Transitions of Care

Transitions of Care (TOC): the movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another (Centers for Medicare & Medicaid Services [CMS], 2013)

• Healthcare reform aims to provide more effective and efficient care, as a result, TOC is a focal point of improvement initiatives across the continuum of care
• Specific information should be included in every TOC to ensure patient safety and the delivery of high-quality care
• Seven Steps outlined to improve TOC at Kindred with a focus on Pain medications

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| Medications        | Ensuring the safe use of medications by patients and their families and based on patient's plan of care. | a. Comprehensive assessment of patient's medication history.  
 b. Patient and family education and counseling about medications.  
 c. Development and implementation of a plan for medications as part of the patient's overall plan of care. |

  a. Comprehensive assessment of patient’s medication history:  
  - Over-the-counter medications, herbs, vitamins, Homeopaths  
  - Pain medications: Anti-inflammatory, Narcotics, Anti-Depressants, Anti-Seizure, Nitrates  
  - Drug interactions  
  - Allergies

  b. Patient and family education and counseling about medications:  
  - Teach-back method to establish understanding of medication plan.  
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  - Importance of safety to take each medication and important side effects to watch for.  
  - Documentation in the medical record

  c. Development and implementation of a plan for medications management as part of the patient’s overall plan of care.  
  - Discuss patient flow metrics and how to get the medications.  
  - Be sure patient flow metrics are part of medication management, involving pharmacists and/or physicians.
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| **5. Follow-Up Care** | Facilitating the safe transition of patients from one level of care or provider to another through effective follow-up care activities. | a. Patients and families timely access to key healthcare providers after an episode of care as required by the patient’s condition and needs  
  b. Confirmation of Primary Care and Specialist Follow-Up (Discharge Patient)  
  c. Make appointments for clinician follow-up and post-discharge testing prior to discharge  
  d. 24-hour, seven day a week access to Health Services Access Line  
  e. Confirmation of primary care and specialist follow-up within 48 hours of discharge  
  f. Appointment within first 5-10 days post an acute care episode  
  g. Communicating with patients and families and other healthcare providers post transition from an episode of care  
  h. Confirming that the primary care provider is responsible for the care of the patient by the next business day to manage the transition  
  i. Patients and families timely access to key healthcare providers after an episode of care as required by the patient’s condition and needs  
  j. Patient and family education and counseling activities  
  k. Open and timely communication among healthcare providers, patients and families  
  l. Clear and timely communication of the patient's care plan to the receiving provider ensuring the smooth transition  
  m. Ensuring that a healthcare provider is responsible for the care of the patient at all times  
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| **6. Healthcare Provider Engagement** | Demonstrating ownership, responsibility and accountability for the care of the patient and family/caregiver at all times. | a. Clearly identified patient’s personal physician (primary care provider)  
  b. Hub of case management activities  
  c. Patient and family education and counseling activities  
  d. Open and timely communication among healthcare providers, patients and families  
  e. Clear and timely communication of the patient’s plan of care  
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| **7. Shared Accountability across Providers and Organizations** | Enhancing the transitions of care process through accountability for the care of the patient by both the healthcare providers transferring and receiving patient information and care. | a. Clear and timely communication of the patient’s plan of care  
  b. Ensuring that a healthcare provider is responsible for the care of the patient at all times  
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- Abdool et al. Difficult healthcare transitions: Ethical analysis and policy recommendations for unrepresented patients, Nursing Ethics 2016, Vol. 23(7) 770-783.
- Care Transition Bundle, Essential Intervention Categories, National Transitions of Care Coalition website