




Care Transition Bundle Seven Essential Intervention Categories

Intervention Category	Description	Examples of Transitions of Care Intervention Considerations
 <p>1. Medications Management Services & Coordination</p>	<p>Ensure the safe use of medications by patients and their identified family caregiver with focus on the patients' plan of care. A pharmacist should be involved as part of the interdisciplinary care team</p> <p>A. Assess patient's medication list and needs</p> <p>B. Assess Social Determinants of Health (SDOH)</p> <p>C. Provide the patient and the identified family caregiver education and counseling about medications</p> <p>D. Develop and implement a plan for medication management services as part of the patient's overall plan of care</p>	<p>a. Perform an assessment of patient's medications intake – ask the patient to name an identified family caregiver, if possible, to assist</p> <ul style="list-style-type: none"> ● Use a pharmacist to check the dosing of medications. ● Pharmacists are able to then check all medications against standard renal dosing. ● Perform a medication review including over-the-counter medications, herbals, vitamins, allergies, and drug interactions and reconcile with the patient's health record. ● Identify problem medications and high-risk medications i.e., Beer's Criteria, STOPP/START Criteria. ● Identify and resolve polypharmacy issues. ● Assess adherence and medication schedules. ● Discuss the need for prescriptions written in the primary language of the patient and refer to pharmacies that provide labeling in different languages when possible. <p>b. Assess Social Determinants of Health (SDOH)</p> <ul style="list-style-type: none"> ● Address SDOH that have impact on access to medications: financial costs, transportation, mobility, mentation. ● Provide community navigation resources to assist with addressing identified issues from the assessment. ● Assess the patients' and their identified family caregivers' health literacy level & primary language. <p>c. Provide the patient and their family identified caregivers' education and counseling about medications</p> <ul style="list-style-type: none"> ● Use a teach back method to establish understanding of medication plan and involve the caregiver. ● Explain what medications to take, when to take, how to take them i.e., with/without food, emphasizing any changes in the regimen. ● Review important side effects with both the patient and caregiver. <p>A. Provide appropriate contacts for questions or side effect symptoms.</p> <p>d. Develop and implement a plan for medication management as part of the patient's overall plan of care</p> <ul style="list-style-type: none"> ● Perform medication reconciliation including pre-hospitalization and post-hospitalization medication lists. ● Ensure the patients' identified family caregiver has a realistic plan about how to get the medications, including review of coverage and transportation to preferred pharmacy. ● Confirm the medication plan - pharmacist follow-up telephone calls after intensive nurse-based patient education upon hospital or post-acute-care (PAC) discharge or transfer. Consider using telehealth/virtual visits. ● Employed coordinated and integrated team approach to medication management, involving pharmacists and/or physicians, case managers and social workers. ● Provide easy to understand medication schedules, confirm patient/family caregivers understanding, by asking them to explain their schedules in their own words, if necessary, use a professional translator.


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 <p>2. Transition Planning</p>	<p>A formal process that facilitates the safe transition of patients from one level of care to another including home or from one practitioner to another.</p> <p>A. Clearly identify a practitioner (or team dependent on setting) to facilitate and coordinate the patients transitions plan</p> <p>B. Manage patients and their family identified caregivers' transition needs</p> <p>C. Use formal transition planning tools</p> <p>D. Complete a transition summary, send it in a timely manner and secure confirmation by the receiving entity</p> <p>E. Develop and implement a plan for the use of medical devices and remote patient monitoring</p>	<p>a. Clearly identify a practitioner (or team dependent on setting) to facilitate and coordinate the patient's transition plan</p> <ul style="list-style-type: none"> ● Use of a transitional care nurse, advanced practice nurse, case manager or social worker to conduct a comprehensive assessment of the patients' and their identified family caregivers' needs. This professional will then coordinate the patient's discharge or transition plan with the Identified family caregiver and healthcare provider team. ● Identify patients and their identified family caregiver's post-episode of care needs. Ensure a specific member of the healthcare team is assigned in collaboration with the others on the team for this coordination. <p>b. Manage the patient's and their identified family caregiver's transition needs</p> <ul style="list-style-type: none"> ● Perform an enhanced assessment, including hospital assessment, comprehensive home assessment, Social Determinants of Health and Life-Care Planning to ensure safe transition. ● Provide coaching, counseling and support to patient and their identified family caregivers regarding healthy lifestyle and health regimen. ● Take consideration of the patients' and their identified family caregiver's literacy level; create materials which are between fifth and eighth grade level. <p>c. Use formal transition planning tools</p> <ul style="list-style-type: none"> ● Make use of a universal discharge or transition checklist ● Create a person-and-family centered plan of care with documented goals ● Ensure the transfer of information from one level of care, setting or provider to another, either electronic, handwritten and if necessary, carried at the time of discharge. <p>d. Complete a transition summary</p> <ul style="list-style-type: none"> ● Expedite transmission, preferably an electronic transfer, of the discharge or transition summary to the physicians, long term care (LTC) (and other services, such as the visiting nurses) accepting responsibility for the patient's care after discharge. Have the receiving entity confirm. ● Provide a written discharge or transition plan at the time of discharge/transition, written at the patient's appropriate literacy level and assess the patients and their identified family caregivers' degree of understanding by having them explain the details in their own Words. <p>e. Develop and implement a plan of care for medical device and remote patient monitoring as needed</p> <ul style="list-style-type: none"> ● Transitioning home, coordinate with durable medical equipment companies for needed equipment and (if applicable) with chronic care management platforms and remote patient monitoring ● Engage the identified family caregiver in the training and use of the home medical device(s); ensure understanding with returned demonstration ● Provide special consideration planning in case of power loss if appropriate ● Assess home oxygen use and maintenance ● Ensure awareness of whom to contact with issues or concerns from the patient or family.


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 <p>3. Patient and Identified Family Caregiver Engagement & Education</p>	<p>Engage and encourage patient and family participation in their own care and shared decision making.</p> <p>A. Ensure patients and their identified family caregivers are knowledgeable about their condition and plan of care</p> <p>B. Communicate transition information in a patient centered format</p> <p>C. Develop patient's self-care management skills</p> <p>D. Facilitate patient engagement with technology including virtual patient visits</p>	<p>a. Ensure patients and their identified family caregivers are knowledgeable about their condition and plan of care</p> <ul style="list-style-type: none"> ● Document who the patient identifies as their family caregiver, i.e., spouse, family member, friend, legal guardian. ● Evaluate current knowledge of the patient's condition with both patient and identified family caregiver. ● Assess the patients' and their identified family caregivers' knowledge about indications that their condition is worsening and how to respond using knowledge of "red flags" or "Color Zone" tools. ● Use appropriate health-literacy materials and language. ● Create and use patient and family education and counseling guides. <p>b. Ensure patient and family-centered transition communication</p> <ul style="list-style-type: none"> ● Provide a complete patient and chosen caregiver assessment for vision deficiencies, cognitive issues, long-term dementia, short-term delirium. Ensure that patient and family have acquired skills for care at next level of care, e.g., wound care, device care, to check for blood sugar, draw and give insulin ● "Translate" information between the provider, patient and the identified family caregiver to ensure that each party really understands what the other has communicated – use the "teach back" process to clarify information and understanding. ● Conduct real time patient and family-centered handoff communication. <p>c. Teach and develop patient self-care management skills</p> <ul style="list-style-type: none"> ● Use the teach back process around specific risk issues to optimize patient and family education practices. ● Assess the patients' and the family identified caregivers' degree of understanding by asking them to explain the details of the plan in their own words (Patient Activation Measure) ● Observe, address and document gaps and plan for demonstration of skills necessary for self-care (e.g., ability to do blood glucose, give insulin injections, monitor oxygen). <p>d. Facilitate patient engagement with technology including digital, virtual and home monitoring</p> <ul style="list-style-type: none"> ● Assess the patient and the identified family caregivers' ability to understand and use technology. ● Assess with the patient and identified family caregiver's broadband capabilities. ● Provide a guide on how to prepare for a virtual visit.


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 <p>4. Information Transfer</p>	<p>Share important care information among patient, identified family caregiver, and healthcare providers in a timely and effective manner.</p> <p>A. Implement clearly defined communication models</p> <p>B. Use of formal communication tools</p> <p>C. Clearly identify practitioner(s) to facilitate timely transfer of essential information</p>	<p>a. Implement clearly defined communication models</p> <ul style="list-style-type: none"> ● Create and enhance communication infrastructure, which will optimize communication with other healthcare providers about a patient (or resident in certain settings) change of status. ● Provide timely feedback and feed-forward of information by utilizing specific communication models that support consistent and clear communication among practitioners and caregivers. - Digital, audio, written, virtual (an interaction between provider and patient using communication technology). ● Assess that patients' and identified family caregivers are able and prepared to use technology formats. ● Where applicable ensure patients have access to their electronic medical records – via computer, or smartphone apps. <p>b. Use formal communication tools</p> <ul style="list-style-type: none"> ● Use a personal health record. ● Utilize specifically designed tools, i.e., transfer tool, transition record, transition summary. ● Utilize an integrated electronic medical record and a Web-based care management tracking tool, i.e., electronic transfer of the discharge or transition instruction form to the receiving healthcare provider. Share the form with the patient and identified family caregiver. <p>c. Clearly identify practitioner(s) to facilitate timely transfer of essential information</p> <ul style="list-style-type: none"> ● Transfer critical patient information, preferably within 24 hours or at the time of discharge. The collaborative care team inclusive of hospitalists, attending physicians, specialists, pharmacists, nurses and social workers must commit to accountability for developing and delivering the documentation regarding patient critical information. ● Care coordinators actively facilitate communications among providers and between the patient and the providers. ● Conduct real time patient and identified family caregiver handoff communication with accepted handoff communication techniques.

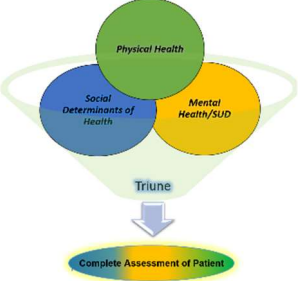
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 <p>5. Follow-Up Care</p>	<p>Facilitate the safe transition of patients from one level of care or provider to another through effective follow-up care activities.</p> <p>A. Ensure patients and identified family caregiver has timely access to key healthcare providers after an episode of care as required by patient's condition and needs</p> <p>B. Communicate with patients and/or identified family caregiver and other healthcare providers post transition from an episode of care</p>	<p>a. Ensure the patient and their identified family caregiver has timely access to key healthcare providers after an episode of care as required by the patient's condition and needs</p> <ul style="list-style-type: none"> ● Schedule and confirm primary care, specialist, and community organization follow-up and any required diagnostics prior to discharge/transition. ● Make appointments for clinician follow-up and post-discharge testing prior to discharge in person or virtual. ● Ensure 24 hour, seven days a week access to a health services access line. Provide the phone number to the patient and their identified family caregiver. Be sure the patient and identified caregiver have a contact number of "Who To Call When." ● Ensure post-acute care follow up, telephonic, face-to-face or virtual visit at home and/or with a primary care physician/specialist within 48 hours of discharge. ● Enhance access and reduce wait times to a provider visit. ● Ensure the patient has an appointment within the first 7-14 days after an acute care episode. <p>b. Communicate with patients and their identified family caregivers and other healthcare providers post transition from an episode of care</p> <ul style="list-style-type: none"> ● Conduct a telephone or virtual reinforcement of the discharge or transition plan and problem solve 2 to 3 days after discharge/transition from an episode of care. This can be reinforcement via EHR using telehealth systems. RN/SW/pharmacist or non-clinician (who will escalate to clinician with specific triggers) can conduct this interaction. Process should be clearly defined by the care team and with the patient and identified family caregiver prior to discharge. ● Coordinate an in home follow up visit by RN/PT to assess safety when appropriate. ● The healthcare team needs to establish the frequency of contacts with their patients and identified family caregivers (or enrollees in payor-based settings). This helps them to detect subtle changes in their patients' or enrollees' conditions and they can react quickly to changing medical, functional, and psycho-social problems. ● Encourage the patient (where available) to enroll in their patient portal to promote ease of access to their healthcare records and providers. ● Clearly communicate the patient's advanced care plan/advance directives to the next care setting.

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 <p>6. Healthcare Provider Engagement & Shared Accountability Across the Healthcare Continuum</p>	<p>Demonstrate ownership, responsibility and accountability for the care of the patient and identified family caregiver at all times.</p> <p>A. Convene the care team to establish processes that improve transitions and care coordination at each level of care</p> <p>B. Establish appropriate communication and networks with all levels of care: acute care, post-acute care, ambulatory and community-based resources.</p> <p>C. Assume responsibility for the outcomes of the care transition process by both the provider (or organization) sending and the one receiving the patient</p>	<p>a. Convene the care team to establish processes that improve transitions and care coordination at each level of care.</p> <ul style="list-style-type: none"> ● Establish communication processes, roles and interaction between the interdisciplinary care team and between the various levels of care within the continuum. ● Develop patient-centered, evidence-based plans of care with the patient and their identified family caregiver. ● Identify and mitigate any gaps in the continuum of care, especially in rural communities. ● Create a check list of the relevant information needed for the next level of care i.e., SNF, rehab hospital, home health, palliative or hospice. ● Assess and ensure the patient and their identified family caregiver are connected with a primary care physician and /or specialist prior to discharge. <p>b. Establish appropriate communication and networks with all levels of care: acute care post-acute care, ambulatory, and community-based resources.</p> <ul style="list-style-type: none"> ● Establish a clear assignment of responsibility for follow up care, testing, and other necessary healthcare tasks needed for successful transitions i.e., SNF, home. ● Institute acceptable timeliness for discharge/transition plans from the interdisciplinary team i.e., hospitalist, specialist, nursing, pharmacy, social worker, case management. ● Prior to any transition, notify the patient's identified family caregiver where and when the patient is being transferred. ● Utilize telehealth services for the coordination, delivery, and management of ongoing care especially with transitions to home. <p>c. Assume responsibility for the outcomes of the care transition process by both the provider (or organization) sending and the one receiving the patient.</p> <ul style="list-style-type: none"> ● Monitor and measure the process and outcome metrics of the care provided. ● Utilize informatics and decision support analytics tools for all phases of assessment, interventions, and outcome measurements. ● Establish sending and receiving care team dual responsibility in the prevention of unnecessary hospitalizations and ED visits. ● Identify any barriers to successful transitions and assess all hospital readmissions to determine key issues where quality improvement interventions may be needed.

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 <p>7. Physical Health, Mental Health, Social Determinants of Health Triune</p>	<p>Physical Health, Mental Health, Social Determinants of Health Triune</p> <p>A. Ensure complete assessment of physical health, mental health including SUD and SDOH to avoid missing crucial factors that may significantly affect the others; they are not separate but integrated.</p>	<p>a. Ensure complete assessment of physical health, mental health including SUD and SDOH to avoid missing crucial factors that may significantly affect the others; they are not separate but integrated.</p> <ul style="list-style-type: none"> ● Support the whole individual and Identified family caregiver ● Ask patients and their family caregivers about home and community goals they would like to achieve. ● Assess health related quality of life (i.e., self-care, mobility, usual activities, pain/discomfort, spiritual & cultural issues and anxiety, depression). ● Consider a discussion with patients and their identified family caregiver using the 4M's Framework; "What Matters", "Medication", "Mentation", and "Mobility", within the Age-Friendly Health System. ● Communicate the outcome of discussion to the next level of care. ● Complete, document and share the patient's preference about their care options including Life-Care Planning directives. ● Arrange and manage referrals including medical equipment. ● Promote effective self-care strategies and highlight resources for additional support as needed. ● Provide periodic reassessment of needs and goals with revision of the interventions as needed. ● Addresses identified family caregiver needs for respite support, particularly those at home



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