Many medical directors of nursing facilities are committed to improving transitions of care, but they are unable to institute a formal program and the associated infrastructure. An alternative approach is to implement individual steps, or even a bundle of initiatives, aimed at strengthening the care-transition process.

Fortunately, the National Transitions of Care Coalition (NTOCC) completed a project to determine seven crucial elements that are involved in every quality transition. NTOCC is a group of concerned organizations and individuals who together address the safety and quality of care for transitioning patients. The “Seven Essential Intervention Categories” as designated by NTOCC are:

▶ Medication management.
▶ Transition planning.
▶ Patient and family engagement/education.
▶ Information transfer.
▶ Follow-up care.
▶ Health care provider engagement.
▶ Shared accountability across providers and organizations.

Medication Management

Three main components are involved with safe medication management by patients and their families in concert with the patient’s plan of care.

First, assess all medications that the patient uses. Evaluate current prescription drugs, as well as over-the-counter medications, herbal supplements, vitamins, medication allergies, and potential drug interactions. Identify high-risk medications and polypharmacy. Check timing of the medication administration, and ensure that the patient actually obtained the drugs prescribed.

Next, use the “teach-back” method to establish the patient’s and the family’s understanding of the medication plan. Emphasize any changes in the drug regimen. Review each medication’s purpose, how to take each medication correctly, and important side effects that should be watched for by patients and families.

Third, perform reconciliation of the current drug regimen with prior ones. Create the medication plan with consideration of the patient’s financial and transportation status. Utilize other clinicians, especially the pharmacist, who can offer suggestions to make the plan better.

Transition Planning

Transition planning is the formal process that facilitates the safe transition of patients from one level of care to another, including safe transition to the home setting. It also encompasses the transition from one clinician to another. Identify who will be performing the transition, facilitating and coordinating medical services at the next site of care, and communicating patients’ and families’ needs to that entity.

Transmit a complete, legible, and timely care summary to clinicians at the new site of care. Give the patient and family the same information in an appropriate format.

Use formal transition-planning tools to ensure the safest possible transition. They’re available at: www.amda.com/tools/clinical/transitions/care.cfm, the NTOCC website www.ntocc.org, and the care transitions website www.caretransitions.org, which was developed under the leadership of Eric Coleman, MD, MPH.
Patient and Family Engagement

Education and counseling of patients and families are intrinsic components of every transfer to enhance their participation in care and promote informed decision making. Patients and families must be knowledgeable about their disease, including warning signs that should prompt them to contact their physicians. When patients and families thoroughly understand their plan of care, it facilitates a positive partnership with medical caregivers.

A key activity is education of patients, families, and caregivers at home about self-care skills to better control the disease process. For example, a patient with diabetes who uses insulin should be able to test blood sugar levels, draw up insulin, inject it, and recognize the signs of low and high blood sugar.

Information Transfer

Sharing important care information among patients, families, caregivers, and health care providers in a timely and effective manner is central to a safe, efficient transition. Pay attention to policies and procedures that ensure correct and expedient transfer of clinical information in a consistent, standard format to medical providers at the next site of care. The patient will need information as well. Standard forms maintained by the patient for information sharing, such as personal health information and medication regimen, are a practical part of quality transitions. Obtain personal health forms at the websites indicated earlier.

Follow-Up Care

Facilitating the safe transition of patients from one level of care to another, or from one provider to another, involves arranging effective clinical follow-up care at the new site of care. Notify the patient and family of primary care, specialty, and other clinician visits that will be necessary, and aid the patient in setting those appointments. Clinical evaluation visits generally should be within 5 to 10 days of departure from the current site of care. Include information on what testing is required, how urgently it needs to be done, and to whom the results should be transmitted.

Contact the patient by phone on the next business day after leaving the facility to monitor the patient’s condition and improvement. Also reinforce the discharge/transition and follow-up plan at that time, and be sure the patient and caregiver can state it.

Health Care Provider Engagement

Demonstrate ownership, responsibility, and accountability for the care of the patient and family/caregiver at all times. This is irreplaceable in promoting quality in transitions. Engage the family/patient in a partnership with their medical caregivers by establishing your facility as a communications “clearinghouse” for useful information and support. Guide the patient and family with written transfer instructions to reinforce their involvement in their care. After providing appropriate, timely information, allow for clear communication and interaction between the discharging facility and the next site of care.

Any nursing facility has the ability to adopt one, several, or all of these interventions to ultimately build a successful care-transitions program.

Shared Accountability

The transition-of-care process is enhanced through shared accountability by the health care provider or entity that is transitioning the patient and the practitioner or entity that is receiving the patient. This ensures that a health care provider is responsible for oversight of the patient’s care at all times during the transition process. The receiving site has the obligation to review the timely and adequate data set from the sending site and then to contact the sender for any questions or gaps in the information. Each site must regularly provide feedback to the other on the quality and timeliness of the flow of information.

Any nursing facility has the ability to adopt one, several, or all of these interventions to ultimately build a successful care-transitions program.

Dr. Lett is a past AMDA president and chaired the AMDA workgroup that created the clinical practice guideline “Care Transitions in the Long-Term Care Continuum,” and currently is chairman of the AMDA Transitions of Care Committee. Comment on this and other columns at www.caringfortheages.com, under “Views.”