WHAT IS A TRANSITION OF CARE?

The term "care transitions" refers to the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness.

Each of these transitions is an opportunity for the patient to “fall through the cracks.”

SNF=skilled nursing facility

POORLY EXECUTED CARE TRANSITIONS HAVE A DIRECT IMPACT ON THE QUALITY AND COSTS OF CARE DELIVERY

• Inefficiencies and duplication of services
• Avoidable increases in the cost of care
• Unnecessary increases in utilization of hospital, emergency, post-acute, and ambulatory services
• Poor clinical outcomes
• Patient complaints and litigation, which require staff time and resources in order to resolve
• Negative publicity

THE COST OF POOR TRANSITIONS OF CARE

$25 billion

$45 billion

• Poor care transitions caused between $25 billion and $45 billion in wasteful medical spending through **avoidable complications** and **unnecessary hospital readmissions**
  - ~50% of patients experience a medical error after hospital discharge
  - Almost **one-quarter experience adverse events**, a substantial proportion of which are drug related
  - **50% of drug-related adverse events** could be either prevented or lessened

STUDIES OF TRANSITIONS OF CARE PROGRAMS SHOW IMPACT ON HOSPITAL READMISSIONS AND COSTS

<table>
<thead>
<tr>
<th>Retrospective Analysis of Medicare Current Beneficiary Survey (MCBS)</th>
<th>Project Re-Engineered Discharge (RED) in Skilled Nursing Facility</th>
<th>Analysis of Transitions of Care Coaching Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>✦ Follow-up visit lowered the risk of readmission within 90 days</td>
<td>✦ Lower rate of returning to the hospital within 30 days</td>
<td>✦ 30-day readmissions fewer for participants who received coaching</td>
</tr>
<tr>
<td>✦ Lowered annual expenditures following discharge by approximately $10,000</td>
<td>✦ More likely to attend medical appointments</td>
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<td></td>
<td>✦ Better prepared for their care transition</td>
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SEVEN BUILDING BLOCKS ARE REQUIRED FOR EFFECTIVE TRANSITIONS OF CARE

SEVEN BUILDING BLOCKS ARE REQUIRED FOR EFFECTIVE TRANSITIONS OF CARE

Continued

<table>
<thead>
<tr>
<th>Building Block</th>
<th>Description</th>
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<tbody>
<tr>
<td>Medication management</td>
<td>Medication reconciliation, with the involvement of pharmacists.</td>
</tr>
<tr>
<td>Transfer of information</td>
<td>Handoffs that involve interpersonal communication (instead of only written or electronic communication).</td>
</tr>
<tr>
<td>Transitional planning</td>
<td>Each patient and family/friend caregiver has a discharge risk assessment completed within the first 24-48 hours of admission. Discharge planning begins immediately after admission.</td>
</tr>
<tr>
<td>Leadership support</td>
<td>Strong leadership support for new transitions processes</td>
</tr>
<tr>
<td>Multidisciplinary collaboration</td>
<td>A care team – including a physician, nurse, pharmacist, social worker, and others as appropriate – communicates, collaborates and coordinates effectively.</td>
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<tr>
<td>Early identification of patients/clients at risk</td>
<td>Assessment to identify factors that must be addressed to assure a good outcome and prevent a readmission.</td>
</tr>
<tr>
<td>Patient and family action/engagement</td>
<td>Teaching the patient and family about their role and responsibility in managing a condition while gaining an understanding of psychosocial issues affecting the patient and family.</td>
</tr>
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</table>

SPECIFIC ELEMENTS OF EFFECTIVE TRANSITIONS OF CARE PROGRAMS

1. Multidisciplinary communication, collaboration and coordination—including patient/caregiver education—from admission through transition
2. Clinician involvement and shared accountability during all points of transition
3. Comprehensive planning and risk assessment throughout hospital stay
4. Standardized transition plans, procedures, and forms
5. Standardized training
6. Timely follow-up, support and coordination after the patient leaves a care setting
7. If a patient is readmitted within 30 days, gain an understanding of why
8. Evaluation of transitions of care measures

**STEPS FOR ORGANIZATIONAL CHANGE**

1. **Form a team**
2. **Identify opportunities for improvement (e.g., review and analyze the last 10 readmissions, chart 30-day readmissions)**
3. **Create a high-level flowchart of the process. Define your transitions of care program**
4. **Develop a clear aim statement for your improvement work. Review existing TOC models**
5. **Standardize the sub-process and measure reliability**
6. **Process redesign and testing changes**
7. **Identify failures in the redesigned standard process**
8. **Increase reliability: redesign the process to eliminate failure**
9. **Spread the reliable design and process**
MINIMUM CARE PLAN ELEMENTS

• Routine needs
• Tracking patient’s progress
  • Documentation of International Normalized Ratio (INR), if necessary
  • Weight
  • Blood pressure
  • Heart rate
• Specific instructions regarding care after the procedure, including:
  • Medication guidelines
  • Wound care
  • Physical activity guidelines
  • Post-procedure symptoms
  • Follow-up schedule
TRANSITION RECORD ELEMENTS

• List of diagnoses and treatments that occurred in the hospital
• Test results and those needing to be completed during follow up
• Fully reconciled medication list with clear instructions for why/how to take/store medications, including potential side effects, and why they were prescribed
• Health care provider contact information in the event a problem occurs
• Written discharge instructions and educational materials
TRANSITION RECORD ELEMENTS

Continued

• Assessment of caregiver status
• Follow-up appointments scheduled
• Home care instructions, including plan for ongoing care at home
• List of symptoms for which to watch (red flags) and what to do if they occur
  • Include contact information — to whom and how to report
• Contact information for provider receiving patient
  • e.g., Cardiologist or Primary Care Physician
PATIENT TOC CRITICAL STEPS

1. Assess patient risk and identify needs on admission
2. Develop comprehensive care plan for patient
3. Coordinate care plan with patient’s multidisciplinary care team
4. Review care plan with patient
5. Activate ancillary services (e.g., home health nursing, rehab facility, social work, etc) as needed
6. Review discharge processes (includes all necessary members of the multidisciplinary team)
7. Educate patient and family on post-discharge plan and self-care
8. Patient follow-up
9. Monitor patient and determine reasons for readmission if occurs and make action plan to address
‘BEST PRACTICES’

• Communication
  • Develop documented care plan that is maintained and shared across settings
  • Ensure timely transfer of patient information to health care professionals (HCPs)
  • Establish an electronic source of communication between providers
  • Fax or email report to referring physician who will follow patient after the procedure with a separate checklist of expected outcomes and the outcomes for which he/she should consult the EP physician who performed the procedure
  • Fax or email anticoagulation clinic or primary care physician who will be following patient for anticoagulation after the procedure
‘BEST PRACTICES’

Continued

• Discharge
  • Offer post-discharge support via telephone, email, etc.
  • Give the patient a copy of EP report and any other pertinent data, such as lab work, echo, and CT results

• Follow-up
  • Coordinate follow-up visits among the different HCPs
  • Schedule follow-up visit prior to discharge
  • Ensure follow-up calls were made to the patient
  • Schedule appointment for post-discharge testing
‘BEST PRACTICES’

Continued

• Medication Reconciliation
  • Make certain the patient understands the importance of taking medications
  • Discuss continued medications; new medications with instructions; and discontinued medications
  • Fully reconcile the medication list and provide clear instructions for why and how to take medications, including potential side effects, to the patient
  • Provide clear instructions on post-procedure expectations: what is normal after the procedure and when the HCP should be contacted
‘BEST PRACTICES’

Continued

• **Patient Education**
  • Discuss care options and treatment plan with the patient
  • Educate family members and caregivers on the condition of AFib and the expectations related to the procedure
  • Educate family members and caregivers, especially those of the elderly, on effective symptom management
  • Educate patient, family members, and caregivers on the need to call referring physician after the procedure to give immediate feedback on how procedure went and if there were any complications
ELEMENTS OF A DISCHARGE CHECKLIST

- Confirm medication plan with medicine reconciliation
- Provide anticoagulation teaching/patient education/teach-back
- Create personalized care record for patient, including pending test results and medications
- Complete and forward a discharge summary to primary care physician and other health care providers within 24 hours
- Review steps on who to contact should a follow-up care issue arise
- Develop a symptom management action plan
ELEMENTS OF A DISCHARGE CHECKLIST

Continued

- Initiate direct verbal communication with post-hospital care provider to review hospital course and follow-up care issues

General Recommendations:

- Schedule appointments for clinician follow up
- Make post-discharge call back to reinforce discharge plan
- Schedule appointment for post discharge testing
- Offer post-discharge telephone support
## Transitions of Care Organizational Self Assessment Tools

<table>
<thead>
<tr>
<th>Tool</th>
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<tbody>
<tr>
<td>National Transitions of Care Coalition</td>
<td><a href="http://www.ntocc.org/TOCEvaluationSoftware.aspx">http://www.ntocc.org/TOCEvaluationSoftware.aspx</a></td>
</tr>
<tr>
<td>AGA Transitions of care readiness worksheet</td>
<td><a href="http://aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/toolkit/docs/AOA_080_CareTransitionsWkSht.pdf">http://aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/toolkit/docs/AOA_080_CareTransitionsWkSht.pdf</a></td>
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HRS TOC RESOURCES

- Rate and rhythm pocket guide
- Managing the patient with AFib pocket guide
- CHADS$_2$ risk assessment calculator
- CHA$_2$DS$_2$ VASc risk assessment calculator
- TOC resources:
  - About Transitions of Care
  - Minimum care plan elements
  - Transition record elements
  - Best practices
  - Discharge checklist

http://resources.hrsonline.org/provider.html
# TOC Examples Across Therapeutic Areas

<table>
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<th>Example</th>
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<tr>
<td>University of California, San Francisco (UCSF) Medical Center</td>
<td><a href="http://www.commonwealthfund.org/~/media/Files/Publications/Case%20Study/2012/Nov/1635_McCarthy_Care_Transitions_UCSF_case_study.pdf">http://www.commonwealthfund.org/~/media/Files/Publications/Case%20Study/2012/Nov/1635_McCarthy_Care_Transitions_UCSF_case_study.pdf</a></td>
</tr>
<tr>
<td>Better Outcomes for Older adults through Safe Transitions (BOOST)</td>
<td><a href="http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/PDFs/Workbook_for_Improvement.pdf">http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/PDFs/Workbook_for_Improvement.pdf</a></td>
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# OTHER RESOURCES

## For Patients and Caregivers

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<thead>
<tr>
<th>Resource</th>
<th>Website/Contact Information</th>
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<tr>
<td>AFib Awareness</td>
<td><a href="http://www.MyAFib.org">www.MyAFib.org</a></td>
</tr>
<tr>
<td>Patient Information</td>
<td><a href="http://www.HRSonline.org/PatientInfo/index.cfm">www.HRSonline.org/PatientInfo/index.cfm</a></td>
</tr>
<tr>
<td>What is AFib?</td>
<td><a href="http://www.nhlbi.nih.gov/health/health-topics/topics/af/">www.nhlbi.nih.gov/health/health-topics/topics/af/</a></td>
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<tr>
<td>Patient AFib Fact Sheet</td>
<td><a href="http://www.hrsonline.org/Patient-Resources/Patient-Information-Sheets#axzz31gwENLHn">http://www.hrsonline.org/Patient-Resources/Patient-Information-Sheets#axzz31gwENLHn</a></td>
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<tr>
<td>Mended Hearts</td>
<td><a href="http://www.mendedhearts.org">www.mendedhearts.org</a> 1-888-(HEART99)</td>
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**OTHER RESOURCES**

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<tr>
<td><strong>Atrial Fibrillation</strong></td>
<td><a href="http://www.hrsonline.org/PatientInfo/HeartRhythmDisorders/AFib/index.cfm">http://www.hrsonline.org/PatientInfo/HeartRhythmDisorders/AFib/index.cfm</a></td>
</tr>
<tr>
<td><strong>Atrial Fibrillation - The Common Arrhythmia</strong></td>
<td><a href="http://www.hrsonline.org/Education/AFib360/AFibSS/">http://www.hrsonline.org/Education/AFib360/AFibSS/</a></td>
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<tr>
<td><strong>Upcoming HRS CME-granting programs</strong></td>
<td><a href="http://www.hrsonline.org/Education/Courses/">http://www.hrsonline.org/Education/Courses/</a></td>
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