Transition of Care: Best Practices

WHAT IS TRANSITION OF CARE?

Transition of Care means moving a patient from an inpatient setting (hospital, ambulatory primary care practice, specialty care practice, long-term care, home health, or rehabilitation facility) to another setting or to home.

Poorly executed Transition of Care from the inpatient setting back to home can result in communication gaps between inpatient and outpatient providers. It can mean intentional and unintentional medication changes and incomplete diagnostic workups. This can also result in the patient, caregiver and provider not fully understanding the diagnoses, medications, and follow-up needs. Therefore, the health outcome of the patient will be poor, and **the end result will be readmission**.

PATIENT ENGAGEMENT AFTER INPATIENT DISCHARGE

The PCP's office must receive the following from the practitioner responsible for the patient's care during the inpatient stay:

- Procedures or treatments required after the patient leaves the inpatient facility.
- Confirmation that all chronic condition diagnoses have been well documented for diagnostic accuracy.
- A complete list of the medications upon discharge.
- Copies of all test results, as well as documentation or orders for pending tests or no tests pending.
- Instructions to the provider for the treatment changes for patient care noted upon discharge.
- Patient engagement must occur within 30 days after discharge by:
  - An outpatient visit at the office or at home;
  - A telephone visit; or
  - A telehealth visit using audio and video communication.

MEDICATION RECONCILIATION POST DISCHARGE

Medication reconciliation is a **critical part** of post-discharge care coordination for all patients taking prescription medications and is imperative to preventing unintended complications.

Reconciliation is a medication review in which discharge medications are reconciled with the most recent medication list in the outpatient medical record. The medication list may include:

- Medication names only
- Medication names, dosages and frequency
- Over-the-counter (OTC) medications, and
- Herbal or supplemental therapies

It is a **best practice** to conduct the medication reconciliation **within seven days of discharge.**

Medication reconciliation of discharge medications with outpatient medications can be done within 30 days from the date of discharge. It can be conducted by:

- The provider, nurse practitioner, physician assistant, a nurse or clinical pharmacist
- It can also be done over the phone

Once the new list has been finalized, it is to be communicated to the patients and caregivers.

BEST PRACTICES TO PREVENT READMISSION

- See Patients within 7 days of being discharged
  - Note: Patient engagement must occur within 30 days of discharge
- Request a complete discharge summary to ensure that all diagnoses, medications, treatments, and test results have been well documented.
- Reconcile medications at the post discharge visit and at every visit.
- Leverage the office staff by having them ask the patient pertinent questions such as:
  - "Do you have anyone who can help you with your care?"
  - "Do you have transportation to the pharmacy or appointments?"
  - "Do you need additional help at home?"
- Begin case management and discharge planning early, target high-risk patients.
- Always identify and have contact information for the primary caretaker
- Teach patients and families how to manage their conditions
  - Use the **teach back method** – ask the patients and caretakers to repeat the instructions/ demonstrations back to verify they understand the treatment plan.
- Maintain a "Lifeline" with high-risk patients after discharge:
  - Frequent communication across the whole care team
  - Provide information regarding out-patient facilities so that the patient can contact them if they are having problems:
    - Inform them that urgent/emergency/postoperative care is available
    - Offer addresses, maps, and phone numbers to those locations
  - Provide contact information regarding post-discharge issues
    - Let the patients know when to call a physician, when to take meds and where to access care.
- Initiate discharge planning on the day of admission.

BEST PRACTICES TO PREVENT PATIENTS FROM BEING ADMITTED TO THE HOSPITAL

Encourage all your senior patients to:

- Stay active both physically and mentally
- Maintain a healthy diet
- Follow the recommended treatment plans established by the provider
- Be sure to communicate all of their symptoms to the provider
- Have a home safety inspection done so to reduce the risk of falls and accidents
- And the most vital factor in keeping seniors out of the hospital is to keep their family members and caretakers involved.