Transitions of Care in the Long-Term Care Continuum

PRACTICE GUIDELINE

amda™

Dedicated To Long Term Care Medicine

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Preface

This clinical practice guideline (CPG) has been developed under a project conducted by the American Medical Directors Association (AMDA), the national professional organization representing medical directors, attending physicians, and other practitioners who care for patients in the long-term care setting. This is one of a number of guidelines undertaken as part of the association's mission to improve the quality of care delivered to patients in these settings.

Original guidelines are developed by interdisciplinary workgroups, using a process that combines evidence and consensus-based approaches. Workgroups include practitioners and others involved in patient care in long-term care facilities. Beginning with a general guideline developed by an agency, association, or organization such as the Agency for Healthcare Research and Quality (AHRQ), pertinent articles and information, and a draft outline, each group works to make a concise, usable guideline that is tailored to the long-term care setting. Because scientific research in the long-term care population is limited, many recommendations are based on the expert opinion of practitioners in the field. A bibliography is provided for individuals who desire more detailed information.

Guideline revisions are completed under the direction of the Clinical Practice Guideline Steering Committee. The committee incorporates information published in peer-reviewed journals after the original guidelines appeared as well as comments and recommendations not only from experts in the field addressed by the guideline but also from "hands-on" long-term care practitioners and staff.

Purpose

AMDA seeks to develop and revise guidelines that focus on specific concerns and common problems in the long-term care setting. Although AHRQ and other agencies, organizations, and associations have developed a number of guidelines for conditions that occur in elderly and chronically ill individuals, many of these guidelines limit or omit considerations that are unique to the long-term care population.

AMDA guidelines emphasize key care processes and are organized for ready incorporation into facility-specific policies and procedures to guide staff and practitioner practices and performance. They are meant to be used in a manner appropriate to the population and practice of a particular facility. Guideline implementation will be affected by resources available in the facility, including staffing, and will require the involvement of all those in the facility who have a role in patient care.

Audience

This guideline is intended for the members of the interdisciplinary team in long-term care facilities, including the medical director, director of nursing, practitioners, nursing staff, consultant pharmacist, and other professionals such as therapists, social workers, dietitians, and nursing assistants who care for residents of long-term care facilities.

AMDA CPGs include many functions and tasks related to recognizing, clarifying, managing, and monitoring various conditions and situations. But the guidelines only sometimes specify who should do these tasks. For example, many disciplines including nursing assistants, licensed nurses, dieticians, and social workers may make and document observations (e.g., that someone does not sleep at night, is more withdrawn, or has a change in usual eating patterns). But only some of them may

be qualified to determine the significance of those observations (for example, what is causing the sleeplessness or change in eating patterns). In contrast, physicians and nurse practitioners may not be present to make observations, but are trained to analyze the significance and causes of symptoms. Thus, each facility should ensure that tasks are done correctly and by appropriate interdisciplinary team members. It is important for observers to make and document findings effectively, but they should get appropriate support for interpreting the findings when this is not within the scope of their training or practice.

Assumptions

Guidelines in the long-term care setting should be consistent with fundamental goals of desirable long-term care practice. Operationally, this requirement means that the nursing facility care team systematically addresses (1) each individual's risk factors for a number of diseases and conditions and (2) the adverse consequences of the diseases and conditions on the patient's functioning and quality of life.

However, when nursing facility patients are at or near the end of life, care goals will shift from functional improvement or physical stability to palliation or comfort care. AMDA guidelines address this transition and provide suggestions for appropriate modification of the patient's care plan.

Long-term care facilities care for a variety of individuals, including younger patients with chronic diseases and disabilities, short-stay patients needing postacute care, and very old and frail individuals suffering from multiple comorbidities. When a workup or treatment is suggested, it is crucial to consider if such a step is appropriate for a specific individual. A workup may not be indicated if the patient has a terminal or end-stage condition, if it would not change the management course, if the burden of the workup is greater than the potential benefit, or if the patient or his or her proxy would refuse treatment. It is important to carefully document in the patient's medical record the reasons for decisions not to treat or perform a workup or for choosing one treatment approach over another.

How to Use These Guidelines

Each guideline includes a narrative portion that covers definition, recognition, assessment, treatment, and monitoring of the condition being addressed. "Recognition" means identifying the presence of a risk or condition. "Assessment" means clarifying the nature and causes of a condition or situation and identifying its impact on the individual. "Treatment" means selecting and providing appropriate interventions for that individual. "Monitoring" means reviewing the course of a condition or situation as the basis for deciding to continue, change, or stop interventions.

Each guideline also includes an algorithm that summarizes the steps involved in addressing the condition. In the algorithm, rectangles signify points where action is to be taken; diamonds indicate points where a decision must be made.

Terminology

We recognize that people who reside in long-term care facilities are "residents". However, we have used the term "patient(s)" throughout these guidelines because we are addressing individuals within the context of treating a medical condition. In addition, these guidelines apply substantially to individuals who come to long-term care facilities for short-term care. When referring to pharmaceutical products, we have avoided the use of brand names and refer to classes of drugs whenever possible.

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There was an important job to be done and Everybody was sure that Somebody would do it. Anybody could have done it, but Nobody did it….Everybody blamed Somebody when Nobody did what Anybody could have done.

– Anonymous

From a system perspective, a safe transition from a hospital to the community or a nursing home requires care that centers on the patient and transcends organizational boundaries.

– Jencks et al, New England Journal of Medicine, April 2009

Transitions of Care
in the Long-Term Care Continuum

Terminology

People who reside in facilities within the long-term care continuum may be referred to by a variety of terms, including **residents, clients**, and **patients.** We have elected to use the term **patient(s)** in these guidelines because we are generally addressing individuals within the context of the care of a medical condition. We have also used the term **family**, which is intended to include other decision makers and proxies who may advocate for the patient or act on the patient's behalf.

We recognize that, although some individuals are transient residents of the LTCC, for many others an LTCC facility is their home. We have therefore used the term **community home** when discussing transitions to a home in the community that is not part of a facility within the LTCC.

We have used the term **medical point of contact** to refer to the practitioner who is designated by the patient or family to be notified of transitions and who is responsible for coordinating the patient's care in the community.

Throughout the guideline we speak of "the facility" as having responsibility for contacting the practitioner or site of care to which the patient is being transferred. We do not prescribe exactly which categories of facility staff should have this responsibility, as this will vary by facility. We also do not intend to imply that these responsibilities fall solely on facility staff. At times, it may be more appropriate for the attending physician, nurse practitioner, or physician assistant to contact the next site of care.

Finally, when referring to pharmaceutical products, we have avoided the use of brand names and refer to classes of drugs whenever possible.
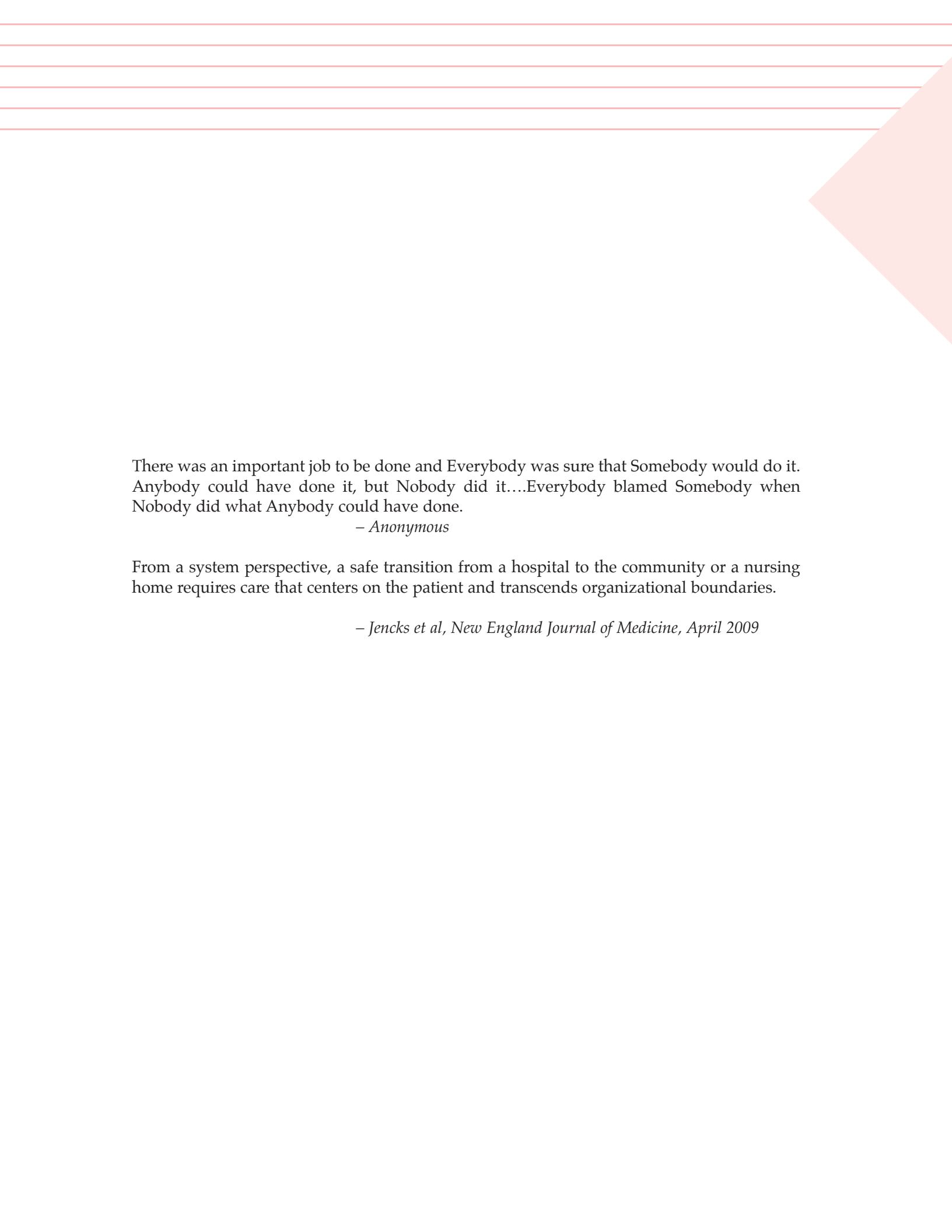
Definitions

Many definitions exist as to the terminology and concepts related to transitions of care. Recognizing that all existing definitions have shortcomings, the AMDA consensus panel has chosen to use the following definitions.

Transition of care refers to the movement of patients between health care locations, providers, or different levels of care within the same location[1] as their conditions and care needs change. Specifically, a transition of care can occur[2]:

◆ Within settings; e.g., primary care to specialty care, intensive care unit to ward;

◆ Between settings; e.g., hospital to subacute care, ambulatory clinic to senior day-care center;

◆ Across health states; e.g., curative care to palliative care or hospice, personal residence to assisted living; or

◆ Between providers; e.g., generalist to specialist practitioner, acute-care provider to palliative care specialist, hospitalist to primary care practitioner (PCP).

Transitional care is a set of actions designed to ensure coordination and continuity of care. It should be based on a comprehensive care plan and the availability of well-trained practitioners who have current information about the patient's treatment goals, preferences, and health or clinical status. It includes logistical arrangements and education of patient and family, as well as coordination among the health professionals involved in the transition.[1,2]

Care coordination is the deliberate organization of patient care activities among two or more participants (including the patient and/or family) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources to carry out all required patient care activities. This is often managed by the exchange of information among participants responsible for different aspects of the care.[2]

The **long-term care continuum** (LTCC) is a comprehensive, longitudinal, patient-centered system of formal and informal health and support services intended to improve, maximize, or stabilize, when possible, the function of patients with chronic disease across various settings over an extended period of time and to provide compassionate care at the end of life. The LTCC encompasses a broad range of sites of care (Table 1).

TABLE 1
Sites of Care Within the Long-Term Care Continuum

Type	Description
Nursing Home/Skilled Nursing Facility (SNF)	An SNF (also known as a nursing home) is a place of care for people who require 24-h nursing and rehabilitation for chronic medical conditions or impaired mental capacity and who have significant deficiencies in activities of daily living. The goal of care is to assist the individual in achieving his or her highest level of function and well-being. Both SNFs and NFs care for frail elderly patients and younger adults with physical disabilities (although pediatric and other specialized SNFs also exist). Many SNFs and NFs offer special care units (e.g., dialysis, ventilator units).
Subacute ("Step-Down") Care Facility	Subacute or "step-down" care can be the bridge between an acute hospital stay and a return to a community home. It combines aspects of both the hospital and the SNF to reduce the cost of services while maintaining quality of care. This type of care requires frequent patient reassessment and review of the clinical course and treatment plan for a limited time period, until the patient's condition has stabilized or a predetermined treatment course is completed.
Long-Term Acute-Care Hospital (LTACH)	Patients who require long-term (usually longer than 25 days), clinically complex acute medical care qualify for admission to an LTACH, which is typically a free-standing unit, although it may be located within an acute-care hospital (i.e., hospital within hospital). LTACHs often specialize in respiratory/ventilator care and accept patients from intensive care units. They may also provide other specialized services such as post-stroke rehabilitation, with the goal of preparing the patient to return to his or her community home.

TABLE 1 (continued)

Sites of Care Within the Long-Term Care Continuum

Type	Description
Intermediate-Care Facility for the Mentally Retarded (ICF/MR)	An ICF/MR provides care for individuals with mental retardation or developmental disabilities. Services provided are based on client needs, which vary according to age and level of disability. Individuals may reside in the facility from youth until old age; thus, the facility becomes a permanent home and its staff a second family. Common goals of ICF/MRs are to assess each individual's level of functioning and help each person achieve his or her potential through education and training.
Assisted Living Community (ALC)	An ALC provides care for individuals who need some help with activities of daily living (ADLs) yet wish to remain as independent as possible. A middle ground between independent living and nursing homes, ALCs aim to foster as much autonomy as the resident is capable of. Most facilities offer 24-h supervision, most often by nonlicensed staff, and an array of support services that may include medication management and dementia care services.
Continuing Care Retirement Community (CCRC) or Life Care Facility	CCRCs offer accommodations at many levels, including independent and assisted living, as well as medical and nursing services up to and including SNF care. Some CCRCs also offer special-care units (e.g., for patients with Alzheimer's disease). Residents are cared for as they age and their health status changes.
Senior housing	Under the Fair Housing Act, "housing for older persons" is housing that: ◆ Is specifically designed for occupation by elderly persons under a Federal, State, or local government program; ◆ Is occupied solely by persons who are 62 or older; or ◆ Houses at least one person who is 55 or older in at least 80% of the occupied units, and adheres to a policy that demonstrates intent to house persons who are 55 or older. The Housing for Older Persons Act of 1995 (HOPA), eliminated the initial requirements for "significant services and facilities" within designated senior housing units or areas. Benefits to senior housing may include location near shopping or medical facilities, security features, safety-equipped (handrails, pull cords) units, and community activities or transportation. Housing options may include luxury retirement living, moderate apartment-style living, or rent-assisted/low-income housing.
Adult Day Care	Families who are unable to provide supervision for a family member during the day due to job responsibilities or other obligations may use adult day care. Adult day-care centers can offer supervision, social and recreational activities, lunch, and possibly health-related over sight during the day for adults who may need care outside of the home or residential care facility. Adult day care also offers respite for those who might normally care for a family member at home.
Home Care/Home Health Care	Many elders, disabled adults, and children with special needs receive health care at home. Services are delivered at home to recovering, disabled, and chronically or terminally ill persons who need medical, nursing, social, or therapeutic treatment or assistance with essential ADLs. These services may include skilled nursing care; home health care; housekeeping; social services; physical, occupational, respiratory, and speech therapy; emergency response; nutrition counseling; and case management.
Hospice	Hospice is a concept of care designed to provide comfort and support to patients and their families when a life-limiting illness is no longer appropriate for cure-oriented treatment. The focus of care is on relieving symptoms and supporting patients as they approach the last stages of life. Hospice care involves a team-oriented approach that incorporates expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Although many hospice patients are diagnosed with cancer, hospice services are also available to patients with AIDS, Alzheimer's disease, heart disease, neurological disorders, pulmonary disease, and other terminal illnesses. Hospice care can be provided in any care setting.
Palliative Care	Palliative care is best understood as a system of care based on a patient-centered, quality-of-life model that values patient autonomy and focuses on anticipating, preventing, and treating the suffering of patients and families regardless of diagnosis or stage of illness. Although the palliative paradigm differs from the more traditional illness-centered, curative model, palliative care can be integrated into curative and restorative treatment plans. Thus, no specific therapy should be excluded from consideration as a palliative treatment if it can enhance comfort or improve the patient's quality of life. Palliative care is usually delivered by an interdisciplinary team. Multiple disciplines are needed to address medical, nursing, and other therapeutic aspects of care and to meet the patient's or family's needs for social, emotional, and spiritual support. (Reference- American Medical Directors Association. Palliative Care in the Long-Term Care Setting. AMDA: Columbia, MD 2007)

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Scope of the Problem

It is common for patients in the LTCC to be transferred from one care setting, level of care, or caregiver team to another. For example, a resident of a facility within the LTCC who experiences an acute change of condition may be transferred to the emergency department (ED), admitted to the hospital, and ultimately discharged from the hospital back to the original care setting. A resident of a senior apartment complex may be hospitalized for a surgical procedure, transferred to a skilled nursing facility (SNF) for rehabilitation, and subsequently transferred either back to his or her senior apartment or, if unable to resume living independently, to an assisted living community (ALC).

It is also all too common for adverse events and avoidable complications to occur as a result of poor communication and coordination among caregivers, health care professionals, and the patient during such transitions. Poorly executed care transitions increase hospital readmissions,[3] duplication of services, and waste of resources.[4] Poor transitions are the leading cause of medication errors, which frequently result from lack of coordination between prescribers across settings.[5-8] It is often unclear which practitioner is responsible for the patient in the interval between discharge from one setting and admission to another.[9] (See **Medication Reconciliation**.)

Some older adults are at particular risk for transition problems following a hospitalization. Those with multiple medical problems, cognitive deficits, or depression or other mental health problems; isolated seniors; non-English speakers, immigrants, and refugees; and those with few financial assets are especially vulnerable.[10]

Hospital Readmissions, Medication Errors, and Adverse Events

Transfers from nursing facilities constitute 8.5% of all Medicare admissions to acute-care hospitals; about 40% of these hospitalizations occur within 90 days of nursing facility admission. Eighty-four percent of these patients are discharged from the hospital back to their original care setting.[11]

Jencks et al[3] recently estimated that close to one fifth of all Medicare beneficiaries discharged from the hospital are readmitted within 30 days, that 90% of these readmissions are unplanned, and that the cost to Medicare of unplanned rehospitalizations amounted to $17.4 billion in 2004. Patients with heart failure accounted for 26.9% of all readmissions within 30 days; patients with pneumonia, 20.9%. When the researchers compared their data with those of a similar study published in 1984,[12] they found that the rehospitalization rate at 60 days had increased from 22.5% to 31%. They concluded that "this larger difference [was] more likely to indicate an actual increase in rehospitalization rates over time, perhaps owing to a shorter duration of index hospitalization or to the increase in ambulatory surgery over the past 30 years."

In an analysis of the use of postacute and SNF settings over a 2-year period by a nationally representative cohort of elders, almost 5 million patients aged over 65 made more than 15 million transitions and 1.1 million of these patients (22.4%) "had subsequent health care use suggesting a potential transition problem." Subsequent health care use included "emergency room visits, potentially avoidable hospital stays, and return to an institutional setting following discharge to the community."[13]

The Centers for Medicare and Medicaid Services (CMS), in its proposed inpatient prospective payment system rule for fiscal year 2009, estimated that nearly 18% of Medicare patients are rehospitalized within 30 days of discharge and that 13% of all readmissions—costing approximately $12

billion—are potentially avoidable.[14] In 2007 the Inspector General of the Department of Health and Human Services estimated that "consecutive stay sequences" (three or more successive admissions to a hospital or SNF, each within one day of the preceding discharge date) associated with quality-of-care problems and fragmentation of services cost the Medicare program $4.5 billion in 2004.[15]

Studies have shown that medication changes upon hospital admission or discharge are a frequent reason for adverse events. A prospective study of 151 patients admitted to general internal medicine units at a teaching hospital found that a regularly used medication was discontinued in 46.4% of cases; 38.6% of these omissions were considered to have the potential to cause moderate or severe discomfort or clinical deterioration.[16]

In a prospective cohort study involving 400 patients discharged from a tertiary care hospital, nearly one in five patients experienced an adverse event (defined as an injury occurring as a result of medical management during the transition from hospital to home). Of these adverse events, 66% were adverse medication events. The investigators considered that one third of all adverse events were preventable (that is, caused by an error) and another one third were ameliorable (that is, earlier corrective action would have decreased their severity).[7] Boockvar et al[6] found that adverse drug events attributable to medication changes occurred in 20% of transfers between nursing homes and acute-care hospitals.

Moore et al[17] found a high prevalence of medical errors relating to loss of continuity when patients were discharged from a hospital setting to the community. In a retrospective review of patients' medical records, the investigators found that patients experiencing a work-up error (defined as the PCP not adequately following up on a work-up recommendation by the inpatient provider) were six times more likely to be rehospitalized within 3 months of the patient's first post-discharge outpatient visit.

Communication Deficiencies
Communication between practitioners in different care settings during transitions of care is frequently deficient. For example, the authors of a systematic review found that during the discharge process, hospital and primary care physicians rarely communicated with each other directly. Hospital discharge summaries often did not identify the responsible hospital physician, main diagnosis, physical findings, discharge medications, or follow-up care plans and rarely provided information about tests pending at discharge or counseling provided to the patient or family. Approximately 11% of discharge letters and 25% of discharge summaries never reached the patient's primary care physician.[5]

In a retrospective review of discharge summaries for more than 600 patients who were discharged from the hospital with test results pending, Were et al[18] found that only 25% of discharge summaries mentioned any pending tests and only 13% documented all pending tests. Seventy-two percent of pending test results requiring a treatment change were not mentioned in discharge summaries and only 67% of discharge summaries identified the health care providers responsible for the patient's follow-up care.

Each year more than 25% of nursing home residents are transferred at least once to an ED for evaluation[19]; however, essential information is frequently not conveyed with the patient. Ten percent of patients are transported to the ED without any documentation; in the remaining 90% of transfers, essential patient information is commonly missing.[20]

Practitioners in different care settings often fail to ensure that[8]:
◆ The essential elements of the patient's care plan that were developed in one setting are communicated to the next team of clinicians,
◆ The necessary steps (e.g., preparation for the goals of care delivered in the next setting, arrangements for follow-up appointments and laboratory testing, and reviewing the current medication regimen) before and after a patient's transfer are properly and fully executed, and
◆ That the requisite information about the care the patient received from the sending care team is communicated to the receiving care team.

Care processes may break down at multiple points during a transition, including[8]:
◆ The preparation of the patient and caregiver,
◆ The communication of vital elements of the care plan,
◆ The reconciliation of the medication regimen that was prescribed before the initial transition with the current regimen,
◆ The transportation of the patient,
◆ The completion of follow-up care with a practitioner
◆ Diagnostic imaging or laboratory testing, and
◆ The availability of advance care directives across settings.

Many practitioners involved in transitional care have not practiced in the settings to which they are sending patients, are unfamiliar with the care-delivery capacity of these settings, and may transfer patients inappropriately.[21]

Segmentation of Primary Medical Care Services
Effective movement of patients through the care continuum is further complicated by the difficulty of defining what "primary care" comprises, as well as by a dwindling supply of PCPs. At the same time, there is increasing segmentation among practitioners who provide "hands-on" medical services, including the emergence of new models of care such as "concierge" or "retainer" practices.

Hospitalists—physicians who practice only within a hospital—provide a valuable service; however, a hospitalist may be reluctant to write orders or prescriptions for a patient who is moving into the community. An outside entity such as a hospice care program may be unwilling to accept orders from a physician who will not follow the patient in the community or be available for later consultation. Skilled nursing facility specialists ("SNFists")—physicians who limit their practice to SNFs—may have similar difficulties connecting patients with community-based services because they themselves do not practice in the community and will not follow the patient once he or she has been transferred there.

As a result of this segmentation of services, PCPs in a traditional practice setting frequently suffer from a serious information and communication gap. For example, a patient may be hospitalized under the care of a hospitalist and subsequently admitted to an SNF under the care of an SNFist. Upon the patient's return to the community, the PCP is often asked to resume care and approve multiple services and prescriptions required as a result of the episode of illness—an illness about which the PCP may have little or no knowledge. In addition, the patient may have been identified as having one or more significant previously unrecognized disorders of which the PCP is unaware. Approval to implement necessary services, medications, or treatment may be delayed until the patient can return to the PCP's office for a follow-up visit, leaving a gap during which no practitioner is overseeing the patient's care.

A crucial subset of patients who suffer from this discontinuity are those transferred from a hospital to SNF care, and particularly to hospice care, who leave the hospital without written prescriptions for narcotics to control their pain. This omission can present a particular problem because opioid analgesics cannot be dispensed without a written prescription from an authorized prescriber. If the hospital physician does not provide the patient with such a prescription, it may take 24 to 48 hours or longer to obtain appropriate pain medication for the patient, an unacceptable delay for a patient who is experiencing pain.

Barriers to Effective Care Transitions

Coleman[8,21] has characterized barriers to effective care transitions as occurring at three levels: the delivery system, the clinician, and the patient.

Delivery-System-Level Barriers
◆ Each care setting functions as a "silo" that lacks formal relationships with other care settings. Independent providers cannot easily access patient information maintained by other independent providers, making care coordination more difficult.[22] Even within a patient-centered medical home,[23] providers may have difficulty accessing patient information.
◆ Information systems (e.g., interoperable computerized records) designed to facilitate the timely transfer of patient information across care settings do not exist. Existing computerized record systems are often incompatible with one another.
◆ Financial incentives to promote transitional care, collaboration across sites, and accountability are lacking. For example, payment policies rarely include reimbursement for care coordination and other activities that facilitate the sending and receiving of a transitioning patient.
◆ Healthcare facilities within the LTCC, as well as health plans and government programs serving specific patients within those entities, have incentives to prescribe or substitute medications according to their own formularies. The constant turmoil of medication switches and generic substitutions creates confusion for the patient, caregivers, and receiving clinicians. Each hospitalization results in modification of the patient's drug regimen, which is followed by another round of therapeutic substitutions when the patient returns to his or her original care setting.
◆ Insurance coverage issues frequently drive service delivery. For example, a change in a patient's insurance may necessitate a change of doctor. Insurance criteria often determine the length of a hospital or SNF stay, which can result in an abrupt, chaotic discharge. Insurance-driven changes in service delivery frequently occur without information-sharing with primary care providers.
◆ The lack of consistent, safe, high-quality transitional care is an under-recognized issue that has received too little attention from health policy makers. The massive scope of actual and potential patient harm resulting from poor transitions, and the consequent excess healthcare costs, are likewise unappreciated.

Clinician-Level Barriers
◆ A single clinician rarely provides continuous care for a patient across care settings. Exacerbating the problem, clinicians caring for the same patient in different care settings do not communicate patient information to one another.
◆ Clinicians and hospitalists may consult multiple specialists about each patient, with each of these encounters potentially leading to additional tests and medications that may be unnecessary, or to

changes in existing medications. A string of follow-up appointments may also be generated without consideration of their relevance to the patient's overall care goals.

◆ Care managers and social workers, who once provided longitudinal care oversight across settings, now are predominantly assigned to specific care settings. Older patients with multiple problems may be assigned to more than one care manager. Without formal mechanisms for ongoing communication and coordination, multiple care managers may contribute to, rather than alleviate, care fragmentation.

Patient-Level Barriers

◆ Patients and families rarely advocate for improved transitional care until confronted with the problem firsthand. They presume that their health care professionals will take care of their needs across the continuum of care and often assume incorrectly that the providers involved in their care are sharing adequate information.

◆ Older patients and their caregivers are often not adequately informed about their disease process and the next steps in their care so that they are able to optimize the care the patient receives in the next setting.

◆ Patients and caregivers may not feel empowered to express their preferences or provide input to the patient's care plan.

◆ The level of information provided to patients has not escalated proportionately with the complexity of the current medical model.

◆ "Take-home" information that patients receive in different care settings may provide conflicting information and leave patients and their caregivers confused.

◆ Differing cultural orientations, expectations, and barriers such as cognitive impairment, limited English fluency, and low literacy may prevent patients and care providers from communicating clearly.

Benefits of Continuity of Care

Evidence is mounting that efforts to ensure continuity of care for older patients during care transitions can improve patient outcomes. By improving core discharge planning and transition processes out of the hospital; improving transitions and care coordination at the interfaces between care settings; and enhancing coaching, education, and support for patient self-management; the rate of avoidable rehospitalization can be reduced.[24]

In a randomized controlled trial (RCT) conducted at an urban academic medical center, a package of discharge services (including arranging follow-up appointments, reconciling medications, and educating patients) decreased ED visits and readmissions within 30 days of discharge by 30%.[25] In the Care Transitions Intervention, also an RCT, a "transition coach" was used to encourage the patient and caregiver to assert a more active role during care transitions, provide continuity across settings, and ensure that the patient's needs were being met irrespective of the care setting. This intervention reduced rates of rehospitalization as far as 6 months out in a population of chronically ill community-dwelling adults aged 65 and older.[26]

A trial that employed advanced practice nurses to play a central role in coordinating care across sites and healthcare practitioners demonstrated reductions in both hospital readmissions and healthcare costs for elders with congestive heart failure,[27] as well as among seniors considered to be at high risk for hospital readmission.[28,29] (See Appendix 1 for a summary of results from three of these trials.)

Qualitative investigation has identified four factors considered by patients and caregivers to be most valuable to them during care transitions. These factors (which were the basis of the Care Transitions Intervention) are:[26]

◆ Assistance with medication self-management;
◆ A patient-centered record owned and maintained by the patient to facilitate cross-site information transfer;
◆ Timely follow-up with primary or specialty care; and
◆ A list of "red flags" indicative of a worsening condition and instructions on how to respond to them.

The importance of care transitions to both overall care quality and patient outcomes is now recognized by numerous national health care organizations, including the Agency for Healthcare Research and Quality, the Joint Commission*, the National Quality Forum, and the National Transitions of Care Coalition. These organizations, among others, are leading a variety of initiatives intended to improve the general quality of care transitions. A coalition of six medical professional societies has published recommendations on principles and standards for managing transitions of care between inpatient and outpatient settings (Appendix 2).[30] In addition, CMS is pilot-testing a Continuity Assessment Record and Evaluation (CARE) tool for use in post-acute care settings[31] and Medicare's Quality Improvement Organization Program is working in 14 states† to coordinate care, promote seamless transitions across settings, and reduce unnecessary hospital readmissions.[32,33] It is an opportune time, therefore, for AMDA to offer this practice guideline, which is intended to provide facilities within the LTCC with practical guidance on improving care transitions.

Appendix 3 presents two scenarios that illustrate both the consequences of poor transitions of care and the benefits of managing transitions to ensure continuity of care for the patient.

Purpose and Scope of This Practice Guideline

This guideline focuses on transitions of care between settings within the LTCC, between LTCC and acute-care settings (e.g., ED, hospital), and between an LTCC setting (e.g., SNF) and the patient's community home. Active involvement of the patient and family in these transitions is to be encouraged; however, this guideline is primarily directed at the health care professionals involved in care transitions. It outlines a process that, if followed, will contribute to ensuring that:

◆ Necessary care transitions are conducted smoothly;
◆ Essential patient information is transmitted successfully to the patient's next care setting; and
◆ Health care professionals involved in the care of the transitioning patient communicate appropriately about the patient's care needs, resulting in a safer, more satisfying transition for the patient.

Guiding Principles

A guiding principle underlying this guideline is the replacement of the concept of discharge from a health care facility with that of transition. Discharge, by implying that "the patient is no longer our responsibility" after he or she leaves the facility or the provider's office, is an outmoded concept that contributes to a lack of continuity of care. Transition, by contrast, extends medical providers' responsibility for a patient not only into the "white space" between one level or setting of care and the next but actually into the next site or level of care. This responsibility persists until the new caregivers acknowledge the assumption of care and any care questions on the part of the new caregivers are

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* Formerly the Joint Commission on Accreditation of Healthcare Organizations
† Alabama, Colorado, Florida, Georgia, Indiana, Louisiana, Michigan, Nebraska, New Jersey, New York, Pennsylvania, Rhode Island, Texas, and Washington

resolved. In any transition, it is essential that the parties sending and receiving patient information validate the transfer, accept the information, clarify any discrepancies, and act on the information in a timely fashion.

A second guiding principle is that unnecessary care transitions should be avoided and necessary transitions managed to ensure continuity of care for the patient. In a CMS-funded special study examining the factors contributing to potentially avoidable hospitalizations among residents of Georgia nursing facilities, expert reviewers concluded that 68% of 200 hospitalizations from 20 nursing facilities were probably or definitely avoidable.[34] Before any decision is made to transfer a patient, the potential for harm from imposing an additional transfer to a new care setting must be weighed against the potential for benefit. Base the decision to transfer on the appropriateness of the match between the proposed care setting and the patient's medical, nursing, and functional needs.[8] For guidance on avoiding unnecessary transitions, please refer to AMDA's *Acute Change of Condition in the Long-Term Care Setting*[a] clinical practice guideline, Protocols for Practitioner Notification in the nursing facility setting[b], and Caregivers Communication Guide for the assisted living communities.[c]

Importance of Accountability
This practice guideline delineates essential steps and actions required for safe movement across care settings. It does not, however, dictate who should be responsible for performing specific tasks associated with care transitions, as this will vary by care setting. Within each care site, every transition task must be assigned to a designated person, consistently with the organizational structure. It is essential that the specific responsibilities of each person with regard to transitions be identified, along with accountability and clear feedback. Specificity and accountability are essential for good outcomes.

Equally important, individual accountability for specific tasks must be supported by a facility-wide culture that places a high priority on safe transitions and considers them to be everyone's responsibility. For example, the processes recommended in this guideline for ensuring that essential information is transmitted with the patient during care transitions will be effective only if the care providers receiving the patient read them carefully and act on them, including requesting clarification from the sending care providers when information is missing or unclear. Furthermore, the sample forms provided in this guideline will be helpful in conveying information only when processes are in place within the facility to ensure that the forms are used as intended.

When assigning individual responsibilities for care transitions, facility managers should keep in mind that some providers to whom information about a transitioning patient is being conveyed may be more receptive to that information when it is conveyed by a provider of equivalent licensure (e.g., physician to physician, director of nursing to director of nursing). Senior facility staff and consultants should be prepared to participate in communications concerning a transitioning patient when necessary.

Relationship-Centered Care
The concept of relationship-centered care focused on the patient and family, who constitute the "unit of care," is essential to this guideline. For purposes of this CPG, **family** or **support system** is defined

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a   American Medical Directors Association. Acute Change of Condition in the Long-Term Care Setting. Clinical Practice Guideline. Columbia, MD.

b   American Medical Directors Association. Protocols for Physician Notification: Assessing and Collecting Data on Nursing Facility Patients - A Guide for Nurses on Effective Communication with Physicians. Columbia, MD.

c   American Medical Directors Association. Caregiver's Communication Guide: Caring for the Older Adult. Protocols for Change of Condition. Columbia, MD

as "a group of persons of multiple ages bonded by affection, biology, choice, convenience, necessity, or law for the purpose of meeting the individual needs of its members."[35] These individuals are selected by the patient to receive personal medical and social information and to either assist in decision-making or actually make decisions as desired by the patient.

It is important to relationship-centered care that health care providers recognize and honor this heterogeneous concept of family by respecting the right of those individuals whom the patient has identified as his or her family or support system to receive information or assist with decision-making in accordance with the patients' wishes.

Importance of Documentation

Across the LTCC continuum, clear communication of appropriate patient information is the foundation of patient safety and of good care transitions. Because the LTCC encompasses a diverse range of care settings, both the extent of patient information that is documented and the manner in which it is maintained vary widely. Some sites, most notably SNFs and hospitals, must adhere to rigid documentation standards. In other LTCC settings, patient information is documented and stored based upon functional need, custom, and payment requirements.

An equally accepted fundamental need is that of respect for patient autonomy. Privacy concerns, whether in regard to ethical issues or Health Insurance Portability and Accountability Act (HIPAA) compliance requirements, must also be considered. This complex mix of autonomy, privacy, and regulation must be negotiated in the patient's best interest.

Mindful of these issues, LTCC facilities should maintain documentation that supports the care of the patients involved and provides subsequent care sites with adequate information to enable a smooth transfer, whether in a planned or unplanned transition. In some circumstances (e.g., when a patient is transitioning to a community home), the most important role for facilities and practitioners may be to encourage and empower patients or families themselves to maintain their health information so that it can be shared with the health care system when necessary.

Practitioners working within the LTCC should comply with applicable documentation standards in the best interest of their patients. Documentation will need to satisfy facility-specific standards in addition to those of regulatory, licensure, and reimbursement entities.

Outcomes Expected from Implementation of This Practice Guideline

This guideline recommends processes that, if implemented, should help LTCC facilities to appropriately coordinate transitional care for patients entering and leaving their care. Potential benefits associated with the implementation of this guideline include the following:

◆ Reductions in:
  ◆ Avoidable care transitions (through a patient-centered review of the risks and benefits to the patient from any change in care site),
  ◆ Costs associated with readmissions to higher-acuity levels of care,
  ◆ Duplicative use of diagnostic services (e.g., electrocardiograms, laboratory tests),
  ◆ Extended hospital stays for observation,
  ◆ Hospital readmissions resulting from avoidable post-discharge complications and adverse events, and
  ◆ Medication-related adverse events.

◆ Increases in:
  ◆ Patient and family investment in participation in the care process,
  ◆ Patient and family satisfaction with care,
  ◆ Patient safety, and
  ◆ Quality of life for patients with complex health care needs.

◆ Improved communication between care providers.

PART 1: CROSS-CUTTING ISSUES IN TRANSITIONS OF CARE

This section considers important systemic issues that affect the environment in which transitions of care take place.

Scope of the Long-Term Care Continuum
The LTCC encompasses a broad range of sites of care (see Table 1) that provide a broad range of services (Appendix 4) and employ a wide variety of health care and support professionals (Appendix 5).

It is important to note that although the services listed in Appendix 3 are all provided within the LTCC, every facility within the LTCC does not provide this range of services. Furthermore, a facility's designated "level of care" does not dictate its precise range or mix of services. Thus, the process of selecting an appropriate facility within the LTCC for a transferring patient must consider that patient's specific service needs. If a patient requires a specific service (e.g., hemodialysis, intravenous infusion therapy, tracheotomy care), it is essential to ensure that a facility is capable of providing that service before arranging to transfer the patient to that facility.

Facilities within the LTCC are subject to varying levels of regulation by local, state, and federal authorities. For example, SNFs are extensively regulated by both federal and state governments. By contrast, no federal regulations apply to assisted living communities (ALCs), which are entirely regulated by the states. In addition, many LTCC facilities may be required to comply with laws and ordinances enacted by local governments. The topic of LTCC regulation is too complex to be adequately addressed in this guideline; please consult these Resources for more information about the regulation of nursing homes and assisted living communities in particular.

Tools To Facilitate Transitions of Care in the Long-Term Care Continuum
Many tools have been developed to facilitate transitions of care, including some that have been devised specifically for use in transitions that involve the LTCC (see **Resources**). Some states (e.g., Rhode Island, New Jersey) have implemented universal transfer forms or "continuity of care" documents that are required by law to be filled out at any time a patient is transferred from any institutional setting.[36]

Institutional Commitment
Institutional commitment to the importance of managing care transitions is essential to overcoming barriers to effective transitions. Facilities may wish to adopt policies and procedures to guide specific transitions, such as that of a nursing home resident to the ED or hospital. (See Appendix 6 for an example of such a policy and procedure).

Institutional commitment includes ensuring the best fit between the patient's care needs and the capabilities of his or her next care setting. Efficient information transfer will not safeguard the patient in an environment that is unable to meet his or her social and medical needs.

Effective communication not only between members of the interdisciplinary care team but also between providers caring for the same patient in different settings is crucial to well-managed care transitions. Many of the steps in Part 2 of this guideline address processes for facilitating effective communication during care transitions.

Accountability for Care Transitions
Facilities should designate staff positions whose responsibilities include management of care transitions. Individuals in these positions should be appropriately trained and empowered to develop relationships with their counterparts (i.e., staff with responsibility for managing care transitions) at sites to which the facility transfers patients or from which it receives transferred patients. For example, if a social worker at a nursing facility is tasked with managing care transitions, he or she should be empowered to contact the transition team (e.g., discharge planner, social worker) at entities such as, but not limited to, the following:
◆ The local hospital to which nursing facility patients are sent when in need of acute care;
◆ Other LTCC facilities involved in transfers;
◆ Home health agencies caring for patients who are being discharged back to their community homes; or
◆ Community service agencies that may be involved in the care of transitioning patients.

A single care transition involves multiple steps that will be performed by caregivers from multiple disciplines: e.g., writing orders, reconciling medications, copying records for the patient or for forwarding to the receiving provider, cleaning the patient's room, contacting the patient's family, arranging transportation. A transition may be thought of as a ballet and the participating disciplines as performers; each dancer must not only perform his or her own movements properly, but must do so within the framework and timing of all the other dancers. Any ill-timed action (e.g., leaping instead of catching another performer, pirouetting instead of remaining still) renders the ballet ugly and unsafe regardless of how well the individual action is performed.

Thus, although it is essential that specific responsibilities with regard to transitions be identified for each individual and discipline, it is coordination of those actions that determines success. A single individual should bear overall responsibility for ensuring that all steps relating to a care transition are carried out in the correct sequence and in synergy with all the other "performers" in the process. This minimizes the likelihood that steps will "fall through the cracks" because one staff member assumed another was responsible for that step.

Inservice Training
Facilities should provide inservice training and education programs for health care professionals at all levels on the management of care transitions. In addition to addressing the benefits of good care transitions (e.g., better patient outcomes, better resource utilization, improved regulatory compliance), such programs should also offer training on providing patient information that is appropriate and useful to providers in the care setting to which a patient is being transferred and deal with differences in how care is organized and provided in other settings. Hospital-based physicians and

medical trainees should know, for example, that few facilities within the LTCC have around-the-clock on-site diagnostic services, laboratory testing facilities, or pharmaceutical services; nor are physicians or other clinical professionals on site at all times.

Interactions With Other Facilities

Interactions and collaborative relationships with local hospitals and other LTCC care settings which patients may be transferred to or from can be very useful. Facilities may use a variety of strategies to build such relationships.

Consider establishing a joint quality committee with participation by hospitals, SNFs, ALCs, home health agencies and any other facilities that are involved in patient transitions to and from each other's care, or invite other entities to participate in a quality improvement initiative to ensure that the right information is being sent with transferring patients and is being received by providers at the next care setting.

Also consider visiting other facilities or inviting others to visit your facility. Facilities may find it helpful to employ a case manager (typically with a background in nursing or social work) whose role is to visit other care settings to screen patients who are candidates for transfer. The information obtained during this evaluation can go a long way toward assuring a smooth patient transition.

Visits can augment knowledge of how to best prepare a patient for a transfer to another site of care. Preparing patients and families for the next site of care demonstrates reassuring competence to the patient and family, shows professionalism to other care sites, and develops a sense of pride in facility caregivers. When your facility is publicly exhibited in a positive light, it will be perceived as a desirable place to live. Thus, the development of good relationships with other entities may be a successful census-building strategy.

An additional role for the case manager is to serve as a bidirectional link between the facility and the other care settings to or from which patients are transferred. Having an identifiable person in this role helps to "close the loop" and adds personal responsibility and accountability to the process.

Role of the Patient and of Family Caregivers in Transitions of Care

Patients in the LTCC vary widely in their ability to be active partners in their health care. Most patients have some degree of physical or mental impairment and are likely to have difficulty navigating care transitions without assistance. Most patients will have formal and informal caregivers who participate in care and decision-making. In addition to advising facilities of their expectations for the patient's plan of care, providing a history of the patient's past and present problem (as well as, to the extent possible, the rationale for previous therapies or decisions not to treat) may be the caregivers' most important role.

Family caregivers have been characterized as the "silent partners" in health care delivery, functioning as *de facto* care coordinators when no care provider fills this role. During care transitions, family caregivers make important, yet often unrecognized and unsupported contributions to ensuring quality, safety, and adherence to patient preferences.[37]

Family caregivers provide most long-term care in the United States; the annual economic value of all such care was estimated at $354 billion in 2006.[38] Although in the aggregate families clearly make an enormous contribution to caregiving, at the individual level there is a wide spectrum of family involvement in the care of patients within the LTCC. Families are diverse and complex and vary widely in their desire or ability to be deeply involved in caregiving.

Family members may be distant from the patient geographically, emotionally, or both. "Family" caregiving may involve persons such as domestic partners (of either the same or opposite sex), friends, neighbors, or a court-appointed guardian, as well as (or instead of) members of the patient's family. This heterogeneity must be recognized and respected. Transitions between sites or levels of care should engage, empower, and involve family members, but should not place the responsibility for care transitions on them. In the case of a patient who suffers from dementia or other cognitive impairments, it is important that the facility identify his or her legally recognized health care agent or decision maker, who may or may not be a family member.

The HIPAA Privacy Rule and Transitions of Care

Since 2002, health care facilities have been required to comply with the HIPAA Privacy Rule‡, which restricts the use and disclosure of individuals' health information. Although the Privacy Rule specifically states that it is not intended to interrupt the flow of necessary information between clinicians and sites of care, facilities' interpretations of what compliance with the Privacy Rule entails can erroneously impair communication. Table 2 presents some examples of myths and facts about the HIPAA Privacy Rule.

A number of web sites offer reliable information to clarify common misconceptions about compliance with the HIPAA Privacy Rule. See **Resources** for a non-comprehensive list of sites that facilities may wish to consult for guidance.

TABLE 2
Examples of Myths and Facts About the HIPAA Privacy Rule

Myth	Fact
Practitioners may not email colleagues about patients.	The privacy rule does not forbid communication about patients by email.
Practitioners must refer to patients by their medical record number, not by name, in e-mail messages.	The privacy rule does not forbid the use of patient names in e-mail messages.
A provider or hospital must have a release signed by the patient in order to provide test results to another provider or hospital that is treating the patient.	Providers involved in a patient's care are permitted to freely share information for treatment purposes without a signed patient authorization.
Prescriptions or insurance authorization forms may not be sent by fax.	The privacy rule does not forbid the faxing of prescription or insurance information.
Practitioners cannot provide any patient information to a patient's family.	As long as a patient does not object, the privacy rule permits practitioners to share needed information with anyone the patient identifies as involved in his or her care.

Sources: Lo et al, JAMA 2005[39]; Fast Facts for Covered Entities, http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/cefastfacts.html[40]

‡ Health Insurance Portability and Accountability Act Standards for Privacy of Individually Identifiable Health Information

Medication Reconciliation

Medication reconciliation is the process of creating the most current, complete and accurate list possible of a patient's medications, comparing that list against medication orders at each stage of the patient's stay in the facility, and resolving any discrepancies.[41] In an analysis of medication errors reported to the U.S. Pharmacopeia's MEDMARX® program, 66% of reconciliation-related errors occurred during transition to another level of care, 22% during admission, and 12% at discharge. Most of these errors involved omissions or prescribing mistakes.[42]

Because each facility may use a unique formulary and the external restrictions of such entities as Medicare Part D, Medicaid, and managed-care drug programs may further modify drug regimens, medication changes and discontinuations frequently occur when a patient transfers to a new service or care setting. Unintended drug omissions can place patients at risk for significant therapy interruptions. Furthermore, abrupt discontinuation of many medications may result in adverse health consequences.[43] At any time a change is made to a patient's medication regimen, practitioners must ensure that the change is made carefully, is documented, and accords with prescribing instructions for the relevant medication(s).

Medication reconciliation should be performed and documented every time a patient is admitted to a facility or transferred to another setting or level of care (including, and especially, when a patient is transferred to a community home). The Joint Commission has made medication reconciliation at care transitions a National Patient Safety Goal for both hospitals and nursing facilities (Appendix 7).[44] This is a higher standard than the CMS guideline for nursing facilities, which requires a medication regimen review by a consultant pharmacist at least monthly, or more frequently when an acute change of condition has occurred. In the case of a patient who is admitted to an SNF for a short stay, however, a medication review within one month may not occur in time to prevent adverse effects from a medication error made at the time of admission, or the patient may have been discharged before the medication review is performed. Medication review should occur upon SNF admission and may reduce the incidence of complications or adverse events resulting from medication errors.

If possible, the SNF should obtain a copy of the medical reconciliation performed at the time of the patient's discharge from his or her prior care site. It is common for changes to be made to a patient's medications when he or she is hospitalized. Upon the patient's transition back to the SNF, medication reconciliation should be performed again and the patient's current medications checked against those he or she was taking before being hospitalized. Nursing staff should notify the practitioner of changes to or omissions from the patient's medication regimen and verify whether the practitioner wishes to reorder any medications that were stopped during the patient's hospitalization.

Ideally, a pharmacist should participate in the medication reconciliation process, although another health care professional may conduct the initial "med rec." In addition to prescription drugs, the "med rec" should include all over-the-counter medications and complementary or alternative remedies (e.g., vitamins, herbal products) that a patient may have been taking before admission to the facility (and may resume taking once discharged back to a community home). Information about any drug allergies the patient has and about medications that were tried and found to be ineffective or were discontinued because of adverse effects should also be part of the medication reconciliation. Ask questions to try to distinguish among adverse drug events, true drug allergies, and ineffective therapies.

Patient-centered engagement requires a practitioner who provides a reconciled medication list to the patient/family and a motivated patient/family who maintains it. This partnership involves open communication about medication problems, nonprescription drug usage, and adherence to the prescription drug program. An example of a useful tool for helping patients and families to keep track

of medications is NTOCC's *My Medicine List*. (http://www.ntocc.org/Home/Consumers/ WWS_C_Tools.aspx)

Table 3 summarizes the common or essential data elements for medication reconciliation suggested by the National Transitions of Care Coalition. (For the complete list of suggested data elements, see Appendix 8.)

TABLE 3
Summary of Suggested Common or Essential Elements for Medication Reconciliation

Category	Essential	Optional
Assessment on access to care (e.g., admission to hospital or nursing facility)		
Demographic information	Patient name Date of birth ID number Gender Contact information Caregiver name and contact information Allergies/intolerances Date of assessment	Primary language Religious, cultural factors
Medications		
Routine	Medication name (generic/trade) Dose Form Frequency Reason for use	Name of prescriber Compliance level
Other	OTC products Herbal remedies Nutritional supplements Time-limited medications	
Patient access to medications		Prescription benefits Out-of-pocket costs Public/private assistance programs Access to a pharmacy
Other		Prescriber's NPI Known conditions in patient's medical history
Assessment/reconciliation on transfer of care		

Continuing medications	Medication name (generic/trade)
	Dose
	
	Form
	Frequency
	Reason for use
	Expected duration of use (chronic,
	  time-limited)
		Monitoring parameters,
		  frequency

Patient access to medications		Prescription benefits Out-of-pocket costs Public/private assistance programs Access to a pharmacy
Validation of transfer information	Name Date Signature	
Point of contact at transferring facility	Name Department Contact information	

Source: NTOCC, 2008c[45]

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Electronic Health Records

The transmission of patient information is more accurate and complete when the sending and receiving entities share a system of electronic communication (e.g., common electronic health record [EHR] or one that is interoperable with the other entities involved in the patient's care). As previously noted, however, most entities within the LTCC, or that interact with the LTCC, do not possess such interoperable computerized records, which could facilitate the timely transfer of patient information across care settings. Although hard data are lacking with regard to LTCC facilities' levels of connectivity to electronic resources, anecdotal information suggests that many facilities have extremely limited access to electronic resources of any kind.

As a general principle, the Care Transitions workgroup endorses the adoption of an interoperable, easily accessible, secure EHR as a key component of safer care transitions. Currently, patients may be assessed or treated at multiple hospitals or LTCC facilities, but in many cases information from one setting about procedures, new findings, or the patient's response to treatment does not travel with the patient to the next care setting. The forms and checklists presented in this guideline are intended to help facilities and practitioners improve the quality and consistency of information that is transferred with the patient in the absence of interoperable computerized records.

Financial Issues

Evidence suggests that unplanned rehospitalizations of Medicare patients are both common and costly to the Medicare program.[3] estimated that about one fifth of Medicare beneficiaries who are discharged from the hospital are rehospitalized within 30 days, that 90% of these readmissions are unplanned, and that the total cost to Medicare of unplanned rehospitalizations in 2004 was $17.4 billion. In its own analysis of this problem, the Medicare Payment Advisory Commission (MedPAC) estimated that nearly 18% of beneficiaries who are discharged from the hospital are readmitted within 30 days. MedPAC concluded that "over 13% of 30-day hospital readmissions and an associated $12 billion in spending (four fifths of all Medicare spending for readmissions) are potentially avoidable through the application of evidence-based best practices."[14]

For fiscal year 2010, CMS is adopting the standardized measure of readmissions within 30 days due to heart failure as a quality requirement for hospitals under the Inpatient Prospective Payment System. Additional standardized measures for readmissions due to heart attack, pneumonia, and other conditions are likely to be adopted in future years.[14] This new CMS policy offers hospitals and LTCC facilities both incentives and opportunity to improve communication and collaboration in the interest of improving patient safety and avoiding unreimbursed readmissions of Medicare patients.

A growing body of research suggests that comprehensive transitional care for hospitalized elders can reduce readmissions, improve patient quality of life and satisfaction with care, and reduce per-patient costs by as much as 37% over a 12-month period.[24-29] Smooth, well-coordinated care transitions can produce cost savings by enabling hospitals to:

◆ Efficiently move patients to the next level of care, making beds available for new admissions;
◆ Reduce the likelihood that discharged patients will need to be readmitted;
◆ Avoid revenue losses stemming from new Medicare payment policies designed to eliminate payment to hospitals for certain readmissions within 30 days (managed-care and insurance companies will almost certainly implement similar policies in due course); and
◆ Maximize utilization of fixed reimbursement programs.

Although evidence-based data linking comprehensive transitional care with improved outcomes and cost savings in the LTCC setting are scant, LTCC facilities may find that well-executed care transitions result in benefits such as:

◆ Improved customer and family satisfaction;
◆ Attention to patient needs and advance directives;
◆ Repeat customers, as patients, families, and payers recognize the facility's professionalism and compassion;
◆ New business, as satisfied customers tell others;
◆ Reduced liability risks as a result of a decrease in errors during transfers;
◆ Better resource utilization through the implementation of a consistent process to administer patient admissions and transfers (whether planned or emergent); and
◆ Where applicable, improved ability to meet regulatory standards.

PART 2: IMPLEMENTATION OF A CARE TRANSITION PROGRAM

This section breaks the care transition process down into a sequence of steps. Certain steps and substeps are particularly relevant in the context of a planned transition, whereas others are most applicable to an unplanned transition (i.e., an urgent or emergent situation). This distinction is indicated in the text as follows: ● planned transition, ▲ unplanned transition, ╫ both planned and unplanned transitions.

STEP 1
╫ BOTH PLANNED AND UNPLANNED TRANSITIONS

The patient has a recognized status change. Management of a care transition generally begins when a patient is identified as having a status change (i.e., deterioration or improvement) that makes it appropriate to evaluate him or her for another setting or level of care.

In some cases, the status change (and the need for a care transition) can be anticipated and planned for in advance. For example, it can be anticipated that a patient who is hospitalized for surgery will transfer from the hospital to another level of care (e.g., rehabilitation facility, community home) within a reasonably predictable period of time.

Other changes of status are unanticipated (e.g., a patient falls, sustaining a head injury, which necessitates a transfer to the ED). Unanticipated transitions are more likely to be problematic, especially when they occur at night or on a weekend or holiday. By definition, such transfers cannot be planned in advance and often occur at times when the practitioner who is most familiar with the patient is unavailable.

The best preparation is anticipating that the unexpected will occur and establishing a process for that eventuality. Facilities are advised to follow the process described in AMDA's clinical practice guideline *Acute Change of Condition in the Long-Term Care Setting*[d] for recognizing and assessing an unanticipated status change. In particular, a system should be in place to enable the caregiver who observes an unanticipated status change to communicate it promptly to a member of the care team who is in a decision-making position.

Secondly, a system should be in place to identify the patient's medical point of contact as soon as possible upon admission and to notify the point of contact promptly when the patient is trans-

[d] American Medical Directors Association. Acute Change of Condition in the Long-Term Care Setting. Clinical Practice Guideline. Columbia, MD: 2003.

ferred to another setting or level of care. Ideally, the medical point of contact will be the patient's PCP. Many community-dwelling patients, however, do not have a PCP. Elders with multiple health conditions often see many different doctors; according to one study, older persons with one or more chronic illnesses saw an average of eight physicians annually.[8] (See <u>Segmentation of Primary Care Services</u>. Page 6.)

In cases where a patient is receiving care from multiple providers in the community, the best approach may be to ask the patient or family which provider they wish to be the patient's medical point of contact. Upon facility admission, establish the most appropriate method of notifying the medical point of contact (e.g., phone call, fax, e-mail) and if the communication method differs during and outside of office hours. At a minimum, the medical point of contact should be notified when the patient is admitted to or discharged from any health care facility and when the patient dies.

STEP 2
⸸ BOTH PLANNED AND UNPLANNED TRANSITIONS

<u>Interdisciplinary team members communicate with each other and with the patient/family (unit of care) to determine the most appropriate care transition.</u> The number and identities of care team members involved in this initial communication will depend on the nature and urgency of the issue. For example, in an emergency, the initial communication may involve only two or three key team members, with the patient's family notified as soon as consistent with patient safety. In a planned transition, the patient and family should be fully involved in the discussion about the proposed care transition. Identification of the most appropriate care transition may also include making a determination that financial resources are available to pay for the proper service or level of care.

It is important that members of the care team communicate with families about the pros and cons of a proposed transition. For example, a family may assume that a patient with Alzheimer's disease who develops a fever or infection will be better treated if transferred to an ED. However, a transition may be so disorienting to a cognitively impaired patient that he or she may become agitated and require restraint or sedation before treatment for the condition that was the reason for the transfer can begin. In such cases, it may be in the patient's best interest for the fever or infection to be treated "in place." Decisions about transitions should also be guided by the patient's advance directives; if the patient so wishes, no transition may be the best decision.

Table 4 lists issues that the sending facility should ensure are addressed before a planned patient transfer to another setting or level of care.

TABLE 4
Facility Pre-Transition Checklist: Issues That Should Be Addressed Before a Planned Patient Transfer to Another Setting or Level of Care

- Discuss transition with the patient and/or family or significant others well in advance
- Have a "discharge appointment" with the patient and others as appropriate to plan a smooth transfer
- Ensure that medication reconciliation has been performed, that the medication list is given to the patient, and that medication questions are answered
- Explain to the patient and/or family that after the transfer he or she should take only the medications on the current list and should not resume taking any prior medications that are not on the current list
- Have a facility policy on what medical information is to be sent with the patient to insure a smooth transition of care
    - Designate one or more specific facility staff members who are responsible for arranging transitions, gathering information to ensure a smooth transfer, and who are available for questions and calls before and after the patient's departure
    - Have a process for copying and assembling medical information that transfers with the patient and designate a staff member who is accountable for implementing this process
- Define next steps in the patient's care
- Clarify, where appropriate, that the family or significant others have the necessary information to make arrangements for:
    - Durable medical equipment
    - Follow-up physician appointments
    - Follow-up appointments for tests
    - Support services (e.g., home health care, Meals on Wheels)
- Ensure that the patient is stable for transfer
- Contact the next site of care to communicate special patient needs and confirm the next site's readiness to receive the patient and ability to deliver the necessary care
- Review advance directives with the patient and others as appropriate and desired by the patient
- If the patient is transitioning to a community home
    - Identify who will care for the patient at home
    - Determine patient's ability to acquire needed medications (including cost and transportation)
    - Provide the patient and family with a list of community care resources (e.g., home health care, Meals on Wheels)
    - Establish when the patient should see his or her primary care physician or primary medical point of contact
    - Ensure that relevant medical information is sent to the patient's primary care physician or medical point of contact

STEP 3
● PLANNED TRANSITION

The sending facility or care entity communicates with the receiving entity. Patient information received by entity prior to patient arrival. This step is crucial to ensuring that the entity receiving the patient has the information necessary to provide appropriate care or treatment upon the patient's arrival. Although oral communication is ideal (i.e., a practitioner or other care team member at the sending facility speaks directly to a practitioner or other care team member at the receiving entity), written communication is the typical means by which patient information is conveyed.

A shared **EHR** greatly enhances the transmission of patient information. Many transitions, however, are likely to occur between entities that do not share such a communication system. In these cases, the sending facility may transmit patient information to the receiving entity by fax or by means

of a paper form or set of paper documents that are sent with the transitioning patient. Verbal communication between providers, supplemented by written documentation, should be encouraged to enrich data exchange and patient safety.

It is crucial that the information transmitted with the patient include contact information for the sending provider, so that the receiving provider knows whom to contact with questions (including who can be contacted outside of normal office hours, and how). Table 5 lists the essential patient information elements that should be transmitted from the sending to the receiving entity during any care transition. Table 6 presents a sample universal transfer form developed by AMDA.

In a planned transition, it is recommended that these essential patient information elements be supplemented by a "course-of-treatment" summary that provides additional information about the patient's medical history, prognosis, and treatment course. In hospitals and nursing facilities, such a summary is traditionally called a discharge summary.

The information in the discharge or course-of-treatment summary gives providers at the receiving facility a much fuller understanding of the patient being transferred into their care. Table 7 lists the recommended elements of a discharge or course-of-treatment summary. See Appendix 9 for a checklist for the discharge of an elderly patient from the hospital.

Medication discontinuations or changes commonly occur during transitions of care and frequently result in adverse effects and complications. The practitioner in the LTCC setting who is transferring a patient to an acute care setting may wish to use a form such as that shown in Table 8 to encourage communication with practitioners at the receiving facility concerning any proposed changes in the patient's medication regimen.

TABLE 5

Essential Information That Should Accompany Every Transitioning Patient

- Patient name
- Primary diagnosis for admission to sending facility
- Accurate medication list with prescription and non-prescription drugs, with doses and frequency*
- Allergies and medication intolerances
- Vital signs
- Copies of advance directives including AND/DNR status
- Name and specific contact information for:
    - Sending facility (including phone number of facility/wing of facility and nurse name)
    - Responsible practitioner at sending and receiving sites of care
    - Responsible family member/decision-maker
- Barriers to communication
    - English comprehension is poor: provide primary language spoken by the patient
    - Vision: requires glasses to appropriately see, blind, etc.
    - Hearing impairment: requires hearing aid to hear spoken communication, etc.
    - Cognitive issues that impair decision-making; who should be contacted for decision-making
    - Health literacy or cultural issues that may inhibit communication
- Reason for transfer (i.e., the acute change in condition or problem precipitating the transfer) along with any acute changes from baseline associated with this transfer (e.g., confusion, unable to walk, unresponsive)
- Medical devices, lines (e.g., central line, dialysis site, pacemaker) or wounds
- Patient's ability to feed self, special dietary needs (e.g., pureed foods, low-salt diet)
- Significant test results
- Tests with results pending, consults or procedures ordered but not yet performed
- Prognosis and goals of care

AND/DNR: Allow Natural Death/Do Not Resuscitate
*In some settings, the patient's medication administration record could serve as the medication list.

TABLE 6
AMDA Universal Transfer Form

AMDA has developed and recommends the use of the Universal Transfer Form (UTF) to facilitate the transfer of necessary patient information from one care setting to another. Patient transfers are fraught with the potential for errors stemming from the inaccurate or incomplete transfer of patient information. Use of the UTF can help to minimize the occurrence of such errors by ensuring that patient information is transmitted fully and in a timely fashion.

Patient's name: _____ Patient Identifier #: _____
Setting Discharged from: _____ Patient's date of birth: _____
Setting Discharged to: _____ Patient's gender Male: _____   Female: _____
Attending physician in setting discharged from: _____
Admission date: / /   Discharge date: / /

A.   Admitting diagnosis: _____

B.   Other diagnoses from this admission:
          1._____   4. _____
          2. _____   5. _____
          3. _____   6. _____

C.   Current diagnoses prior to admission:
          1._____   4. _____
          2. _____   5. _____
          3. _____   6. _____

D.   Surgical procedures and endoscopies during admission (include name of physician who performed the
     procedure) None __   Physician name: _____
          1._____   Date/results _____ (may attach)
          2. _____   Date/results _____ (may attach)
          3. _____   Date/results _____ (may attach)

E.   Laboratory values (please record most recent results, with date)
          WBC   / /   _____   BUN   / /   _____
          Hgb   / /   _____   Creatinine   / /   _____
          Na+   / /   _____   CL   / /   _____
          K+   / /   _____ CO_2 / /   _____
          Fasting glucose   / /   _____   Other   / /   _____

F.   Results and dates of pertinent studies (radiology, CT, MRI, nuclear scans, etc.) (may attach)
          1. _____
          2. _____
          3. _____
          Chest X-ray: Date performed:_____   Results: No active disease:_____
          Or description if abnormal:_____

G.   Allergies:
          Medication: _____   Reaction: _____

          Medication: _____   Reaction: _____

          Foods: _____   Reaction: _____

          Other: _____   Reaction: _____

H.   Admission weight_____   Discharge weight:_____

TABLE 6 (continued)
AMDA Universal Transfer Form

I.   Advance directives:

	Yes	No
CPR	___	___
Artificial Nutrition	___	___
Further hospitalization	___	___

Other: _____
(Attach copies)

J.   Has patient had a recent fall? Yes ___   No___   Did the patient wander unsafe while hospitalized?

Yes ___ No ___

K.   Comments on inpatient course: (may attach narrative)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

L.   Is the patient aware of his/her diagnosis(es)?   Yes ___   No __
        If No, why not? _____

M.   Patient's cognitive status for decision-making:
        ___ Independent   ____Modified independence (some difficulty in new situations)
        ___ Moderately impaired (decisions poor) ___Severely impaired (never/rarely makes decisions)

N.   Is the patient a candidate for rehabilitation therapy?   Yes ___   No ___
        If yes, state goals for rehabilitation:
        _____
        _____
        _____

O.   Discharge medication orders:
        1._____   Rationale: _____
           Dose _____ Route _____ Frequency _____

        2. _____   Rationale: _____
           Dose _____ Route _____ Frequency _____

        3. _____   Rationale: _____
           Dose _____ Route _____ Frequency _____

        4._____   Rationale: _____
           Dose _____ Route _____ Frequency _____

        5. _____   Rationale: _____
           Dose _____ Route _____ Frequency _____

        6. _____   Rationale: _____
           Dose _____ Route _____ Frequency _____

TABLE 6 (continued)
AMDA Universal Transfer Form

7._____   Rationale: _____
   Dose _____   Route _____   Frequency _____

8. _____   Rationale: _____
   Dose _____   Route _____   Frequency _____

9. _____   Rationale: _____
   Dose _____   Route _____   Frequency _____

10. _____   Rationale: _____
   Dose _____   Route _____   Frequency _____

11. _____   Rationale: _____
   Dose _____   Route _____   Frequency _____

P.   Diet: _____

Q.   Immunizations: Influenza: ____ Date: _____   Pneumococcal: ____ Date: _____
                           Tetanus-Diphtheria: ____ Date: _____
    Tests: PPD: __   Results: __+/- __   Date: _____

R.   Additional orders: _____
      _____
      _____
      _____
      _____

S.   Follow-up on consults/tests/procedures recommended: _____
_____
_____
_____
_____

T.   Is patient the primary decision maker? Yes ____ No: ____
      If no, name of the substitute or surrogate:
      _____

Name of physician /designee completing form:_____
Contact phone number: (   ) _____-_____ Extension or beeper: _____
Date form completed: /   /

Name of Primary Care Physician
Contact phone number: (   ) _____-_____ Extension or beeper: _____

TABLE 7
Recommended Elements of a Discharge or Course-of-Treatment Summary

◆ Reason for course of treatment (i.e., disease process)
◆ New diagnoses arising during course of treatment
◆ Surgery or other procedures performed during course of treatment
◆ Consultants utilized during course of treatment
◆ Complications encountered during course of treatment (e.g., falls, iatrogenic infections, patient harm)
◆ Changes from pre-admission baseline (e.g., change in ability to communicate, cognitive issues, functional decline)
◆ Treatment goals and advance directives discussed with patient/family
◆ Anticipated treatment goals at time of transition:
  ◆ Return to previous site of living vs. stay at a level of care different from pre-admission status
  ◆ Total recovery vs. partial recovery vs. recovery not likely (i.e., rehabilitation potential)
  ◆ Palliative care/hospice
◆ Test results pending at time of transition (e.g., biopsies, lab tests, radiology studies)
◆ Next steps planned in patient's care plan, with specifics as to why and when and which practitioner(s) need to be involved

TABLE 8
Practitioner Request for Notification of Medication Changes

Dear Receiving Physician,

I am the practitioner for (name of patient) _____

Before discontinuing or changing the following medications, please contact me.

_____   _____
_____   _____
_____   _____
_____   _____
_____   _____
_____   _____
_____   _____
_____   _____

Dr. _____
Facility _____
Phone _____
Pager _____

Your cooperation is greatly appreciated.

▲UNPLANNED TRANSITION

<u>The patient has an acute change of condition and transfer to an emergency department is appropriate.</u> Patient transfers between an LTCC facility and an ED can be especially problematic.[46] Patients are frequently transferred to the ED from LTCC facilities without essential patient information,[20] making it difficult for ED staff to even determine the reason for the transfer. Some EDs compound the information barrier by refusing to accept oral communication about a patient unless the transferring physician speaks to an ED physician. Such policies can present particular problems for transfers from LTCC facilities because the attending physician is often not at the facility at the time a patient's transfer to the ED is deemed necessary.

The use of a standard transfer form (Table 9; <u>Appendix 10</u>) may improve communication between a nursing facility and an ED.[20,46] Standardization of patient records facilitates communication between care settings and assists providers in efficiently reviewing records.[47] Additionally, caregiving staff may find it helpful to use AMDA's protocols for practitioner communication[e,f] both to standardize the patient evaluation that determines the need for an ED transfer and to obtain the data that should be transferred with the patient if a transfer is deemed appropriate.

Facilities may also wish to consider placing an identification armband on a patient who is being transferred to the ED. In addition to the patient's name, date of birth, and contact information for the nursing facility, the armband should also provide critical information such as the patient's DNR/AND[§] status and drugs to which the patient is allergic. Such information is particularly helpful if the patient is being transferred to the ED without an accompanying caregiver, has cognitive problems, or has a decreased level of consciousness. Appendix 11 provides a list of quality indicators for transitions between nursing facilities and EDs.

TABLE 9

Example of a Skilled Nursing Facility-to-Emergency Department

Source: Davis et al, 2005[46]

[See next page]

NOTE: This is an example of a form that facilities may wish to modify or adapt to meet their own needs. Shaded areas of the form can be completed at any time after the patient's admission to the nursing home (i.e., *before* an emergency occurs) with multiple copies made. The form can then be readily available and placed in a designated location in the patient's chart or other known site within the facility. Practitioners at some LTCC facilities update these forms while making their rounds. In an emergency, a nurse can take a copy of the form and complete the non-shaded areas. The filled-out copy goes with the patient to the ED and the original form remains in the patient's chart.

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e   American Medical Directors Association. Protocols for Physician Notification: Assessing and Collecting Data on Nursing Facility Patients - A Guide for Nurses on Effective Communication with Physicians. Columbia, MD.

f   American Medical Directors Association. Caregivers' Communication Guide: Caring for the Older Adult Protocols for Change of Condition. Columbia, MD.

§   Do Not Resuscitate/Allow Natural Death

RESIDENT TRANSFER FORM

Name of Nursing Home _____

Address _____

Date of Transfer to the Emergency Room _____/_____/_____

Print only and answer each question (Please do not leave any blanks) Shaded areas may be completed prior to the Date of the emergency and updated as needed.

Resident's Last Name First Name MI	Sex ❑ M ❑ F	Date of Birth ___/___/_____

Name of unit//floor resident transferring from   Phone No. of unit/floor   Unit Fax No.

Attending Physician	DNR Orders ❑ Yes ❑ No	Advance Directive sent ❑ Yes ❑ No

Name Resident's Next of Kin/ Health Care Power of attorney Phone Number	Next of Kin notified ❑ Yes ❑ No	Religion

(Check if present)			Functional Status	Indep	Asst	Depend
Disabilities	**Incontinence**	**Impairments**	Mental Status ___A___O			
❑ Amputation	❑ Bladder	❑ Speech	Feeding	❑	❑	❑
❑ Paralysis	❑ Bowel	❑ Hearing	Bathing/Dressing	❑	❑	❑
❑ Contracture	❑ Saliva	❑ Vision	Transfer	❑	❑	❑
❑ Pressure Ulcer			Ambulation	❑	❑	❑

Behavior Issues

Copy of the MAR with current medications (within the last 24 hrs.) highlighted. ❑ Yes ❑ No *(If no, list current medications below)*	Allergies

Chief complaint(s) that bring(s) the patient to the Emergency Room (If altered mental status is the chief complaint, please describe behavior prior to the change.) Date of onset/duration ___/___/____.	Diagnosis	Past Medical History

Lab or other Tests ordered prior to transfer or within 24 hrs. ❑ Yes (send copy of results) ❑ No	Diet/Therapies

Resident uses ❑ Glasses ❑ Feeding tube ❑ Cane ❑ Other(explain) _____ ❑ Hearing aid ❑ Foley Catheter ❑ Crutches _____ ❑ Dentures ❑ Tracheostomy ❑ Walker ❑ Ostomy ❑ Dialysis Access (describe) _____	Sent with Resident ❑ Glasses ❑ Crutches ❑ Hearing aid ❑ Walker ❑ Dentures ❑ Other _____ ❑ Cane

Name of MD/NP/PA who made the decision to send patient Beeper Number	Physician's orders attached: ❑ Yes ❑ No

Vital signs at the time of transfer T_____ P_____ R_____ B/P_____	Transport via ❑ Ambulance ❑ Other (explain) _____

Signature of the Transfer Nurse Print Name	Date of transf. ___/___/___	Time of transf. ____/____/___

ER Dispatch Fax #___/___/____ (Cover letter required.)   Last rev. 3/21/02
**ER Dispatch #___/___/____ (Phone notification of NH transfer to the ER. Call to be brief and to the point.
Give patient name, NH name, exact reason for patient transfer to the ER & ETA. (Do not give a full report.)
Resident Transfer form.**

DNR + Do Not Resuscitate; MAR = medication administration record; NP = nurse practitioner; PA = physician assistant; NH – nursing home; ER = emergency room; ETA = estimated time of arrival

The patient is being transferred to another care site by emergency medical services. Emergency medical services (EMS) may be involved in both emergent patient transfers (e.g., to the ED) and non-emergent transfers between care settings. Clear communication between the sending facility and the EMS personnel is essential to ensuring a smooth patient transfer. It may be helpful to regard the EMS transfer as a patient transition in itself and the EMS personnel as a "receiving facility."

When the EMS receives a call requesting patient transportation, the service dispatcher will ask for certain patient information (Table 10). The transfer will proceed more smoothly if the facility staff member making the request has this information readily available. For example, the dispatcher may ask for the patient's weight because this helps to determine whether the patient may need special handling (e.g., an extremely heavy patient may require a special stretcher). Information about the patient's insurance coverage is necessary to establish whether Medicare or other insurance will reimburse for the transportation service. Ambulance transportation of Medicare patients is reimbursed only if it meets CMS's medical necessity guidelines (Table 11). Medicare Advantage plans and other insurers may have different coverage guidelines for ambulance transportation.

EMS personnel will request certain information when they arrive to collect a patient; the sending facility may supplement this information with further relevant data that it considers important for EMS personnel to know (Table 12). If a transferring patient has requested DNR/AND status, EMS personnel must receive written documentation of this status. In the absence of written documentation of DNR/AND status, EMS personnel are generally legally required to attempt to resuscitate a patient.

Facilities should consider developing relationships with EMS providers and sharing information about each other's information needs through inservice training sessions. Facility nursing staff should be trained to know when ambulance transportation is appropriate and what patient information to provide to EMS personnel when making a transportation request. EMS personnel should understand the special needs of frail elderly patients who may be cognitively impaired and must be familiar with state-specific regulations concerning the requirement for resuscitation.

As in any transition of care, careful attention is essential to ensure a safe "handoff" between EMS personnel and the LTCC facility. For example, EMS personnel should verbally notify facility nurses and caregivers of the patient's arrival or departure. The sending facility must ensure that EMS personnel have all the pertinent information that is to be transferred with the patient and understand that this information is to be delivered with the patient to the caregivers at the receiving site of care.

If at all possible, after transporting a patient to the next site of care, EMS personnel should make a follow-up call to the sending facility to verify that the transfer has been completed and communicate any information that the sending facility may need for its records. For example, if the nearest ED was on diversion, the sending facility needs to know to which alternate ED the patient was taken.

TABLE 10

Patient Information That May Be Requested By an Emergency Medical Service Dispatcher

- Name, date of birth, social security number
- Primary condition patient is being treated for
- Weight
- Insurance coverage

TABLE 11

Summary of CMS Medical Necessity Guidelines for Ambulance Transportation of Medicare Patients

Ambulance transportation of a Medicare patient is covered when satisfactory documentation can be provided that the patient's illness or injury contraindicated transportation by other means. Generally, documentation must show that the patient:

- Was transported in an emergency situation, e.g., as a result of an accident, injury, or acute illness; or
- Needed to be restrained to prevent injury to him/herself or others; or
- Was unconscious or in shock; or
- Required oxygen or other emergency treatment during transport to the nearest appropriate facility; or
- Exhibited signs and symptoms of acute respiratory or cardiac distress (e.g., chest pain, shortness of breath); or
- Exhibited signs and symptoms indicating the possibility of acute stroke; or
- Had to remain immobile because of a fracture that had not been set or the possibility of a fracture; or
- Was experiencing severe hemorrhage; or
- Could be moved only by stretcher; or
- Was bed-confined before and after the ambulance trip.

Source: CMS, 2007[4]

TABLE 12

Information Exchange Between EMS Personnel and Sending Facility

When picking up a transferring patient from a nursing facility, EMS personnel may request the following information:
◆ Patient's diagnosis on admission to facility
◆ Identity of patient's next of kin
◆ Report of patient's acute change of condition, including when it occurred
◆ List of patient's medications
◆ Written documentation of DNR/AND status

When picking up a transferring patient from a hospital, EMS personnel may request the following additional information:
◆ Report of history and physical
◆ Other notes regarding the patient's condition or treatment
◆ Documentation of medical necessity
◆ Written documentation of DNR/AND status

Other patient information that the sending facility may consider important to convey to EMS personnel may include the following:
◆ Primary language and need for interpreter
◆ Sensory impairments
◆ Allergies

DNR/AND: Do Not Resuscitate/Allow Natural Death

STEP 3C

● PLANNED TRANSITION
Patient's condition has improved to the extent that transfer to his or her community home is appropriate. When a patient is transferring to a community home, the family members or other caregivers who will be supporting the patient at home constitute the "receiving facility." Because the success of the plan for the patient's continuing care depends on these caregivers,[49] it is essential that they be prepared for the patient's transition before it occurs. Many readmissions to acute or SNF care settings occur because family caregivers are poorly prepared to meet the patient's needs and providers are given inadequate information to successfully continue the plan of care after the transition to a community home.

Facility staff must discuss with family caregivers the level of care the patient will require at home and determine whether they are able to provide that level of care. Offer family caregivers training, if necessary, to perform caregiving tasks such as changing dressings, administering medications, or maintaining medical devices (e.g., dialysis access sites, Foley catheters, suprapubic catheters). Educate family caregivers about warning signs for which they should seek medical attention (e.g., medication side effects, symptoms indicating a worsening of disease). Discuss options such as home health care and meal delivery services that can offer additional support or fill gaps in the patient's care.

Caregiver assessment is an important tool for understanding family caregivers' needs and capacities and improving quality of care for the patient. It has been defined as "a systematic process of gathering information that describes a caregiving situation and identifies the particular problems, needs, resources and strengths of the family caregiver. It approaches issues from the caregiver's perspective and culture, focuses on what assistance the caregiver may need and the outcomes the family member wants for support, and seeks to maintain the caregiver's own health and well-being."[49] Purposes and principles of caregiver assessment are presented in Table 13. (See Appendix 12 for recommended domains and constructs for caregiver assessment.)

Evaluation of caregivers' ability to understand and act on health information is a crucial aspect of caregiver assessment. "Health literacy" includes the ability to understand instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms, and the ability to negotiate complex health care systems.[50] The Institute of Medicine has estimated that nearly half of American adults (90 million people) have difficulty understanding and acting upon health information.[51] Appendix 13 presents interventions that have been shown to improve comprehension among patients with low health literacy and impaired cognitive function. See **Resources** for sources of guidance that may be helpful on presenting health information to patients and caregivers in an understandable fashion.

TABLE 13
Purposes and Principles of Caregiver Assessment

Purposes
◆ Identifying the primary caregiver and other informal caregivers.
◆ Improving caregivers' understanding of their role and the abilities needed to carry out the required tasks.
◆ Understanding the caregiving situation, including service needs, unresolved problems, and potential risks—so that the caregivers' needs can be met.
◆ Identifying services available for the caregivers and provide appropriate and timely referral for services.
◆ Determining the patient's eligibility for services that also help the caregiver.

Principles
◆ Because family caregivers are a core part of health care and long-term care, it is important to recognize, respect, assess and address their needs.
◆ Caregiver assessment should embrace a family-centered perspective, inclusive of the needs and preferences of both patient and caregivers.
◆ Caregiver assessment should result in a plan of care (developed collaboratively with the primary caregiver), that indicates the provision of services and intended measurable outcomes.
◆ Caregiver assessment should be multidimensional in approach, should be periodically updated, and should reflect culturally competent practice.
◆ Those assessing family caregivers must have specialized knowledge and skills. Practitioners' and service providers' education and training should equip them with an understanding of the caregiving process and its impacts, as well as of the benefits and elements of an effective caregiver assessment.

Source: Caregiver Assessment: Principles, Guidelines and Strategies for Change. Report from a National Consensus Development Conference.[52]

● PLANNED TRANSITION

Patient is approaching the end of life and comfort care only is appropriate. Transfers as life draws to a close are intrusive and can diminish life quality. Any transfer should occur in the context of the patient's expressed wishes. Although every patient's situation is unique, the approach outlined in Table 14 may provide a guide.

Discussions about withholding aggressive treatment at the end of life may meet with resistance from members of a patient's family. The term "Allow Natural Death" may be more acceptable to families than "Do Not Resuscitate." Please refer to AMDA's information series *Palliative Care in the Long-Term Care Setting*g, which provides extensive resources for decision-making for palliative care.

TABLE 14

Determining A Patient's Wishes Regarding End-of-Life Care

◆ **Determine who speaks for the patient**. Many patients who are approaching the end of life can speak for themselves about their wishes. However, if a patient lacks the capacity to understand or make care decisions, an appropriate designee must be identified promptly.

◆ **Discuss the patient's wishes concerning end-of-life care.** An unwanted transfer must never occur because no one asked the patient, or his or her designee, to specify end-of-life care wishes.

◆ **Determine the patient's primary goals.** Does the patient desire longevity, functional independence, or simply comfort?

◆ **Provide adequate, unbiased information.** Appropriate patient decisions must be based on full disclosure concerning the condition, treatment options, and likelihood of treatment success, among other issues.

◆ **Revisit advance directives at every stage throughout the LTCC.** Goals of care may radically alter as health status changes.

STEP 4

● PLANNED TRANSITION

The patient is physically handed over to the receiving level or setting of care. The issues to be addressed when a patient is physically handed over to another level or setting of care will depend on the nature of the transition. Routinely, a standard form must be completed when a patient is transferred to a nursing facility, ALF, or home health agency from any other care setting. Many other sites of care require that a practitioner complete admission forms. The key to a successful transition is communication with the next site of care and transmission of both required information and any additional data considered essential to the provision of quality care.

Step 4A

● PLANNED TRANSITION

Patient is being discharged to his or her community home. As discussed in **Step 3B**, a patient who is discharged home is being transitioned into the care of family and community caregivers. When this

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g American Medical Directors Association. LTC Information Series: Palliative Care in the Long-Term Care Setting. Columbia, MD.

transition occurs, the facility must ensure that these caregivers have the information and resources they need to successfully assume the patient's care. At a minimum, a designated facility staff member should ensure that all tasks listed in Table 4 have been carried out before the patient is discharged home.

Although not every patient will be using home health care services, facilities should anticipate this potential need and make arrangements in advance to avoid a last-minute, often flawed, rush to complete the necessary documentation and obtain the required signatures. As noted previously, the facility should ensure that the patient is connected with his or her primary care providers and that the patient and family understand what the next step in the patient's care is, where it will take place, and the reason(s) it is necessary.

STEP 5

⸸ BOTH PLANNED AND UNPLANNED TRANSITIONS

Both sending and receiving entities verify that the patient has been handed over and that essential patient information has been received. The transition is not complete until both sides have verified that the handoff has occurred and the providers at the receiving facility have assumed responsibility for the patient's care. The receiving facility must review the information sent with the patient to ensure its clarity and completeness and follow up with the sending facility to obtain any missing information or necessary clarifications. When a patient has been transferred from a hospital to a nursing facility, for example, the facility may wish to request copies of any lab test results, radiology studies, or notes from specialty consultations conducted during the patient's hospital stay that were not transmitted with the patient.

Table 15 lists issues that the sending facility should ensure are addressed in the period immediately following a patient's transition to a community home or to another level or site of care.

STEP 6

⸸ BOTH PLANNED AND UNPLANNED TRANSITIONS

Sending facility follows up to confirm that the patient has been successfully transitioned to the new level or setting of care. It is recommended that the sending facility contact the receiving facility within 24 hours after a patient transition has occurred to confirm that the transition has been completed and that providers at the receiving facility have all the information they need to care for the patient appropriately.

During the interval between the patient's departure for the next site of care and confirmation that the receiving care site has accepted responsibility for the patient, the sending facility and practitioner should be prepared to respond, to the extent possible, to patient requests for help or information. The sending practitioner's willingness to be responsive during this brief interval should not be interpreted as a commitment to provide ongoing post-transition care, unless such a commitment has been explicitly agreed to by both patient and practitioner.

In some cases, lab tests may have been ordered at the sending facility before the transition occurred, but the results not obtained until after the patient has been transferred. These results should be conveyed to the receiving facility in a timely fashion. The sending facility should also verify that any necessary appointments for follow-up care have been made, or at least clearly requested in the transfer documentation.

TABLE 15
Facility Post-Transition Checklists

A. Issues That Should Be Addressed Upon or Shortly After a Planned Patient Transfer to a Community Home

1. Ensure that patient's PCP or other medical point of contact has been notified of the following:
   - That the patient has been discharged
   - When the patient has been advised to arrange a follow-up appointment
   - What information about the patient has been sent to the PCP, when, and how
   - Name and contact information of attending practitioner in the LTCC facility who may be contacted if the PCP considers this appropriate
   - Name and contact information for a facility staff member that the PCP may contact for further information

   If the patient does not have a PCP or medical point of contact, reaffirm the need to acquire one
   - Reaffirm that the facility cannot be the patient's PCP
   - Advise the patient/family that the facility is willing and able to send information to the new caregiver

2. Call the patient/family 24-48 h after discharge for follow-up with the following:
   - Confirm that previously arranged support services (e.g., home health care, Meals on Wheels) have made contact and initiated services. If not, provide contact information for these services to the patient/family again. In exceptional instances the facility may assist the patient in contacting support services.
   - Review the list of medications given to the patient at discharge from the facility and the schedule for taking them. Reinforce the importance of adhering to this new medication schedule and not resuming prior medications until the patient is seen by his or her PCP.
   - Verify that the patient/family has contacted the patient's PCP to make a follow-up appointment.
   - Verify that the patient/family has made appointments for follow-up tests as necessary or has kept previously made appointments.
   - Verify that the patient/family understands the next steps in the patient's care.

3. Document all of the above contacts in the patient's record, noting the date, time, and a summary of the information exchanged.

B. Issues That Should Be Addressed Upon or Shortly After a Planned Patient Transfer to Another Facility or Level of Care

1. Ensure that patient's PCP or other medical point of contact has been notified of the following:
   - That the patient has been discharged
   - Name and contact information of attending practitioner in the LTCC facility who may be contacted if the PCP considers this appropriate
   - Name and contact information for a facility staff member that the PCP may contact for further information

   Document the call to the medical point of contact in the patient record, noting the date, time, and a summary of the information exchanged.
   - Advise the patient/family and receiving facility that the sending facility is willing and able to send information to the patient's new caregivers. Provide contact information for the person at the sending facility who can provide this information.
   - Call both the receiving facility and the patient/family 24-48 h after transfer to confirm the patient's arrival at the new facility and obtain closure of any unresolved questions or issues.

A successful transition may be envisioned as a closed loop (Figure 1). To ensure that the loop is closed, the sending and receiving facilities must interact, verify, and clarify that key patient information is both transmitted and acted upon in a timely fashion.

STEP 7

╬ BOTH PLANNED AND UNPLANNED TRANSITIONS
<u>Monitor the facility's performance in managing care transitions.</u> Review the management of care transitions through the facility's quality improvement process. Table 16 suggests indicators that a facility may wish to use to measure the success of care transitions. Appendix 14 presents selected performance measurement indicators for transitional care from existing tools that facilities may wish to incorporate or modify to meet their needs.

SUMMARY

Care transitions have emerged as a critical health care issue. Patient transfers across sites of care were once an infrequent event that typically occurred during the resolving stage of an acute, defined illness. Today, by contrast, a chronic-disease model of care is characterized by an aging population sustained by medications and interventions unimaginable even a decade ago. In this paradigm, patients experience years of disease and disability marked by repeated admissions to health care facilities.
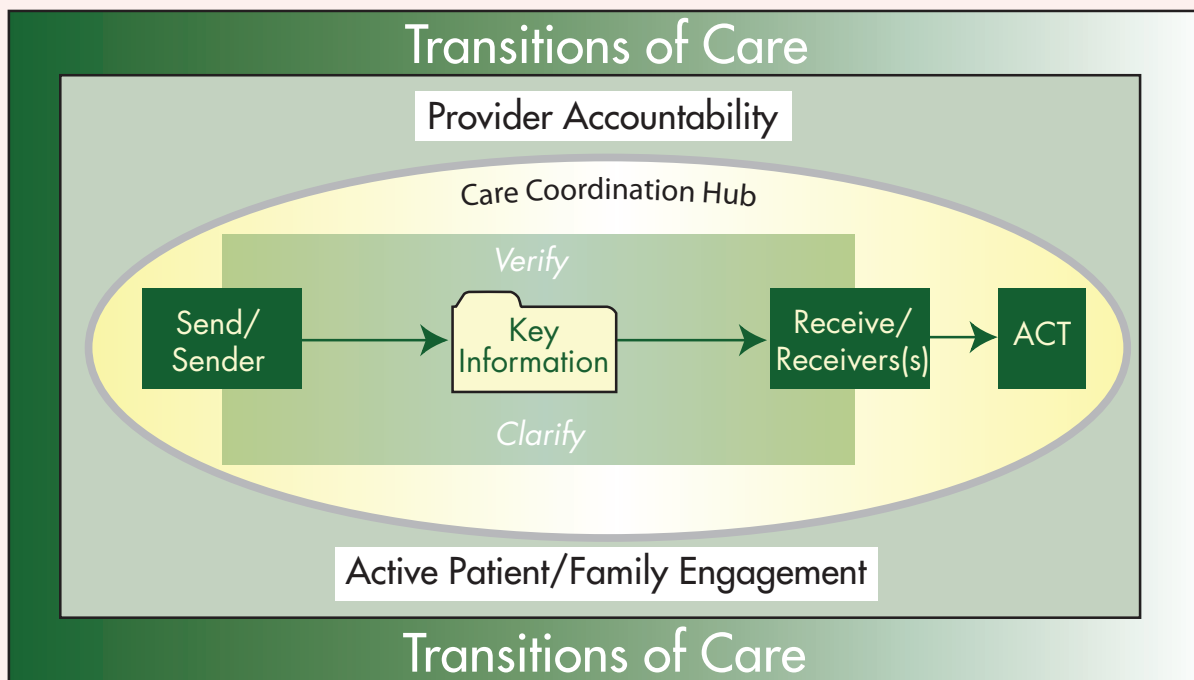
Whereas *health care facility* once meant *hospital*, numerous non-hospital facilities now provide many elements of the care received by older adults. A partial list of such institutions includes skilled nursing facilities, assisted living facilities, senior housing facilities, adult day care facilities, hospice programs, and even the community home setting. Given the panoply of specialists frequently involved in chronic disease care, and the consequent numerous medications that are prescribed to older adults, it is clear that a bewildering amount of information must be transmitted at any time a patient transfers to another level or setting of care. Unfortunately, the ability of health care professionals and systems to organize and coordinate care across settings has not kept pace with the increased quantity and complexity of data that must be transmitted to assure quality of patient care following a transition.

Uncoordinated transitions of care all too often result in duplication of services and waste of resources, as well as adverse events and avoidable complications such as hospital readmissions, extended stays in the emergency department for observation, medical errors, and – most importantly – potential and real patient harm. Evidence is mounting, however, that efforts to ensure continuity of care for all patients, and especially older patients, during care transitions can improve patient outcomes.

The science of care transitions is still emerging. Defining good outcomes is difficult given the heterogeneous nature of the population transitioning through the long-term care continuum. For a patient with metastatic cancer, a good outcome may well be a peaceful death or the avoidance of a transition. For a patient who has just had a hip replacement, a good outcome may be a return to independence at home or assurance that the patient and family know the next step in care after he or she leaves the nursing home. Both in the literature and in practice, however, some concepts appear to be consistently associated with perceived good outcomes for patients.

First, care transitions are a patient-centered activity. Information moves with the patient, the

FIGURE 1
A Conceptual Model for Transitions of Care

Transitions of Care

Provider Accountability

Care Coordination *Hub*

Verify

Send/Sender → Key Information → Receive/Receivers(s) → ACT

Clarify

Active Patient/Family Engagement

Transitions of Care

The care transition process involves both the **sender** and the **receiver** of critical medical and health-related information.

◆ The sender is accountable for ensuring that the key information transferred to the **receiver** is complete and timely. In this case, the **sender** must **verify** that the information was received by the intended recipient.

◆ The **receiver** is also accountable and must respond as well as acknowledge the receipt of complete information from the **sender** in a timely manner.

◆ The **sender** is available to answer any questions that the **receiver** may have regarding the information received (that is, to **clarify**).

◆ The **receiver** acts upon the information received; i.e., evaluates the information received and determines whether the plan of care for the patient needs to be altered before continuing its implementation, and if so, in what way.

◆ Measuring both the sender and receiver promotes shared accountability across care settings and providers.

Source: NTOCC 2008a[2]

patient and family participate in decisions after being provided with adequate information, and the needs of the patient predominate in decision-making. Health care providers should determine and respect the patient's wishes as expressed in advance directives. Second, medication reconciliation must occur with every transition at both the sending and receiving care sites. Third, care transitions are the ultimate interdisciplinary team activity. Every member of the care team must be involved, accountable, and responsive to ensure the timely and appropriate transfer of information to the next level or setting of care. Fourth, caregivers from the sending site of care must maintain responsibility, or at least availability, for patients until the caregivers at the receiving site assume clinical responsibility.

Finally, communication of adequate clinical data is instrumental to safe transitions. Information must be appropriate in amount; it should be communicated by a method useful to the receiving site of care and with the urgency necessary to ensure timely delivery. Achieving these objectives may involve the use of standardized forms, phone calls, fax transmission, electronic transfer, or other methods, as appropriate to the nature of the transfer.

TABLE 16
Sample Performance Measurement Indicators

Process indicators
◆ Facility has adopted and implemented policies and procedures to guide care transitions to the hospital, emergency department, community home, and other LTCC facilities
◆ Appropriately trained staff members are designated as responsible for managing care transitions
◆ Facility provides appropriate inservice training and education programs for health care professionals at all levels on the management of care transitions
◆ Facility utilizes a standard form to provide essential patient information to receiving entities in care transitions
◆ Documentation of DNR/AND status is routinely sent with any patient who is transferred to an emergency department
◆ Patients' wishes concerning end-of-life care are documented and advance directives are revisited at regular intervals as health status and care goals change
◆ Designated staff members follow up as a matter of course to ensure that a transferred patient has successfully transitioned to the new setting or level of care

Outcome indicators
Decreases in:
◆ Avoidable care transitions
◆ Readmissions resulting from avoidable post-discharge complications and adverse events
◆ Costs associated with readmissions
◆ Duplicative use of diagnostic services
◆ Medication-related adverse events
◆ Patient harm resulting from errors in the transition process

Increases in:
◆ Patient safety
◆ Quality of life for patients with complex health care needs
◆ Patient and family satisfaction with care

This CPG, developed by a multidisciplinary expert consensus panel, delineates essential steps and actions required for safe patient transitions across levels and settings of care. The processes outlined in this CPG will, if followed, contribute to ensuring that necessary care transitions are conducted smoothly, essential patient information is transmitted successfully to the patient's next care setting, and health care professionals involved in the care of the transitioning patient communicate appropriately about the patient's care requirements. This will result in a transition that meets the patient's needs and is safer and more satisfying for the patient and family.

RESOURCES

Evidence-Based Models of Transitional Care
Care Transitions Intervention
http://www.caretransitions.org

The Care Transitions Intervention is a randomized controlled trial conducted within a large integrated health care delivery system in Colorado and designed to address potential threats to quality and safety during care transitions by providing patients and caregivers with tools and support. Publications, tools developed to facilitate the intervention, and other resources are available on the project web site.

Guided Care
http://www.guidedcare.org/

In this transitional care model developed by researchers at Johns Hopkins University, a guided care nurse, based in a primary care office, works with patients and families to improve their quality of life and make more efficient use of health services. In a pilot study, patients who received guided care rated their quality of care significantly higher than patients who received usual care and average insurance costs for guided-care patients were 25% lower over a 6-month period. The program is currently being tested in a randomized trial at eight primary care sites in the Baltimore–Washington, D.C., area.

Project RED (Re-Engineered Discharge)
http://www.bu.edu/fammed/projectred/index.html

Project RED is a randomized controlled trial at Boston Medical Center to re-engineer the discharge process for patients from a network of community health centers who are discharged from a general medical service at an urban hospital. Publications, tools developed to facilitate the intervention, and other resources are available on the project web site.

Other Care Transitions Resources for Health Care Professionals

Health Literacy
The following resources are some examples of sources of guidance on presenting health information to patients and caregivers in an understandable fashion:

Health Literacy
Health Resources and Services Administration, U.S. Department of Health and Human Services
http://www.hrsa.gov/healthliteracy/

Quick Guide to Health Literacy
Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services
http://www.health.gov/communication/literacy/quickguide/

Clear Communication: An NIH Health Literacy Initiative
National Library of Medicine, National Institutes of Health
http://www.nih.gov/icd/od/ocpl/resources/clearcommunication/healthliteracy.htm

HIPAA Privacy Rule
The following is a non-comprehensive list of web sites that offer reliable information to clarify common misconceptions about compliance with the HIPAA Privacy Rule.

Fast Facts for Covered Entities
http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/cefastfacts.html

Debunking some common myths about the HIPAA privacy rule
http://www.acpinternist.org/archives/2003/09/privacy.htm#myths

FAQs regarding HIPAA
http://www.ifsmed.com/hipaa.html

10 Myths About HIPAA, Patients and Medical Records Privacy
http://patients.about.com/od/yourmedicalrecords/ss/hipaamyths.htm

The List: Six HIPAA Myths Debunked
http://www.physicianspractice.com/index/fuseaction/articles.details/articleID/1270.htm

HIPAA Myths and Facts
http://www.ahima.org/pdf_files/HIPS_Mythsfootnotes.pdf

Myths and Facts about the HIPAA Privacy Rule
http://www.healthprivacy.org/newsletter-url2306/newsletter-url_show.htm?doc_id=173459

National Patient Safety Goals
http://www.jointcommission.org/patientsafety/nationalpatientsafetygoals/
(Also see Appendix 6)
This program of the Joint Commission (formerly the Joint Commission on Accreditation of Health Care Organizations) helps accredited organizations address patient safety concerns. The goals are developed and regularly updated by a panel of patient safety experts and professionals with hands-on experience addressing patient safety issues in a variety of health care settings.

Physician Orders for Life-Sustaining Treatment Paradigm
www.polst.org
This program is intended to improve the quality of end-of-life care. Health care providers use a standardized medical order form to indicate which types of life-sustaining treatment a seriously ill patient wants or does not want if his or her condition worsens. Signed by both the physician and the patient, the form requires health care providers to engage patients with serious, life-limiting illnesses in a discussion about their preferences for end-of-life medical interventions and intensity of care. The form moves with the patient and must be honored across all care settings.

Project BOOST (Better Outcomes for Older adults through Safe Transitions)
Society of Hospital Medicine
http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm

An initiative to improve care transitions out of the hospital by using a team approach. An online "resource room" provides a wealth of materials to assist with optimizing the discharge process.

Regulation of the Long-Term Care Continuum

NH Regulations Plus
http://www.hpm.umn.edu/nhregsPlus/

This site contains federal nursing home regulations and nursing home regulations for all states and the District of Columbia (updated as of July 2007), comparative analyses of more than 70 topics dealing with nursing home regulation, and resources and publications relevant to nursing home regulation.

Assisted Living State Regulatory Review
http://www.ncal.org/about/state_review.cfm

This report, published annually by the National Center for Assisted Living, provides a state-by-state summary of assisted living regulations covering 21 categories; provides contact information for state agencies that oversee assisted living activities; and includes each agency's Web site address.

Resources for Finding and Comparing Health Care Facilities and Services

Centers for Medicare and Medicaid Services Resources
CMS provides several tools that may help consumers to find and compare health care facilities and services.

Home Health Compare
http://www.medicare.gov/HHCompare

Hospital Compare
http://www.hospitalcompare.hhs.gov

Nursing Home Compare
http://www.medicare.gov/NHCompare

Eldercare Locator
http://www.eldercare.gov/Eldercare/Public/Home.asp
(800) 677-1116 (weekdays 9:00 a.m.-8:00 p.m. Eastern Time)

A service of the U.S. Administration on Aging, this web site links older adults in need of assistance with state and local agencies on aging and community-based organizations that serve older adults and their caregivers.

Other Resources for Older Adults and Family Caregivers

CMS Support for Caregivers
http://www.cms.hhs.gov/partnerships/downloads/CMSCaregivers91907.pdf

This paper describes CMS' legal authority to support caregivers and HIPAA rules pertaining to the disclosure of information to caregivers.

Family Caregiver Alliance - National Center on Caregiving
http://www.caregiver.org
(800) 445-8106

FCA offers an array of services and publications based on caregiver needs as well as local, state, and national programs of education and support for caregivers.

National Clearinghouse for Long-Term Care Information
http://www.longtermcare.gov

This web site was developed by the U.S. Department of Health and Human Services to provide information and resources that help individuals and families plan for future long-term care needs. It includes a comprehensive glossary of long-term care terms and extensive information on resources to assist with long-term care financial planning, etc.

National Family Caregivers Association
http://www.nfcacares.org

NFCA is a nonprofit organization that offers education, support services, and resources for family caregivers.

Next Step in Care
http://www.nextstepincare.org/

Next Step in Care provides information and advice to help family caregivers and health care providers plan safe and smooth transitions for patients.

National Transitions of Care Coalition
http://www.ntocc.org/

NTOCC was formed in 2006 to address problems associated with transitions of care and define solutions that improve safety and quality of care for transitioning patients. The NTOCC web site offers information and tools for patients and caregivers as well as for health professionals. Resources for patients and caregivers include

Taking Care of MY Health Care
http://www.ntocc.org/Portals/0/Taking_Care_Of_My_Health_Care.pdf
A guide for patients and caregivers to help them be active participants in their care.

My Medicine List
http://www.ntocc.org/Home/Consumers/WWS_C_Tools.aspx
A tool to help patients and caregivers keep track of medications.

Products

(Please note that inclusion of any product in this list is for informational purposes only and implies no endorsement by the American Medical Directors Association.)

Clockwork ED Best Practice Reports
The Advisory Board Company
Clinical Initiatives Center
(202) 672-5600
www.advisoryboardcompany.com

This three-volume series examines best practices designed to address bottlenecks in hospital emergency departments and strategies for minimizing delays and reducing lengths of stay.

eMPOWERx
www.empowerx.com

This wireless device (similar to a personal digital assistant) offers clinical information and decision support tools, including an electronic prescribing tool that enables the user to access the patient's prescription history, check for medication interactions, and securely transmit a prescription directly to the pharmacy.

ePOCRATES
www.epocrates.com
This line of clinical information and decision support tools is available online and for download to a "smart" phone or other wireless device. The content is developed by physicians and pharmacists and is continuously updated.

REFERENCES

1. [JAGS, 2003a]. Coleman EA, Boult C. The American Geriatrics Society Health Care Systems Committee. Improving the quality of transitional care for persons with complex care needs. J Am Geriatr Soc 2003; 51: 556-557.

2. [NTOCC, 2008a]. National Transitions of Care Coalition. Transitions of Care Measures. 2008. Available at: **http://www.ntocc.org/**. Accessed 9/10/09.

3. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. N Engl J Med 2009; 360(14): 1418-1428.

4. Sabogal F, Coots-Miyazaki M, Lett JE. Effective care transitions interventions: Improving patient safety and healthcare quality. CAHQ Journal 2007 (Quarter 2).

5. Kripalani S, LeFevre F, Phillips CO, et al. Deficits in communication and information transfer between hospital-based and primary care physicians: Implications for patient safety and continuity of care. JAMA 2007; 297(8): 831-841.

6. Boockvar K, Fishman E, Kyriacou CK, et al. Adverse events due to discontinuations in drug use and dose changes in patients transferred between acute and long-term care facilities. Arch Intern Med 2004; 164(5): 545-550.

7. Forster AJ, Murff HJ, Peterson JF, et al. The incidence and severity of adverse events affecting patients after discharge from the hospital. Ann Intern Med 2003; 138(3): 161-167.

8. Coleman EA. [JAGS, 2003b]. Falling through the cracks: Challenges and opportunities for improving transitional care for persons with continuous complex care needs. J Am Geriatr Soc 2003; 52(5): 855-856; author reply 856.

9. HMO Workgroup on Care Management. One Patient, Many Places: Managing Health Care Transitions. February 2004. Washington, DC: AAHP-HIAA Foundation. Available at: **http://www.ahip.org/content/default.aspx?bc=38|72|69|5743**. Accessed 9/10/09.

10. Brown-Williams H, Neuhauser L, Ivey S, et al. From Hospital to Home: Improving Transitional Care for Older Adults. April 2006. Health Research for Action: University of California, Berkeley, CA. Available at: **http://healthresearchforaction.org/downloads/h2hsummaryrpt.pdf**. Accessed 9/10/09.

11. Hutt E, Ecord M, Eilertsen TB, et al. Precipitants of emergency room visits and acute hospitalization in short-stay Medicare nursing home residents. J Am Geriatr Soc 2001; 50: 223-229.

12. Anderson GF, Steinberg EP. Hospital readmissions in the Medicare population. N Engl J Med 1984; 311: 1349-1353.

13. Murtaugh CM, Litke A. Transitions through postacute and long-term care settings: Patterns of use and outcomes for a national cohort of elders. Med Care 2002; 40(3): 227-236.

14. [CMS, 2008a]. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. CMS-1533-P, Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates (Proposed Rule). Federal Register, Vol. 72, No. 85, May 3, 2007. Available at: **http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-1920.pdf**. Accessed 9/10/09.

15. [DHHS, 2007]. U.S. Department of Health and Human Services, Office of Inspector General. Consecutive Medicare Stays Involving Inpatient and Skilled Nursing Facilities (OEI-07- 05-00340). June 2007. Available at: **http://oig.hhs.gov/oei/reports/oei-07-06-00340.pdf**. Accessed 9/10/09.

16. Cornish PL, Knowles SR, Marchesano R, et al. Unintended medication discrepancies at the time of hospital admission. Arch Intern Med 2005; 165(4): 424-429.

17. Moore C, Wisnivesky J, Williams S, McGinn T. Medical errors related to discontinuity of care from an inpatient to an outpatient setting. J Gen Intern Med 2003; 18(8): 646-651.

18. Were MC, Li X, Kesterson J, et al. Adequacy of hospital discharge summaries in documenting tests with pending results and outpatient follow-up providers. J Gen Intern Med 2009; 24(9): 1002-1006.

19. Terrell KM, Miller DK. Challenges in transitional care between nursing homes and emergency departments. J Am Med Dir Assoc 2006; 7(8): 499-505.

20. Terrell KM, Brizendine EJ, Bean WF, et al. An extended care facility-to-emergency department transfer form improves communication. Acad Emerg Med 2005; 12(2): 114-118.

21. Coleman EA, Berenson RA. Lost in transition: Challenges and opportunities for improving the quality of transitional care. Ann Intern Med 2004; 141(7): 533-536.

22. Bodenheimer T. Coordinating care—A perilous journey through the health care system. N Engl J Med 2008; 358(10): 1064-1071.

23. American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint principles of the patient-centered medical home. March 2007. Available at: **http://www.medicalhomeinfo.org/Joint%20Statement.pdf**. Accessed 9/8/09.

24. Boutwell A, Griffin F, Hwu S, Shannon D. Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions. 2009. Cambridge, MA: Institute for Healthcare Improvement.

25. Jack BW, Chetty VK, Anthony D, et al. A reengineered hospital discharge program to decrease rehospitalization: A randomized trial. Ann Intern Med 2009; 150(3): 178-187.

26. Coleman EA, Parry C, Chalmers S, Min SJ. The care transitions intervention: Results of a randomized controlled trial. Arch Intern Med 2006; 166(17): 1822-1828.

27. Naylor MD, Brooten DA, Campbell RL, et al. Transitional care of older adults hospitalized with heart failure: A randomized, controlled trial. J Am Geriatr Soc 2004; 52(5): 675-684.

28. Naylor MD, Brooten D, Campbell R, et al. Comprehensive discharge planning and home follow-up of hospitalized elders: A randomized clinical trial. JAMA 1999; 281(7): 613-620.

29. Naylor M, Brooten D, Jones R, et al. Comprehensive discharge planning for the hospitalized elderly. A randomized clinical trial. Ann Intern Med 1994; 120(12): 999-1006.

30. Snow V, Beck D, Budnitz T, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. J Gen Intern Med 2009; 24(8): 971-976.

31. RTI International. Overview of the Medicare Post Acute Care Payment Reform Initiative. Available at: **http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/PACPR_RTI_CMS_PAC_PRD_Overview.pdf**. Accessed 9/8/09.

32. [CMS, 2008b]. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Fact Sheet: CMS Awards Contracts For Quality Improvement Organizations' 9th Statement Of Work. August 5, 2008. Available at: **www.cms.hhs.gov/qualityimprovementorgs-/.../9thsowannouncement080508.pdf**. Accessed 9/8/09.

33. [CMS, 2009]. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Quality Improvement Organizations. Statement of Work. Available at: **http://www.cms.hhs.gov/QualityImprovementOrgs/04_9thsow.asp#TopOfPage**. Accessed 9/8/09.

34. Georgia Medical Care Foundation. Reducing Avoidable Hospitalizations of Nursing Home Residents: A Center for Medicare and Medicaid Services Special Study. Draft Final Report. February 4, 2008. Publication No. 8SOW-GA-NHSS-07-34.

35. Aging Services Standards Manual. 2009. Washington, DC: Commission on Accreditation of Rehabilitation Facilities.

36. [NTOCC, 2008b]. National Coalition on Transitions of Care. Improving on Transitions of Care: How to Implement and Evaluate a Plan. April 2008. Available at: **http://www.ntocc.org/Portals/0/ImplementationPlan.pdf**. Accessed 9/8/09.

37. Coleman EA, Williams MV. Executing high-quality care transitions: A call to do it right. J Hosp Med 2007; 2(5): 287-290.

38. Gibson MJ, Houser AN. Valuing the invaluable: A new look at the economic value of family caregiving. June 2007. Washington, DC: AARP Public Policy Institute. Publication ID IB82. Available at: **http://www-static-w4-ca.aarpmagazine.org/research/housing-mobility/caregiving/ib82_caregiving.html**. Accessed 9/8/09.

39. Lo B, Dornbrand L, Dubler NN. HIPAA and patient care: The role for professional judgment. Jama 2005; 293(14): 1766-1771.

40. U. S. Department of Health and Human Services. Fast Facts for Covered Entities. Available at: **http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/cefastfacts.html**. Accessed 9/15/09.

41. Institute for Healthcare Improvement. Reconcile Medication at All Transition Points. Available at: **http://www.ihi.org/IHI/Topics/PatientSafety/MedicationSystems/Changes/Reconcile+Medications+at+All+Transition+Points.htm**. Accessed 9/8/09.

42. U.S. Pharmacopeia, Center for the Advancement of Patient Safety (CAPS). USP Patient Safety CAPSLink, October 2005. Available at: **http://www.usp.org/pdf/EN/patientSafety/capsLink2005-10-01.pdf**. Accessed 9/8/09.

43. Graves T, Hanlon JT, Schmader KE, et al. Adverse events after discontinuing medications in elderly outpatients. Arch Intern Med 1997; 157(19): 2205-2210.

44. The Joint Commission. 2008 National Patient Safety Goals. Available at: **http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/09_hap_npsgs.htm**. Accessed 9/8/09.

45. [NTOCC, 2008c]. National Transitions of Care Coalition. Medication Reconciliation Elements. Available at: **http://www.ntocc.org/Portals/0/Medication_Reconciliation.pdf**. Accessed 9/8/09.

46. Davis MN, Brumfield VC, Smith ST, et al. A one-page nursing home to emergency room transfer form: What a difference it can make during an emergency! Ann Long-Term Care 2005; 13(11): 34-38.

47. [NTOCC, 2008d]. National Transitions of Care Coalition. Improving Transitions of Care: The Vision of the National Transitions of Care Coalition. May 2008. Available at: **http://www.ntocc.org/Portals/0/PolicyPaper.pdf**. Accessed 9/14/09.

48. [CMS, 2007]. Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual. Chapter 10 - Ambulance Services. Rev. 68, 03-30-07. Available at: **www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf**. Accessed 9/15/09.

49. Family Caregiver Alliance, National Center on Caregiving. Family Caregiving: State of the Art,

Future Trends. Proceedings of a conference on March 6, 2007, in Chicago, IL. Available at: **http://www.caregiver.org/caregiver/jsp/content/pdfs/2007_asa_preconference_proceedings.pdf** . Accessed 9/8/09.

50. [NNLM, 2008]. National Network of Libraries of Medicine. Health Literacy. Available at: **http://nnlm.gov/outreach/consumer/hlthlit.html**. Accessed 9/8/09.

51. Nielsen-Bohlman L, Panzer AM, Kindig DA, eds. Health Literacy: A Prescription to End Confusion. Committee on Health Literacy. 2004. Washington, DC: Institute of Medicine, National Academy of Sciences. Available at: **http://www.iom.edu/?id=19750**. Accessed 9/8/09.

52. Family Caregiver Alliance, National Center on Caregiving. Caregiver Assessment: Principles, Guidelines and Strategies for Change. Report from a National Consensus Development Conference, Vol. I. San Francisco: 2006. Available at: **http://www.caregiver.org/caregiver/jsp/content/pdfs/v1_consensus.pdf**. Accessed 9/15/09.

BIBLIOGRAPHY

Anthony D, Chetty VK, Kartha A, et al. Re-engineering the hospital discharge: An example of a multifaceted process evaluation. In: Advances in patient safety: From research to implementation. Vol. 2. 2005. Rockville, MD: Agency for Healthcare Research and Quality, 2005. (AHRQ publication no. 05-0021-2.) Available at: http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=aps.section.3224. Accessed 4/14/09.

Boockvar KS, Burack OR. Organizational relationships between nursing homes and hospitals and quality of care during hospital-nursing home patient transfers J Am Geriatr Soc 2007; 55: 1078-84.

Chiu W, Newcomer R. A systematic review of nurse-assisted case management to improve hospital discharge transition outcomes for the elderly. Prof Case Manag 2007; 12(6): 330-335.

Coleman EA. Safety in numbers: Physicians joining forces to seal the cracks during transitions. J Hosp Med 2009; 4(6): 329-330.

Cortes TA, Wexler S, Fitzpatrick JJ. The transition between hospitals and nursing homes: Improving nurse to nurse communication. J Gerontol Nurs 2004; 30(6): 10-15.

Duggle W, Berry P. Transitions and shifting goals of care for palliative patients and their families. Clin J Oncol Nurs 2005; 9(4): 425-428.

Field TS, Gurwitz JH, Avorn J, et al. Risk factors for adverse drug events among nursing facility residents. Arch Intern Med 2001; 161: 1629-34.

Gladden JC. Information exchange: Critical connections to older adult decision-making during health care transitions. Geriatr Nurs 2000; 21(4): 213-218.

Grachek MK. Joint commission accreditation: A framework for coordinating care for older adults. Geriatr Nurs 2000; 21(6): 326-327.

Hughes LC, Hodgson NA, Muller P, et al. Information needs of elderly postsurgical cancer patients during transition from hospital to home. J Nurs Scholarsh 2000; 32(1): 25-30.

Kane RL, Lin WC, Blewett LA. Geographic variation in the use of post-acute care. Health Serv Res 2002; 37(3): 667-682.

Lee DT, Woo J, Mackenzie AE. A review of older people's experiences with residential care placement. J Adv Nurs 2002; 37(1): 19-27.

McDonald KM, Sundaram V, Bravata DM, et al. Care Coordination. Vol 7 of: Shojania KG, McDonald KM, Wachter RM, Owens DK, eds. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Technical Review 9. AHRQ Publication No. 04(07)-0051-7. June 2007.Rockville, MD: Agency for Healthcare Research and Quality. Available at: http://www.ahrq.gov/clinic/tp/caregaptp.htm#report. Accessed 3/11/09.

Peikes D, Chen A, Schore J, Brown R. Effects of care coordination on hospitalization, quality of care, and health care expenditures among Medicare beneficiaries: 15 randomized trials. JAMA 2009; 301(6): 603-618.

Sedlak SK, Roberts A. Implementation of best practices to reduce overall emergency department length of stay. Topics in Emergency Medicine. Focus on Creating the Future 2004; 26(4): 312-321.

Shearer NB. Endnotes: Loss of power with the nursing home zone. J Gerontol Nurs 2002; 28(11): 54-56.

Weaver LA, Doran KA. Telephone follow-up after cardiac surgery. Facilitating the transition from the hospital to home. Am J Nurs 2001: 101(5):24OO, 24QQ, 24SS-24UU.

APPENDIX 1

Summary of Results of Three Randomized Controlled Trials of Transitional Care Teams

Authors, Pub. Date	Setting	Clinical Focus	Subjects/ Group	Years	Duration	Intensity	Savings/ Patient ($)
Naylor et al, 1999[28]	2 university hospitals	Varied	~180	1992–1996	6 months	High	$3,301
Naylor et al, 2004[27]	6 urban hospitals	Heart failure	~120	1997–2001	12 months	High	$4,845
Coleman et al, 2006[26]	HMO, 1 hospital, 8 NHs, 1 HHA	Varied	~360	2002–2003	6 months	Low	$488

HHA, home health agency; HMO, health maintenance organization; NHs, nursing homes.

Naylor MD, Brooten D, Campbell R, et al. Comprehensive discharge planning and home follow-up of hospitalized elders. A randomized clinical trial. JAMA 1999; 281: 613-620.

Naylor MD, Brooten DA, Campbell RL, et al. Transitional care of older adults hospitalized with heart failure: A randomized controlled trial. J Am Geriatr Soc 2004; 52: 675-684.

Coleman EA, Parry C, Chalmers S, Min S. The Care Transitions Intervention: Results of a randomized controlled trial. Arch Intern Med 2006; 166: 1822-1828.

Adapted from: Boling PA. Care transitions and home health care. Clin Geriatr Med 2009; 25(1): 135-148, viii.

APPENDIX 2
Principles for Managing Transitions in Care Between the Inpatient and Outpatient Settings From the ACP, SGIM, SHM, AGS, ACEP, and SAEM

◆ Accountability
◆ Communication: Clear and direct communication of treatment plans and follow-up expectations
◆ Timely feedback and feed-forward of information
◆ Involvement of the patient and family member, unless inappropriate, in all steps
◆ Respect for the hub of coordination of care
◆ All patients and their family/caregivers should have and be able to identify a medical home or coordinating clinician (i.e., practice or practitioner)
◆ At every transition point the patient and/or family/caregivers need to know who is responsible for the patient's care, who to contact, and how
◆ National standards for transitions in care should be adopted and implemented at the national and community levels through public health institutions, national accreditation bodies, medical societies, medical institutions, etc., in order to improve patient outcomes and patient safety
◆ To bring about quality improvement and accountability, standardized metrics (related to the national standards recommended above) should be used to monitor and improve transitions

ACP, American College of Physicians
SGIM, Society of General Internal Medicine
SHM, Society of Hospital Medicine
AGS, American Geriatrics Society
ACEP, American College of Emergency Medicine
SAEM, Society of Academic Emergency Medicine

Adapted from: Snow V, Beck D, Budnitz T, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. J Gen Intern Med. 2009 Aug;24(8):971-6 (jointly published in J Hosp Med)

Transitions of Care: Two Contrasting Scenarios

Background

Helen is a 79-year-old woman who lives with her husband in their own home. She has a history of a renal transplant 7 years ago, for which she now takes immunosuppressants and steroids. She also takes more than a dozen medications daily for her multiple illnesses, which include essential hypertension and pulmonary hypertension. Her medication-induced osteoporosis has resulted in spinal deformity. Gait instability and falls have produced several fractures despite her intermittent use of a cane. She continues to drive (much to the dismay of her family) and acts as caregiver for her 80-year-old husband, who is now legally blind from macular degeneration and suffering from early cognitive deficits.

Helen and her husband both developed a flu-like illness, eating and drinking little, with resulting dehydration and weakness. Helen fell on the way to the bathroom and could not get up, even with the help of her husband.

Scenario A (Poor Care Transition)

Helen's husband remained at her side without calling for help. Finally, a neighbor checked on them and found both on the bedroom floor.

Upon arrival at the emergency department, Helen was diagnosed with congestive heart failure, pneumonia, and dehydration, and subsequently admitted to the hospital. Additional findings in the hospital included delirium and elevated blood glucose, requiring multiple blood glucose readings and insulin administration. Although Helen's condition improved and she gained strength, she was not able to walk safely.

At 11:00 a.m. on the fourth day of Helen's hospitalization, someone appeared to tell Helen she would be discharged at "2 or 3 p.m. today," one reason being that she was not making progress in therapy. This was the first indication that discharge was being considered. Helen had received no explanation for her elevated blood glucose except that now she was "a diabetic." She had received no training in checking her blood glucose or administering insulin at home. Although the worst of her delirium had resolved, her memory was still suspect.

Multiple frenzied phone calls to a son in California (a geriatric physician), local granddaughters, and a former daughter-in-law resulted in a decision that Helen could not return home safely. The family's refusal to allow her to be discharged home resulted in the hospital producing a list of long-term care facilities to which she might go. A facility was chosen following further calls to a personal friend of the son and Helen was transferred that day for "rehabilitation" under the care of the son's physician-friend.

Evaluation at the nursing home revealed that Helen could not walk because her foot hurt with bearing weight, a complaint that she had made repeatedly at the hospital. An x-ray revealed two foot fractures suffered in the initial fall at home.

Helen's husband was cared for by an informal committee of friends, neighbors, and family members who took care of housekeeping, food, and safety. They rotated driving him to the nursing facility daily, as absences from Helen were unsettling for him.

Helen's elevated blood glucose (a common temporary occurrence in the face of combined stress, infection, and steroids) resolved as she improved clinically. As the fractures healed, Helen was able to walk again. She returned to her home to resume care of her husband.

Scenario B (Excellent Care Transition)

Fortunately, after Helen's last fall, her doctor had convinced her to carry an emergency alert device at all times. Activation of the device promptly summoned emergency personnel to take her to the hospital.

In the emergency department (ED), the admitting nurse noted that Helen and her husband both seemed to have cognitive deficits. A quick search of personal effects disclosed the personal health record (PHR) that Helen always carried in her purse. The emergency physician was able to determine her medications, health problems, and medication allergies, as well as the names of her nephrologist, cardiologist, renal transplant surgeon, and family doctor.

The PHR also contained contact information for the people who had agreed to care for Helen's husband in just such an emergency. The hours invested by the transition coach from the prior hospitalization in convincing the couple to make arrangements for the husband's care and complete the PHR were invaluable to the ED treatment team. The alert ED staff,

noting confusion in both the patient and the husband, notified the discharge planning department that a difficult discharge was anticipated and that care issues for the husband needed to be addressed.

When contacted the next day, Helen's family doctor accessed her electronic medical record. He warned the attending hospital physician that Helen's blood glucose had risen before with acute illness, but resolved with medical stabilization. The family doctor confirmed that Helen's confusion was new, and thus likely to be delirium, and that before admission she could ambulate easily with a cane. The hospital doctor reassured Helen that she did not have diabetes and would need blood glucose treatment for a short time only. The family was reassured that her mild delirium would resolve. The inability to ambulate was immediately noted as a change in status based upon the information provided by the family doctor. Helen's painful, swollen foot was x-rayed and two fractures were found. Physical therapy followed orthopedic consultation, strengthening her upper body.

Discharge planning felt that the involvement of a transition coach was appropriate. The coach called Helen's family to find that several members lived locally and were willing to assist in post-discharge care. Daily discussions between the care team members, the transition coach, and the family resulted in a plan that served everyone well. Helen made enough progress with the early physical therapy and diagnosis of her fracture that she could stay one more day than planned in the hospital and return home with walker ambulation, without insulin treatment, with home physical therapy and home health follow-up. The transition coach coordinated the home care for Helen. He also arranged for the husband's informal caregivers to spend less time at the home, since Helen could now return directly home. Daily calls from the transition coach assured him that Helen was taking her medications properly after the multiple changes made in the hospital. Follow-up appointments were made with Helen's doctors and transportation was arranged for the doctor visits. Helen returned home to resume care of her husband under the watchful eyes of her care team.

APPENDIX 4
Examples of Services Provided in the Long-Term Care Continuum

NOTE: This list illustrates the range of services that may be found within the LTCC. Not all of the services listed will be available at every LTCC facility or care site. When considering transferring a patient to an LTCC facility, please determine whether the range of services provided at that facility will meet the patient's needs.

Category	Examples of Services
Activities	Bingo Cognitive therapy Exercise classes Library Movies Music therapy Pet therapy Therapeutic outings
Administration	Admissions/marketing Central supply Food services Financial management/support Housekeeping Medical records/health information technology Transportation services
Consultant services	Dental care Hearing evaluation/care Medical specialty services (e.g., endocrinology, nephrology) Mental health care/counseling Podiatric care Vision care Wound/stoma care
Diagnostic services	Laboratory testing EKG, ultrasound, X-rays
Dialysis	Hemodialysis Peritoneal dialysis
Dietary services	Gastrostomy assessments Meal/dietary planning Nutritional needs assessment (e.g., for a patient who is losing weight)
Hospice/palliative care	Care of patients who have serious medical conditions and (usually) limited life expectancy
Medical	Oversight of patients' medical care needs
Nursing	Care planning Patient assessment Direct patient care Supervision of caregiving staff
Pharmacy services	Medication reviews Monitoring of intravenous medications, warfarin dosing, etc.
Rehabilitation services	Durable medical equipment assessment and training Occupational therapy Physical therapy Speech therapy Supervision of restorative care
Respiratory therapy	Nebulizer treatment Oxygen therapy Tracheotomy care and suctioning

Examples of Services Provided in the Long-Term Care Continuum

Category	Examples of Services
Social services	Case management Chaplaincy Counseling Discharge planning Family support Liaison with community services (e.g., home health care, support groups) Liaison with other departments and levels of care

EKG, electrocardiogram.

APPENDIX 5

Examples of Health Care and Support Professionals Found in the Long-Term Care Continuum

NOTE: This list illustrates the range of health care and support professionals that may be found within the LTCC. Not all of these professionals will be available at every LTCC facility or care site. When considering transferring a patient to an LTCC facility, please determine whether the range of professional staff available at that facility will meet the patient's needs.

◆ Activities director and assistants
◆ Administrator
◆ Admissions coordinator
◆ Advanced practice nurses
◆ Attending physicians
◆ Catering manager
◆ Chaplain
◆ Consultant pharmacist
◆ Consultant physiatrist
◆ Dietitians
◆ Director of nursing
◆ Director of social work
◆ Financial officers
◆ Hospice care consultant
◆ Housekeeper
◆ Licensed practical nurses
◆ Medical director
◆ Medical technicians
◆ Nursing assistants
◆ Occupational therapists
◆ Physical therapists
◆ Physician assistants
◆ Registered nurses
◆ Respiratory therapists
◆ Social workers, social work assistants
◆ Specialist consultants (e.g., dentists, optometrists, physician specialists, wound care specialists)
◆ Speech therapists
◆ Therapy aides

APPENDIX 6
Sample Policy and Procedure for Care Transition

Policy and Procedure for Nursing Home Resident Transfer to ED/Hospital

Title: *Appropriate and patient-centered transfer* *of a resident to the emergency department or hospital*	Approved by: _____ Approved by:
Effective date: June 1, 2008	Revised:

Purpose:

◆ To make clear the appropriate information that should be included with a resident who is transferred to an emergency department, hospital, or other facility for care

◆ To set responsibility among the professional staff and support services with respect to transfers

◆ To maintain patient-centered care by involving the resident and his/her family member(s) or legally authorized representative whenever possible

Procedure:

One key individual involved in the care of the patient (e.g., the unit nurse) will be responsible for coordinating the transfer process. This individual will ensure that all necessary action has been taken to:

a) facilitate transport to the receiving facility

b) gather all necessary documents and information for communication with the receiving facility (include the list here)

c) communicate directly with the receiving facility about the resident being transferred

d) communicate with the resident's primary care physician

e) communicate with the resident's family or legally authorized representative

f) document all communication and activities in the resident's medical chart

Use the approved checklist to document that all of the above procedures have been carried out.

Extracts from Joint Commission National Patient Safety Goals 2009

The National Patient Safety Goals may be accessed in their entirety at:
http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/09_hap_npsgs.htm

GOAL 2
Improve the effectiveness of communication among caregivers

NPSG.02.05.01
The [organization] implements a standardized approach to hand-off communications, including an opportunity to ask and respond to questions.

Rationale for NPSG.02.05.01
Health care has numerous types of [patient] hand-offs, including, but not limited to, nursing shift changes; physician transfer of complete responsibility for a [patient]; physician transfer of on-call responsibility; acceptance of temporary responsibility for staff leaving the unit for a short time; anesthesiologist report to post-anesthesia recovery room nurse; nursing and physician hand-off from the emergency department to inpatient units, different hospitals, nursing homes and home health care; and critical laboratory and radiology results sent to physician offices. The primary objective of a hand-off is to provide accurate information about a [patient's] care, treatment, and services, current condition, and any recent or anticipated changes. The information communicated during a hand-off must be accurate in order to meet [patient] safety goals.

Elements of Performance for NPSG.02.05.01
1. The hospital's process for effective hand-off communication includes the following: Interactive communications that allows for the opportunity for questioning between the giver and receiver of patient information.
2. The hospital's process for effective hand-off communication includes the following: Up-to-date information regarding the patient's condition, care, treatment, medications, services, and any recent or anticipated changes. (See also NPSG.08.01.01, EP 4)
3. The hospital's process for effective hand-off communication includes the following: A method to verify the received information, including repeat-back or read-back techniques.
4. The hospital's process for effective hand-off communication includes the following: An opportunity for the receiver of the hand-off information to review relevant patient historical data, which may include previous care, treatment, and services.
5. Interruptions during hand-offs are limited to minimize the possibility that information fails to be conveyed or is forgotten.

GOAL 8
Accurately and completely reconcile medications across the continuum of care

NPSG.08.01.01
A process exists for comparing the [patient]'s current medications with those ordered for the [patient] while under the care of the [organization].

Rationale for NPSG.08.01.01
[Patient]s are at high risk for harm from adverse drug events when communication about medications is not clear. The chance for communication errors increases whenever individuals involved in a [patient]'s care change. Communicating

Extracts from Joint Commission National Patient Safety Goals 2009

about the medication list, making sure it is accurate, and reconciling any discrepancies whenever new medications are ordered or current medications are adjusted are essential to reducing the risk of transition-related adverse drug events.

Elements of Performance for NPSG.08.01.01

At the time the patient enters the hospital or is admitted, a complete list of the medications the patient is taking at home (including dose, route, and frequency) is created and documented. The patient, and family as needed, are involved in creating this list.

◆ The medications ordered for the patient while under the care of the hospital are compared to those on the list created at the time of entry to the hospital or admission.

◆ Any discrepancies (that is, omissions, duplications, adjustments, deletions, additions) are reconciled and documented while the patient is under the care of the hospital.

◆ When the patient's care is transferred within the hospital (e.g., from the ICU to a floor), the current provider(s) inform the receiving provider(s) about the up-to-date reconciled medication list and document the communication. (See also NPSG.02.05.01, EP 2)

  Note: Updating the status of a patient's medications is also an important component of all patient care hand-offs.

NPSG.08.02.01

When a [patient] is referred to or transferred from one [organization] to another, the complete and reconciled list of medications is communicated to the next provider of service and the communication is documented. Alternatively, when a [patient] leaves the [organization]'s care directly to his or her home, the complete and reconciled list of medications is provided to the [patient]'s known primary care provider, or the original referring provider, or a known next provider of service.

Note: When the next provider of service is unknown or when no known formal relationship is planned with a next provider, giving the [patient], and family as needed, the list of reconciled medications is sufficient. The accurate communication of a [patient]'s reconciled medication list to the next provider of service reduces the risk of transition-related adverse drug events. The communication enables the next provider of service to receive thorough knowledge of the [patient]'s medications and to safely order/prescribe other medications that may be needed. This communication is especially important at transitions in care when a [patient] is referred or transferred from one organization to another.

Rationale for NPSG.08.02.01

The accurate communication of a [patient]'s reconciled medication list to the next provider of service reduces the risk of transition-related adverse drug events. The communication enables the next provider of service to receive thorough knowledge of the [patient]'s medications and to safely order/prescribe other medications that may be needed. This communication is especially important at transitions in care when a [patient] is referred or transferred from one organization to another.

Elements of Performance for NPSG.08.02.01

◆ The patient's most current reconciled medication list is communicated to the next provider of service, either within or outside the hospital. The communication between providers is documented.

◆ At the time of transfer, the transferring hospital informs the next provider of service how to obtain clarification on the list of reconciled medications.

NPSG.08.03.01

When a [patient] leaves the [organization]'s care, a complete and reconciled list of the [patient]'s medications is provided directly to the [patient], and the [patient]'s family as needed, and the list is explained to the [patient] and/or family.

Extracts from Joint Commission National Patient Safety Goals 2009

Rationale for NPSG.08.03.01
The accurate communication of the [patient]'s medication list to the [patient] and to the [patient]'s family, if needed, reduces the risk of transition-related adverse drug events. A thorough knowledge of the [patient]'s medications is essential for the [patient]'s primary care provider or next provider of service to manage the subsequent stages of care for the [patient].

Elements of Performance for NPSG.08.03.01
1. When the patient leaves the hospital's care, the current list of reconciled medications is provided and explained to the patient, and their family as needed. This interaction is documented.

   Note: Patients and families are reminded to discard old lists and to update any records with all medication providers or retail pharmacies.

APPENDIX 8
Suggested Common or Essential Elements for Medication Reconciliation

Source: NTOCC, 2008c [available at: http://www.ntocc.org/Portals/0/Medication_Reconciliation.pdf]. Reproduced with permission.

NOTE: Users may create their own medication reconciliation forms by selecting from the elements in the following table those that are most relevant in their own environments.

[NTOCC table appears on next 3 pages]

Source: Halasyamani L, Kripalani S, Coleman E, et al. Transition of care for hospitalized elderly patients—Development of a discharge checklist for hospitalists. J Hosp Med 2006; 1: 254-360. Reproduced with permission.

APPENDIX 8 (continued)
Suggested Common or Essential Elements for Medication Reconciliation

Suggested Common/Essential Data Elements for Medication Reconciliation

ASSESSMENT ON ACCESS TO CARE SETTING (E.G. HOSPITAL ADMISSION, NURSING HOME ADMISSION)

Category	Element	Source(s)	Barrier(s)	Comments
Demographic	Name	Patient/caregiver	Cognitive status	Universally available unique identifier information
	Date of birth			
	ID Number			
	Gender			
	Contact information			
	Caregiver name and contact information	Caregiver	Caregiver knowledge of patient	
	Allergies/intolerances	Patient/caregiver		
	Date of assessment	Interviewer		May also include time of transport of info
Medications (active, taken chronically)	Name - generic/trade	Patient/caregiver	Patient/caregiver knowledge of complete medication list, cognitive status	NDC will be used in automated systems - name + dose
	Dose			
	Form			
	Frequency			
	Reason for use			
Other medications/OTC/herbal remedies/nutritional supplements/time-limited medications	Name - generic/trade			Stop dates for short term medications
	Dose			
	Form			
	Frequency			

Other elements for consideration

Category	Element	Source(s)	Barrier(s)	Comments
Demographic	Primary language	Patient/caregiver	Patient/caregiver knowledge of complete medication list, cognitive status	
	Religious, cultural factors			
Medications	Prescriber			Variety of methods to provide info on compliance
	Compliance level			
Medical history	Known medical conditions			To be able to identify conditions that may not be treated
Primary health care provider	NPI#			

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APPENDIX 8 (continued)
Suggested Common or Essential Elements for Medication Reconciliation

Category	Element	Source(s)	Barrier(s)	Comments
Patient access to medications	Prescription benefits, out-of-pocket costs, public and manufacturers' pharmaceutical assistance programs, patient/caregiver access to pharmacy (e.g., in rural areas or in neighborhoods Where pharmacies Won't carry certain Drugs, such as pain medications)	Patient/caregiver, health care setting personnel	Patient/caregiver lack of knowledge regarding, or difficulty navigating, benefit plans or programs, lack of patient/caregiver financial resources, gaps in public and manufacturers' pharmaceutical assistance	To ensure patients will be able to obtain prescribed medications

ASSESSMENT/RECONCILIATION ON TRANSFER OF CARE

Category	Element	Source(s)	Barrier(s)	Comments
Medications (to be continued at home, in long term care facility, etc.)	Name - generic/trade	MAR, health care setting personnel, physicians orders, universal order sheet	Incomplete documents, missing information, poor communication among care providers	Transfer information can serve as admission information on subsequent access to care.
	Dose			
	Form			For home care or other self care setting, should include a plan to enhance adherence.
	Frequency			
	Reason for use			
	Expected duration of use (chronic, time limited)			Assign specified duration of use as appropriate for selected medication (e.g., end date, number of days). Examples include high risk medications such as anticoagulants following surgery, antibiotics, and steroids
	Ability to self medicate	Patient/caregiver		Patient/caregiver should be able to reconcile new medication list with previous list if self medicating at home
	Allergies/intolerances			
Validation	Name/date/signature	Health care provider, other	Poor coordination of transfer, provider/other not available to validate	Person taking responsibility for accuracy of list on transfer and communication with patient and caregivers
Medications	Reason for use	Health care provider	Time to provide information, gather documents	Could be provided in portable document file, printed documents
	Monitoring parameters, frequency			
Patient access to medications	Payer or other source	Patient/caregiver or health care personnel	Patient/caregiver/health care setting personnel lack of knowledge	To ensure patient will be able to obtain medications prescribed on transfer
Point of contact	Person/department	Health care provider, other	Poor coordination of transfer	Who to contact in the previous health care setting regarding medication issues

Suggested Common or Essential Elements for Medication Reconciliation

NTOCC realizes that health care systems vary in their method of data collection, access, and communication. This list of essential data elements is an attempt to provide a list of variables one should commonly and routinely consider when an individual is entering and leaving a different system or level of health care. Other elements are also offered for completeness when the resources and technology are available to complete the medication record.

Some important questions to consider with implementation of a medication reconciliation program are:
1. How is the information transferred or "harmonized" within the permanent medication record?
2. Who is responsible for signing off on the reconciliation tool?
3. Who is responsible to close the list and pass this document on to the next provider?
4. How is a provider reimbursed for completing this medication reconciliation form?
5. How is the information from the medication reconciliation tool at the provider's level to be transferred to the patient's personal medication list?

Rev. 4/17/08

Ideal Discharge of the Elderly Patient: A Hospitalist Checklist

Data Elements	Processes		
	Discharge Summary	Patient Instructions	Communication to follow-up clinician on day of discharge
Presenting problem that precipitated hospitalization	X	X	X
Key findings and test results	X		X
Final primary and secondary diagnoses	X	X	X
Brief hospital course	X		X
Condition at discharge, including functional status and cognitive status if relevant	X – functional status O– cognitive status		
Discharge destination (and rationale if not obvious	X		X
Discharge medications: -Written schedule	X	X	X
-Include purpose & cautions (if appropriate) for each	O	X	O
-Comparison with pre-admission medications (new, changes in dose/frequency, unchanged, "meds should no longer take")	X	X	X
Follow-up appointments with name of provider, date, address, phone number, visit purpose, suggested management plan	X	X	X
All pending labs or tests, responsible person to whom results will be sent	X		X
Recommendations of any sub-specialty consultants	X		0
Documentation of patient education and understanding	X		X
Any anticipated problems and suggested interventions	X	X	X
24/7 call-back number	X	X	
Identify referring and receiving providers	X	X	
Resuscitation status and any other pertinent end-of-life issues	O		
X = required element O = optional element			

Source: Halasyamani L, Kripalani S, Coleman E, et al. Transition of care for hospitalized elderly patients—Development of a discharge checklist for hospitalists. J Hosp Med 2006; 1: 254-360. Reproduced with permission.

Example of a Post-Acute Care to Emergency Department/Hospital Transfer Form

AKRON REGIONAL HOSPITAL ASSOCIATION

POST ACUTE CARE TO EMERGENCY DEPARTMENT/ HOSPITAL TRANSFER FORM

Name of Facility: _____

Phone Number: _____

Date of Transfer _____	Time of Transfer _____	Transport Via: ❑ Ambulance ❑ Other	Name of person sending resident to hospital: _____

Level:
❑ Independent Living   ❑ Skilled Acute   ❑ Hospice   Name of Hospice:_____
❑ Assisted Living   ❑ Long term Acute   ❑ Other
❑ Intermediate   ❑ Rehab

Resident's Last Name First Name MI	Sex: ❑ M ❑ F DOB: _____	Religion _____ Primary Language _____

Primary Contact _____   ❑ DPOA/HC   Notified? ❑ Yes
                                         ❑ POA   ❑ No
Relationship to Patient _____   ❑ Legal Guardian

CHIEF COMPLAINT

Past Medical History:

Influenza Vaccinations   ❑ Wound/S
     ❑ Yes   ❑ No   Date _____   Site/S _____
Pneumo Vaccinations
     ❑ Yes   ❑ No   Date _____

Date of Onset ___/___/___	Vital signs at time of transfer
	T:_____ P:_____ ❑ O$_2$
Time of Onset _____ ❑ am ❑ pm	R:____ B/P____LITER FLOW_____

Primary Diagnosis

Mental Status   ❑ Alert   ❑ Oriented
Baseline: ❑ Aggressive   ❑ Elopement Risk
            ❑ Secured Unit   ❑ Confused
How to best approach _____
	Advanced Directive Sent:
	
	     ❑ Yes ❑ No
	
	Copy must be sent
		DNR: ❑ Yes ❑ No
		DNR Status: ❑ CC ❑ CC Arrest
		   ❑ Full Code
		   ❑ No Transfusions or other_____
		   ❑ Other_____

Copy of MAR with current medications (within the last 24 hours)   ❑ Yes   ❑ No (List & attach current medications)

Lab or other Tests ordered (to assist with baseline)   ❑ Yes (send copy of results)   ❑ No

Name of MD/NP/PA who made decision to send to patient: _____ Beeper: _____ Phone: _____	Attending Physician: _____ _____ Specialists: _____

Disabilities	Incontinence	Impairment	Functional Status	Indep.	Assist.	Depend	Infection: ❑ TB
❑ Amputation	❑ Bladder	❑ Speech	❑ Feeding:	❑	❑	❑	❑ MRSA ❑ VRE
❑ Paralysis	❑ Bowel	❑ Hearing	❑ Transfer:	❑	❑	❑	❑ CDIFF ❑ ESBL
❑ Contracture	❑ Saliva	❑ Vision	❑ Ambulation:	❑	❑	❑	

Allergies:	Diet:	To Be Referred to (i.e. hospital or doctor): _____ _____

Resident Uses:
❑ Glasses   ❑ Cane   ❑ Feeding tube   ❑ Ostomy   **Items Sent with Resident:**
❑ Hearing Aid   ❑ Crutches   ❑ Foley Cath   ❑ Implant Defib   ❑ Glasses   ❑ Cane   ❑ Prothesis:
❑ Dentures   ❑ Walker   ❑ Tracheostomy   ❑ Pacemaker   ❑ Hearing aid   ❑ Crutches   ❑ Left
                                                             ❑ Dentures   ❑ Walker   ❑ Right
    Other_____   ❑ Other:_____

Copy and send in the order listed:	❑ Face Sheet ❑ Medication Record	❑ Current DX List ❑ Current Orders w/ new phone orders	❑ Recent Labs ❑ Progress Notes

NURSING HOME: PLEASE PLACE I.D. ARMBAND ON PATIENT BEFORE TRANSFER

Source: Akron Regional Hospital Association. Reproduced with permission.

Quality Indicators for Transitions Between Nursing Facilities and Emergency Departments

If a nursing home resident is transferred to an ED, the nursing home should provide the following written information in the transfer paperwork:

1. Reason for transfer.
2. Resuscitation status.
3. Medication allergies.
4. Contact information for the nursing home, primary care or on-call physician, and the resident's legal health care representative or closest family member.
5. Medication list.
6. *If a nursing home provider requests that specific tests be performed in the ED,* the emergency physician should document performance of the requested tests (or document in the medical record why the tests were not performed).
7. *If the nursing home resident will be released from the ED back to the nursing home,* the emergency physician should document communication with a nursing home provider or on-call physician prior to the resident's discharge from the ED (or document attempts to do so).
8. *If a nursing home resident is discharged from the ED back to the nursing home,* the ED should provide the follow ing written information in the transfer paperwork:
9. ED diagnosis.
10. Tests performed with results (and tests with pending results).
11. *If a nursing home resident is discharged from the ED back to the nursing home and physician follow-up is recommended,* the patient should receive the follow-up (or the medical record should indicate why the follow-up did not occur).
12. *If a nursing home resident is discharged from the ED back to the nursing home and the ED provider prescribes or recommends a medication,* the nursing home should administer the medication (or document in the medical record why the medication was not administered).

Adapted from: Terrell KM, Hustey FM, Hwang U, et al. Quality indicators for geriatric emergency care. Acad Emerg Med 2009; 16: 441-449.

These domains and constructs are applicable across settings (e.g., home, hospital) but need not be measured at every assessment. Domains and specific questions may differ for
◆ Initial assessments compared to reassessments (the latter focus on what has changed over time);
◆ New versus continuing care situations;
◆ An acute episode, prompting a change in caregiving, versus an ongoing need; and
◆ Type of setting and focus of services.

Recommended Domains and Constructs for Caregiver Assessment

Domains	Constructs
Context	• Caregiver relationship to care recipient • Physical environment (home, facility) • Household status (number in home, etc.) • Financial status • Quality of family relationships • Duration of caregiving • Employment status (work/home/volunteer)
Caregiver's perception of health and functional status of care recipient	• Activities of daily living (ADLs; bathing, dressing) and need for supervision •Instrumental Activities of Daily Living (IADLs; managing finances, using the telephone) • Psycho-social needs • Cognitive impairment • Behavioral problems • Medical tests and procedures
Caregiver values and preferences	• Caregiver/care recipient willingness to assume/accept care • Perceived filial obligation to provide care •Culturally based norms • Preferences for scheduling and delivery of care and services
Well-being of the caregiver	• Self-rated health • Health conditions and symptoms • Depression or other emotional distress (e.g., anxiety) • Life satisfaction/quality of life

Consequences of caregiving	• Perceived challenges
	  • Social isolation
	  • Work strain
	  • Emotional and physical health strain
	  • Financial strain
	  • Family relationship strain
	• Perceived benefits
	  • Satisfaction of helping family member
	  • Developing new skills and competencies
	  • Improved family relationships

Skills/abilities/knowledge to provide care recipient with needed care	• Caregiving confidence and competencies • Appropriate knowledge of medical care tasks (wound care, etc.)
Potential resources that caregiver could choose to use	• Formal and informal helping network and perceived quality of social support • Existing or potential strengths (e.g., what is presently going well) • Coping strategies • Financial resources (health care and services benefits, entitlements such as Veteran's Affairs, Medicare) • Community resources and services (caregiver support programs, religious organizations, volunteer agencies)

Interventions for Improving Comprehension Among Patients with Low Health Literacy and Impaired Cognitive Function

Target Population	Intervention
Low health Literacy	Provide graphic instructions
	Provide instructions using a variety of media
	Use pictures to illustrate instructions
	Provide verbal and written instructions
	Teach-Back/check for understanding/simulations
	Engage patient in dialogue/face-to-face communication
	Implement follow-up telephone calls to reinforce instructions
	Tailor materials to individuals' strengths
	Make effective communication an organizational priority/ promote organizational awareness of health literacy
	Focus print materials on patient action and level of motivation
	Check for patient understanding, then reframe instructions if needed
	Computerized assistant to reinforce discharge instructions
	Provide post visit services/support
	Implement Ask Me$_3$
	With appropriate provisions for privacy, include literacy levels in medical record to increase awareness among all providers
Impaired cognitive Functioning	Evaluate cognitive status at admission
	Provide additional detailed counseling to family caregivers, paid and unpaid caregivers
	Involve social services from time of admission to explore whether patient may need to be in a more supervised care setting
Both low health literacy and impaired cognative functioning	Involve family caregivers and schedule discharge instructions when they can be present
	Train interdisciplinary team in strategies to improve comprehension
	Simplify written materials and discharge instructions
	Redesign written instructions, including use of larger fonts, color
	Limit instructions to focus on essential information
	Restructure sequence of written instructions: put most important points first
	Provide an illustrated medication schedule
	Employ pharmacist based interventions for improving medication comprehension and adherence

Source: Chugh A, Williams MV, Grigsby J, Coleman EA. Better transitions: improving comprehension of discharge instructions. Front Health Serv Manage 2009; 25(3): 11-32.
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Selected Performance Measurement Indicators for Transitional Care From Existing Tools

Source: HMO Workgroup on Care Management. One Patient, Many Places: Managing Health Care Transitions. February 2004. Washington, DC: AAHP-HIAA Foundation.

Facilities may wish to incorporate or modify these indicators when utilizing quality improvement processes to review their management of care transitions.

Citations:
California Health Care Foundation. Results from the Patients' Evaluation of Performance (PEP-C) Survey. 2003. Available at: http://www.chcf.org/documents/quality/PEPCTechReport.pdf.

Coleman EA, Parry C, Chalmers SA, et al. The central role of performance measurement in improving the quality of transitional care. Home Health Care Services Quarterly 2007; 26(4):93-104.

Wenger NS, Young RT. Quality indicators for continuity and coordination of care in vulnerable elders. [ACOVE-3 quality indicators]. J Amer Geriatr Soc 2007; 55: S285–S292.

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Exhibit 2. Selected Items Pertaining to Transitional Care from Existing Measures.

Assessing Care of Vulnerable Elders Measure (13)

- If a vulnerable elder is discharged from a hospital to home and he or she received a new prescription medication or a change in medication before discharge, then the outpatient medical record should acknowledge the change within 6 weeks of discharge.

- If a vulnerable elder is discharged from hospital to home and survives at least 4 weeks after discharge, then he or she should have a follow-up visit or documented telephone contact within 6 weeks of discharge and the physician's medical record documentation should acknowledge the recent hospitalization.

- If a vulnerable elder is discharged from hospital to home, then there should be a discharge summary in the outpatient physician or nursing home record within 6 months.

Care Transitions Measure (14)[3]

- The hospital staff took my preferences into account in deciding what my health care needs would be after discharge.

- Before I left the hospital, the people that were going to help me when I got home clearly understood what my health care needs were.

- Before I left the hospital, I had a phone number I could call day or night to get answers to my questions.

- Before I left the hospital, I clearly understood how to take each of my medications.

Patients' Evaluation of Performance in California Survey (15)

- Transition to home: How well did doctors and nurses explain what to expect after patients leave the hospital?

- Coordination of care: How organized and efficient were doctors, nurses, and other hospital staff?

- Respect for patient preferences: Did patients feel treated with respect and as a partner in the health care process?

- Involvement of family and friends: Did hospitals encourage the involvement of family and friends?

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