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fastfacts
Resources for Nursing Home Professionals

California HealthCare Foundation

Coordinating Care Transitions

Care transitions between hospitals and nursing facilities and between nursing facilities and home are often poorly coordinated, resulting in medical errors, higher risk of rehospitalization, and duplication of services. This FastFacts focuses on effective interventions nursing home leaders can use to better coordinate care across clinical settings.

Care Transitions Compromise Quality and Safety

- **Increased risk of medication errors.** Adverse drug events occur during care transitions due to transcription and prescribing errors, yet about half are preventable. Improved legibility in documentation can substantially decrease medication errors. In a study of hospitalized patients transferred to nursing homes, medication documentation was illegible 28 percent of the time.
- **Residents with multiple chronic conditions are at higher risk.** When care across multiple settings is not coordinated, residents with multiple chronic conditions are at higher risk for poor outcomes. These residents typically require more hospital services, physician care, and prescription drugs than those without chronic conditions.
- **Lack of proper follow-up care.** Patients who move from provider to provider may feel vulnerable and are not prepared to cope with fragmented delivery and financial systems. Often there is no single provider in charge during transitions and residents receive conflicting care advice. Without an advocate, residents' medical care may suffer.
- **Duplication of services.** Many patients receive duplicate tests or procedures because their records are incomplete or illegible, or key information has not been shared among providers. This results in increased costs for residents and providers.

Focus on Process Improvement

- **Standardize handoffs.** Promote a safe handoff culture in your facility. Prepare standardized written and oral instructions to pass information to the next provider. Include administrative data, patient background, up-to-date clinical information, current conditions, a to-do list, and contingency plans, as well as an opportunity for questions.
- **Focus on discharge planning.** Use structured instructions and checklists to prepare residents for treatment and follow-up visits. Residents and caregivers should be aware of warning symptoms and adverse reactions that may indicate a resident's condition has worsened.
- **Use care transition measures.** Assess the quality of care transitions within your facility using a patient-centered tool, such as Dr. Eric Coleman's Care Transitions Measure©™ Tool Kit.

Strengthen Communication

- **Increase communication between providers.** Interdisciplinary team interventions such as case management, multidisciplinary health care team coordination between providers, and planning for community-level health referrals improve patient health and satisfaction. Clear communication ensures that providers have complete clinical information that is passed to the next point of contact. Use "read-back" to ensure that all parties agree and understand.

Improve Workflow Efficiency

- **Promote medication reconciliation at admission and discharge.** The Joint Commission mandates medication reconciliation of all prescription and non-prescription medications across all clinical settings. Reconciliation is the process of comparing medications the patient is taking at discharge with medications taken during admission to a new facility. Medication reconciliation helps avoid transcription errors, duplication of therapy, and drug-related interactions.

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Involve Residents and Caregivers

- **Prepare patients and caregivers.** Provide residents and caregivers with appropriate discharge information, treatment regimens, and follow-up appointments to reduce transitional stress and improve coping skills.
- **Equip residents with self-management skills.** Empower residents to take a more active role in managing their care. Teach self-management skills to allow patients to determine goals and treatment plans, and provide them with tools to expand their knowledge and confidence.
- **Utilize personal health records.** Enable residents and caregivers to have a patient-centered health record that includes core data elements to facilitate continuity of care. The record should include a list of medications and allergies, chronic illnesses, red flags, advance care directives, and patients' questions and concerns in preparation for the next medical visit. Samples of personal health records are available online at www.caretransitions.org.

Use Interactive Teaching Strategies

- **Train residents and caregivers on care transition pitfalls.** Educate residents and caregivers about warning symptoms and adverse reactions that may indicate their condition has worsened after discharge from the nursing home. Provide emergency contact information.
- **Train staff on effective care transitions.** Emphasize the elements of effective communication: interactive questioning, checking for understanding using "read-back," focused attention, a quiet space for communication, and adequate time for interaction. Conduct role-playing exercises on how to conduct effective sign-out.

References

Brown-Williams, H. 2006. "Dangerous Transitions: Seniors and Hospital-to-Home Experience." *Perspectives* 1 (2).

Coleman, E.A. 2003. "Falling through the cracks: challenges and opportunities for improving transitional care for persons with continuous complex care needs." *Journal of the American Geriatrics Society* 51 (4); 549-555.

Coleman, E.A., J.D. Smith, J.C. Frank, S.J. Min, C. Parry, and A.M. Kramer. 2004. "Preparing patients and caregivers to participate in care delivered across settings: the Care Transitions Intervention." *Journal of the American Geriatrics Society* 52 (11); 1817-1825.

Health Research for Action. *Summary Proceedings Transitional Care Leadership Summit.* Berkeley, CA: University of California, Berkeley, 2006.

Web Resources

Care Transitions Program www.caretransitions.org

Ready, Aim, Improve—Discharge to Community at MEDQIC http://tiny.cc/discharge

TeamSTEPPS™: Strategies and Tools to Enhance Performance and Patient Safety www.ahrq.gov/qual/teamstepps/

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