

Recommended Actions for Improved Care Transitions

The transition period between care settings is the most vulnerable time for patients and their caregivers. Information that may have seemed clear while in the hospital may be difficult to understand when the patient is home. Many patients believe that care providers pass information between care settings in a timely and effective manner. Patients may find themselves dealing with a knowledge gap when providers do not communicate with each other. Patients often don't know what changes in their condition could mean, which means they don't understand the importance or urgency of the change or who to call if a change occurs, leaving them vulnerable for emergency room visits and readmissions or worse.

The RARE campaign was formulated to focus efforts across the state to improve the quality of care for patients transitioning across care systems and to reduce avoidable readmissions by 20% by the end of 2012. For our patients this means 16,000 nights of sleep at home rather than in a hospital bed.

The RARE campaign calls upon hospitals and their partners along the care continuum to focus on five key areas known to improve care and thereby reduce avoidable hospital readmissions.

In this document, we provide recommendations that are core strategies for improvement. These recommendations based on best practice, evidence and consensus are key practices that organizations should be working to implement.

Other strategies are given that organizations may consider given their issues, needs and resources.

More detailed information on these recommendations and strategies is available at <http://www.RAREadmissions.org>.

The Five Key Areas

The issues that influence avoidable readmissions are complex and many. Improvement work needs to be done in each care setting and across care settings to make an impact. In analyzing the literature, local and national programs, five areas have been identified as a focus for quality improvement efforts.

- #1 Patient and Family Engagement and Activation
- #2 Medication Management
- #3 Comprehensive Transition Planning
- #4 Care Transition Support
- #5 Transition Communication

#1 Patient/Family Engagement and Activation

In our culture, many patients and their families have been relegated to a passive role in their health care. Patients and families have wide variation in their knowledge of the health care system and their understanding of the issues that affect them. Hospitalized patients may be impaired by their illness, pain, sedatives or simply confused by what they are experiencing. These factors, along with cultural and language issues, may prevent patients from being fully engaged in their healthcare processes and decision-making.

The patient and their family live daily with their condition and they need to be as engaged as possible as they make numerous decisions about their care often in the absence of any guidance by health care professionals. Organizations working to improve in this area focus on ensuring that processes are in place to engage patients/family, elevate the status of family caregivers as essential members of the team, and prepare the patient and family to manage care at home.

(Coleman, 2011)



Recommendations:

- Care team members are strongly encouraged to use the Teach Back method when giving instructions to patients for information that the patient will need to act upon during and after transitions. Teach Back assures the care provider that the patient/caregiver understands the information. Care providers should include family members and/or caregivers in the teaching as well whenever possible. If Teach Back is unsuccessful or the patient is unable to do the requirements of the care plan, the plan needs to be modified. This may be by engaging family members or other caregivers to carry out the plan. (Project BOOST)
- Care team members must develop methods and processes to ensure that caregivers are engaged in developing the plan of care and give preferences for the type, intensity or setting of care they receive.
- Care providers must utilize health literacy standards such as the AHRQ Health Literacy Universal Precautions Toolkit to ensure that spoken language and written materials are easy to understand from the patient's perspective. (DeWalt, 2010)

#2 Medication Management

Medications are important components of an overall strategy to manage chronic conditions. However, the number and complexity of medication regimes may leave the patient and their caregivers in a quandary of how to follow so many instructions. Patients and caregivers need support in how they can become active managers of their medications regimes, including why, how and when to take them. Further improvement opportunities exist in ensuring patients are prescribed only what they need and that the benefits of prescribed medications outweigh the risks.

Recommendations:

- Medication reconciliation must be completed at each patient transition, not as a checked task, but to ensure safety, accuracy and necessity of the medication as well as to facilitate communication and shared understanding between the care team and the patient. (CMS and TJC Standards).
- The newly reconciled medication list should indicate the purpose for taking each medication and the date of reconciliation should be noted at the top.
- When transitioning out of the hospital, changes in the medication regime from pre-hospital medications should be made clear to the patient and caregivers.
- Any discrepancy in the medications must be evaluated and acted upon.
- Teach Back is an effective strategy and should be used to elicit the level of understanding of the patient/caregiver to take medications safely and as prescribed. (Project BOOST)

Other Strategies:

- Medication Therapy Management should be offered in the acute and ambulatory care settings for high-risk patients.
- The pharmacist should review orders at the time of transition for accuracy and necessity, potential side effects and/or interactions for high-risk patients. (Frاندzel, 2012)
- The pharmacist should provide medication instruction for high-risk patients and should include an assessment of the patient's ability to accurately and reliably take medications. (Schnipper, 2006)
- A home visit to reconcile the medication list with what the patient is actually taking may be offered to high-risk patients.



#3 Comprehensive Transition Planning

The comprehensive transition plan (formerly called discharge instructions) is a guide developed collaboratively by the sending care team and the patient/caregiver for the tasks that are to be done by the patient or caregiver post-hospitalization. The focus is to ensure that all of a patient's needs are considered and are delivered in a way that the patient/caregiver can understand and use as a reference. (Sheppard, 2010) (Project RED)

Recommendations:

A written patient-centered transition plan must include the following:

- Reason for hospitalization, including information on disease/condition in terms the patient can understand.
- Medications to be taken post-transition, including, as appropriate, resumption of pre-admission medications.
 - Purpose of medication
 - Dosage of medication
 - When to take medication
 - How to take medication
 - How to obtain medication and refills
- Self-care activities
 - Diet
 - Physical activity level or limitations
 - Weight monitoring, etc.
- Durable medical equipment (DME)
 - Supplies the patient will need
 - Purpose of DME/supplies
 - Where/how to obtain DME/supplies
- Symptom recognition and management, including:
 - Symptoms that indicate the patient should respond and understand what care seeking options are available (red flags)
 - What to do if a red flag occurs, including the urgency of the issue, who to contact, how to contact them, and what to do in an emergency

- Coordination and planning for follow-up appointments.
 - Appointment should be made prior to transition and usually within 5 business days of transition (based on the patient's condition).
 - Involves coordination with the patient/caregiver to assure they will be able to get to and keep the appointment.
- The transition plan must be written in easy-to-understand, plain language, using only as many words as necessary, meeting as many health literacy standards as possible. Also avoid medical jargon, abbreviations and acronyms. Teach Back may also be useful in this regard.

#4 Care Transition Support

The transition period between care settings is the most vulnerable time for patients and their caregivers. Patients often don't know what changes in their condition could mean, which means they don't understand the importance or urgency of the change or who to call if a change occurs, leaving them vulnerable for emergency room visits and readmissions or worse.

Recommendations:

Post-hospitalization follow-up: (Nersesian, 2011)

- The patient must have a follow-up appointment with their primary care physician within 5 business days post-hospitalization or sooner if their condition warrants, to review their progress and plan of care. (Nersesian, 2011)
- The receiving provider should allow appointments slots for transitioned patients to be seen within 5 business days.
- Follow-up appointments should also be made with specialists, ancillary services such as PT, OT, respiratory therapy, pharmacists, etc. as indicated by the patient's condition.
- Within 72 hours of transition, a purposeful contact with the patient should be made by a team member with knowledge of the patient's history and plan of care.



- Teach back and open-ended questions should be used to assess and assure the patient understands and is able and willing to follow through on the plan of care.
- The content of the follow-up visit should focus on:
 - Patient’s goals for the visit, factors contributing to admission or ER visit, medications the patient is taking and on what schedule, medication reconciliation.
 - Patient’s needs for medication adjustment, follow-up on test results, monitoring and testing, advance directives, specific future treatments such as Physician Orders for Life Sustaining Treatment (POLST)
 - Patient needs for instruction on self-management using Teach Back
 - Explanation of warning signs and how to respond using Teach Back
 - Instructions for seeking emergency and non-emergency after- hours care (Coleman, 2010)

Other Strategies:

- Care Transitions Intervention® – This intervention developed by Dr. Eric Coleman and his team at the University of Colorado uses a coach to support the patient through their transition. The coach focuses on helping the patient and family caregiver develop skills and confidence to assert their treatment preferences and ensure that their needs are being met during transitions. <http://www.caretransitions.org> (Coleman, 2006)
- Case or care managers have a series of regular follow-up communications with the patient to ensure that medications, medical devices, meals/nutrition, transportation, appointments and other needs of the patient are in place.

#5 Transition Communication

Lack of timely and adequate information between providers and sites of care contributes to discontinuity of care and the risk of readmissions for patients. Transition information may be too much, not enough, or in a format that renders it suboptimal or even useless.

Recommendations:

- The primary care provider (PCP) should be notified on the same day of admissions and transitions. PCPs should be notified the following morning of evening and overnight admissions. Hospitalists and PCPs should reach consensus on the content, timing and mode of communication.
- At every point during care transitions, patients/caregivers must know who is responsible for care and how to contact them. Care providers must also know who is responsible at each transition.
- The transition communication responsibilities of the hospital physician should be explicitly stated in policy or in medical staff bylaws.
- Concise transfer forms with key elements as identified in the [MHA Safe Transitions of Care](#) program must be sent with the patient transferring to sites of care, such as skilled nursing facilities or transitional care units.
- When a patient transfers from one facility to another, direct reports between nursing staff should take place.
- Complete transition summaries should be received by the accepting facility within 3 business days. (Nersesian, 2011)

Other Strategies:

- Develop a universal patient care plan that would be used by all providers.
- Utilize a Patient Health Record that is maintained by the patient and is brought to and reviewed at all patient/provider encounters. ([Care Transitions.org](#))
- Allow access to hospital electronic health records for those facilities commonly in receipt of patients transitioned from that hospital.



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Recommendations and Location of Care

RARE Standard	Hospital	Ambulatory Care	Long-Term Care	Community
Patient/Family Engagement				
1. Utilize the Teach Back method	✗	✗	✗	✗
2. Ensure caregivers are engaged in developing the plan of care	✗	✗	✗	✗
3. Utilize health literacy standards	✗	✗	✗	✗
Medication Management				
1. Medication reconciliation completed at each patient transition	✗	✗	✗	✗
2. Medication list should indicate purpose and dates	✗	✗	✗	✗
3. Medication changes should be made clear to patient	✗	✗	✗	✗
4. Any discrepancy in the medications is evaluated and acted upon	✗	✗	✗	✗
5. Teach Back method is used	✗	✗	✗	✗
Comprehensive Transition Plan				
Includes:			TCU discharges	
1. Reason for hospitalization	✗		✗	
2. Medications	✗		✗	
3. Self-care activities	✗		✗	
4. Durable medical equipment	✗		✗	
5. Symptom recognition and management	✗		✗	
6. Coordination and planning for follow-up appointments	✗		✗	
7. Easy to understand language	✗	✗	✗	✗
Care Transition Support				
1. Follow-up appointment within 5 business days	✗	✗		
2. Assure appointments are available		✗		
3. Coordinate appointments with ancillary services	✗	✗	✗	✗
4. Within 72 hours, purposeful contact made with the patient	✗	✗	✗	
5. Utilize teach back	✗	✗	✗	✗
6. Content of follow-up visit		✗		
Transition Communication				
1. Notify primary care of admissions and discharges	✗			
2. Responsibilities assigned for care provider during each phase of transition	✗	✗	✗	✗
3. Medical bylaws contain responsibilities of hospital physician	✗			
4. Concise transfer form with key elements	✗	✗	✗	✗
5. Direct report between nursing staff	✗	✗	✗	✗
6. Discharge summaries completed and sent within 3 business days	✗	✗	✗	✗

Care Settings Definitions

Hospitals: Acute care facilities, including admit or observation status.

Ambulatory Care: Primary care and specialty care clinics.

Long Term Care: Includes skilled nursing facilities, transitional care and rehabilitation units, and assisted living facilities.

Community Care: Includes home care, Area Agency on Aging, community health workers, group homes and other community-based providers.

Note: The recommended actions in this document meet or exceed CMS and The Joint Commission's standards.



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