1: Demographics and Prevalence
- Section 2: Medicare Service Utilization
- Section 3: Medicare Spending
- Section 4: Chronic Condition Co-morbidity

Improving Transitions of Care & Reducing Hospital Readmissions

Resources You Can Use

There and Home Again, Safely -- 5 Responsibilities of Ambulatory Practices in High Quality Care Transitions (developed by the American Medical Association, Center for Patient Safety)

The American Medical Association has outlined five key responsibilities physicians should adopt when providing care for patients recently discharged from the hospital.

The recommendations listed in the report were developed to improve safety and reduce hospital readmissions for patients returning home, according to the AMA Center for Patient Safety, which is attempting to build a bridge between inpatient and outpatient settings. With the new guidelines, The Center for Patient Care study says it hopes to break a historic trend that left the responsibility for transition plans almost solely in the hands of the inpatient clinical teams.

The five responsibilities outlined in the report include:

1. Assessment of the patient's health;
2. Goal-setting to determine desired outcomes;
3. Supporting self-management to ensure access to resources the patient may need;
4. Medication management to oversee needed prescriptions;
5. Care coordination to bring together all members of the health care team.

Chronic Disease Self-Management Program: A Toolkit for Hospitals

(Developed by Holy Cross Hospital, Silver Spring, MD)

This toolkit for hospitals and community partners provides information on the benefits of starting and sustaining a Chronic Disease Self-Management Program (CDSMP) for people with chronic conditions. The information presented outlines cost savings, reduction in days spent in the hospital, and reduction in readmissions. The toolkit also provides tips and guides on how to address the needs of people with chronic conditions by improving self-management skills.

Topics covered include:

- Implementation
- Identifying potential internal referral sources
- Marketing materials
- Outcome measurements
- Community partnerships
- Resources

Coordinated-Transitional Care Toolkit

(Developed by University of Wisconsin-Madison School of Medicine & Public Health; William S Middleton Memorial Veterans Hospital)

Coordinated-Transitional Care (C-TraC) is a low-resource, telephone-based, protocol-driven program designed to reduce 30-day rehospitalizations and to improve care transitions during the early post-hospital period. The goal of this toolkit is to help hospital systems that serve

populations with high rates of patient dispersion, cognitive impairment, and vulnerability improve care coordination and post-discharge outcomes such as reduced medication discrepancies. Free registration is required to download the toolkit.

This toolkit is designed to help clinicians and researchers execute the C-TraC program protocol. Highlights of the C-TraC program toolkit include the following:

1. An overview of barriers to providing high-quality transitional care
2. Core components of the C-TraC program protocol
3. A step-by-step guide to executing the C-TraC program protocol
4. An overview of common challenges to managing the C-TraC program protocol

[The Aging Network and Care Transitions: Preparing your Organization Toolkit](#)

Developed for States, Area Agencies on Aging, Aging and Disability Resource Centers, Tribal Organizations, and other local service providers within the National Aging Network, the Administration on Aging Care Transitions Toolkit is targeted to organizations that are interested in learning more about how to prepare their organization for a role in care transitions programs. Whether your organization has historically developed partnerships with health care providers or programs that span the continuum of care such as Community Living, Money Follows the Person, Aging and Disability Resource Centers, or others, the tools and resources here can assist in formalizing your efforts for future funding and program opportunities.

Transition of Care Models

The Transitional Care Model (TCM), Penn Nursing Science

More than 10 million Medicare beneficiaries, approximately 20% of older Americans, are living with five or more chronic conditions. Effective care management of this population is often complicated by several other health and social risk factors. The Transitional Care Model (TCM) provides comprehensive in-hospital planning and home follow-up for chronically ill high-risk older adults hospitalized for common medical and surgical conditions. For the millions of Americans who suffer from multiple chronic conditions and complex therapeutic regimens, TCM emphasizes coordination and continuity of care, prevention and avoidance of complications, and close clinical treatment and management - all accomplished with the active engagement of patients and their family and informal caregivers and in collaboration with the patient's physicians. :

Care Transitions Intervention (CTI/Care Transition Program); Eric A. Coleman, MD, MPH; see especially *The Medication Discrepancy Tool*. TM

Project RED (Re-Engineering Discharge) - Project RED is a research group at Boston University Medical Center that develops and tests strategies to improve the hospital discharge process in a way that promotes patient safety and reduces re-hospitalization rates. The RED (re-engineered discharge) intervention is founded on 12 discrete, mutually reinforcing components and has been proven to reduce rehospitalizations and yields high rates of patient satisfaction.