Transitions in Care

Why They Are Important and How to Improve Them

U. Ohuabunwa MD
Learning Objectives

- Define transitions in care and the roles patients and providers play in safe transitions
- Describe the care transitions process and identify potential multilevel lapses
- Describe the effects of unsafe transitions
- Recognize the key elements of safe transitions
Case 1

- An older woman had back surgery and was sent home without instructions on how to care for herself and without home health care services. She had great difficulty getting out of bed to use the toilet, she could not take care of the surgical wound on her back, and she could not prepare meals for herself. She was frightened and did not know who to call for help.
An older woman had a stroke and was discharged from the hospital to home without any plan for follow up care. Her primary care physician was not notified of her recent hospitalization or new diagnosis. The patient's condition worsened and she had to be readmitted to the hospital within a few days.
Case 3

- An older man was discharged from the hospital with incomplete discharge instructions. Consequently he did not understand what medications he should take, when he needed to see his doctor in follow-up, what laboratories he needed. He didn't know how to obtain refills on his medications and because he did not get along with his primary care physician, he didn't want to go in for an appointment. Although a visiting nurse was sent out to his home, she did not know what medications he should be taking or what his follow-up needs were.
Case 4

- An older man who takes medication to thin his blood to prevent a future stroke is hospitalized for an unrelated condition. Because the doctors in the hospital don't know what the usual dose of his blood thinning medication was before the hospitalization and they do not contact the nurse that monitors this medication, they inadvertently change the dose and send him home. The new dose turns out to be twice as potent as his usual dose and within two days he is re-hospitalized with uncontrollable bleeding.
What is the Problem?

- Patients with complex care needs require care across different health care settings

- Outpatient
  - Older persons with multiple chronic conditions see 8 different physicians over the course of a year

- Post-hospitalization
  - 23% of hospital patients discharged to another institution
  - 11.6% discharged with home care
What is the Problem?

- Skilled Nursing Facilities
  - 19% of patients transferred back within 30 days
  - 42% within 24 months

- In all of these cases, a successful “handoff” of care between professionals in each setting is critical to achieving optimal outcomes.
What is the Problem?

- Patients experience heightened vulnerability during transitions between settings

- Quality and patient safety are compromised during transitions period
Hazards of Poorly Executed Transitions of Care

- High rates of medication errors
- Inappropriate discharge and discharge setting
- Inaccurate care plan information transfer
- Lack of appropriate follow-up care
Hazards of Poorly Executed Transitions of Care

- Problems that occur during transitions have been codified. Leading problems:
  - Medication management
  - Continuity of the care plan

- 49% of discharged patients had lapses related to medications, test follow-up, or completion of a planned workup

Moore et al JGIM 2003; 8:646–651
Outcomes of Poorly Executed Transitions

- Re-hospitalization
- Greater use of hospital emergency, post-acute, and ambulatory services
- Further functional dependency
- Permanent institutionalization
Hospital Readmissions

- 19.6% of Medicare beneficiaries readmitted in 30 days

- Readmission results in
  - Increased healthcare costs
  - Iatrogenic complications, such as adverse drug events, delirium, and nosocomial infections
  - Progressive functional decline

Jencks et al, NEJM 2009;360:1418-1428
Hospital Readmissions

- Potential high cost savings – unplanned readmissions cost Medicare $17.4 billion in 2004

- 19% of Medicare discharges followed by an adverse event within 30 days
  - 2/3 are drug events, most often judged “preventable”

- Only half of patients re-hospitalized within 30 days had a physician visit before readmission

Jencks et al, NEJM 2009;360:1418-1428
HOW DO THINGS GO WRONG
## Care Transitions Process

<table>
<thead>
<tr>
<th>Patient Admitted</th>
<th>Patient Treated</th>
<th>Patient Improved and Discharged</th>
<th>Post Discharge Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assessment</td>
<td>• Investigations</td>
<td>• Readiness for Discharge</td>
<td>• DC Summary</td>
</tr>
<tr>
<td>• Define Problem</td>
<td>• Procedures</td>
<td>• Discharge Setting</td>
<td>• Medication Reconciliation</td>
</tr>
<tr>
<td>• Treatment Plan</td>
<td>• Consultations</td>
<td>• Discharge Education</td>
<td>• Follow-up appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Care Coordination</td>
<td>• Follow-up Consultations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Provider Communication</td>
<td>• Follow-up tests</td>
</tr>
</tbody>
</table>

- Patient Admitted
- Patient Treated
- Patient Improved and Discharged
- Post Discharge Follow-up
Provider Role in Care Transitions

Patient Admitted
- Assessment
- Define Problem
- Treatment Plan

Patient Treated
- Investigations
- Procedures
- Consultations

Patient improved and discharged
- Readiness for Discharge
- Discharge Setting
- Discharge Education
- Care Coordination
- Provider Communication

Post Discharge Follow-up
- DC Summary
- Medication Reconciliation
- Follow-up appointments
- Follow-up Consultations
- Follow-up tests
Potential Lapses in Care Transitions Process

Patient improved and ready for discharge
- Readiness for Discharge
- Discharge Setting
- Discharge Education
- Medication Reconciliation
- Care Coordination
- Provider Communication
  - PCP communication
  - DC Summary

Discharged to the next care setting
- Medication Compliance
- Dietary Compliance
- Keep follow-up appointments
- Transportation
- Caregiver support
- Home Health/Community Resources

Post Discharge Follow-up
- DC Summary review
- Medication Reconciliation
- Follow-up appointments
- Follow-up Consultations
- Follow-up tests
Factors Contributing to Failure in Transitions of Care

- System-Related Factors
- Provider-Related Factors
- Patient-Related Factors

Failed Transitions
Figure 2. Taxonomy of errors at time of hospital discharge

- **Discharge**
  - **Health Care System**
    - Lapse of communication
      - Discharge summary to PCP
      - Inpatient team to PCP
      - Community services with PCP
    - Inadequate Patient Education
    - Medication Error
    - Lack of timely follow-up
    - Lapse in community services
  - **Patient**
    - New Medical Problem
      - Deteriorization of known medical problem
    - Distant from discharge
    - Early Post-discharge
    - Drug/Alcohol use
    - Language/Cultural barrier
    - Medication non-adherence
    - Doesn't keep follow-up appointment
  - **Clinician**
    - Lab/Test error
      - Not ordered
      - Not performed
      - Not seen
      - Not acted upon
    - Inappropriate discharge
    - Inappropriate medication
    - Inadequate use of community services

**Rehospitalization**
BREAK- OUT SESSION
Case 1

- An older woman had back surgery and was sent home without instructions on how to care for herself and without home health care services. She had great difficulty getting out of bed to use the toilet, she could not take care of the surgical wound on her back, and she could not prepare meals for herself. She was frightened and did not know who to call for help.

- Identify any lapses in transitions of care
Discharge Readiness Assessment

• Was this patient ready for discharge?

• Indicate reasons as to why this patient should or should not have been discharged
Pre-discharge Assessment

• Does it appear as if any form of pre-discharge assessment was completed on this patient?

• List all types of pre-discharge assessments that should be completed on all patients to determine discharge readiness
Pre-discharge Assessment

- Clinical Assessment – Resolution of acute medical issues
- Functional Assessment
  - ADLs
  - IADLs
  - Mobility
- Cognitive Assessment
- Psychosocial Assessment
Pre-discharge Assessment

- Psychosocial functioning assessment
  - Family and community support
  - Cultural factors
  - Health literacy and linguistic factors
  - Financial factors
  - Spiritual and religious functioning
  - Physical and environmental safety
Discharge Setting Assessment

- Was this patient discharged to an appropriate location - Home?

- Indicate reasons as to why this patient should or should not have been discharged home

- List alternative discharge settings and identify which setting is most appropriate for this patient
Discharge Setting

- Discharge sites:
  - Home
  - Assisted living
  - A nursing facility for rehabilitation
  - Acute rehab
  - Hospice
Case 2

- An older woman had a stroke and was discharged from the hospital to home without any plan for follow up care. Her primary care physician was not notified of her recent hospitalization or new diagnosis. The patient's condition worsened and she had to be readmitted to the hospital within a few days.

- What are the lapses in transitions of care?
Care Coordination

- List what aspects of care coordination that were adequate in this patient?

- List aspects of care coordination that were inadequate and should have been completed in this patient?
Care Coordination

• Does the patient/client have a primary care physician?
  ◦ Communication
  ◦ Appointments

• Does the patient/client have a specialty physician, e.g., cardiologist?
  ◦ Communication
  ◦ Appointments
Care Coordination

- Does the patient/client have an outpatient case manager who should be notified?

- Ensure all transitions services and care (medications, equipment, home care, SNF, hospice) are coordinated and available for patient use
Communication Skills

- Did communication with other accountable persons at the point of transition appear adequate?

- Who are the other accountable persons at the point of transition that the in-patient physician should communicate with pre-discharge?

- Define the components of the care plan to be communicated with these stakeholders
Communication

- Accountable provider at point of transition
  - Case manager/social worker/discharge planner
  - PCP/SNF/LTAC/NH
  - Patient
  - Family and paid caregivers
<table>
<thead>
<tr>
<th>Data Elements</th>
<th>Discharge Summary</th>
<th>Patient Instructions</th>
<th>Communication to follow-up clinician on day of discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenting problem that precipitated hospitalization</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Key findings and test results</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final Primary and Secondary Diagnoses</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Brief Hospital Course</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Condition at discharge, including functional status and cognitive status if relevant(^{25, 26})</td>
<td>x—functional status</td>
<td>o -- cognitive status</td>
<td></td>
</tr>
<tr>
<td>Discharge destination (and rationale if not obvious)</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Discharge Medications: Written schedule</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Include purpose and cautions (if appropriate) for each(^{24})</td>
<td>o</td>
<td>x</td>
<td>o</td>
</tr>
<tr>
<td>Comparison with pre-admission medications (new, changes in dose/fREQ, unchanged, “meds should no longer take”(^{23}))</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Follow-up appointments with name of provider, date, address, phone number, visit purpose, suggested management plan(^{31})</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>All pending labs or tests, responsible person to whom results will be sent(^{7})</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Recommendations of any sub-specialty consultants</td>
<td></td>
<td></td>
<td>o</td>
</tr>
<tr>
<td>Documentation of patient education and understanding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any anticipated problems and suggested interventions</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>24/7 call-back number</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify referring and receiving providers</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resuscitation Status And any other pertinent end-of-life issues(^{26})</td>
<td></td>
<td></td>
<td>o</td>
</tr>
</tbody>
</table>
Case 3

- An older man was discharged from the hospital with incomplete discharge instructions. Consequently he did not understand what medications he should take, when he needed to see his doctor in follow-up, what laboratories he needed. He didn't know how to obtain refills on his medications and because he did not get along with his primary care physician, he didn't want to go in for an appointment. Although a visiting nurse was sent out to his home, she did not know what medications he should be taking or what his follow-up needs were.

- Identify the lapses in transitions of care
Patient/ Caregiver Education

- Did this patient appear to be adequately educated?
- List essential components that were omitted from his education?
- List the essential components of patient discharge education. Identify an optimal method of patient education that facilitates patient understanding.
# SHM Communication Checklist

<table>
<thead>
<tr>
<th>Data Elements</th>
<th>Processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenting problem that precipitated hospitalization</td>
<td>Discharge Summary</td>
</tr>
<tr>
<td>Key findings and test results</td>
<td>x</td>
</tr>
<tr>
<td>Final Primary and Secondary Diagnoses</td>
<td>x</td>
</tr>
<tr>
<td>Brief Hospital Course</td>
<td>x</td>
</tr>
<tr>
<td>Condition at discharge, including functional status and cognitive status if relevant</td>
<td>—functional status</td>
</tr>
<tr>
<td>Discharge destination (and rationale if not obvious)</td>
<td>x</td>
</tr>
<tr>
<td>Discharge Medications:</td>
<td>Discharge Summary</td>
</tr>
<tr>
<td>Written schedule</td>
<td>x</td>
</tr>
<tr>
<td>Include purpose and cautions (if appropriate) for each</td>
<td>0</td>
</tr>
<tr>
<td>Comparison with pre-admission medications (new, changes in dose/freq. unchanged, “meds should no longer take”1234)</td>
<td>x</td>
</tr>
<tr>
<td>Follow-up appointments with name of provider, date, address, phone number, visit purpose, suggested management plan51</td>
<td>x</td>
</tr>
<tr>
<td>All pending labs or tests, responsible person to whom results will be sent8</td>
<td>x</td>
</tr>
<tr>
<td>Recommendations of any sub-specialty consultants</td>
<td>x</td>
</tr>
<tr>
<td>Documentation of patient education and understanding</td>
<td>x</td>
</tr>
<tr>
<td>Any anticipated problems and suggested interventions</td>
<td>x</td>
</tr>
<tr>
<td>24/7 call-back number</td>
<td>x</td>
</tr>
<tr>
<td>Identify referring and receiving providers</td>
<td>x</td>
</tr>
<tr>
<td>Resuscitation Status</td>
<td>x</td>
</tr>
<tr>
<td>And any other pertinent end-of-life issues91</td>
<td>o</td>
</tr>
</tbody>
</table>
Case 4

- An older man who takes medication to thin his blood to prevent a future stroke is hospitalized for an unrelated condition. Because the doctors in the hospital don't know what the usual dose of his blood thinning medication was before the hospitalization and they do not contact the nurse that monitors this medication, they inadvertently change the dose and send him home. The new dose turns out to be twice as potent as his usual dose and within two days he is rehospitalized with uncontrollable bleeding.
Issues Identified

• Discuss medication reconciliation issues identified in this instance

• Discuss best practices during a Post Discharge Visit with you as the PCP
Post Discharge Visit with PCP

- DC Summary
- Medication Reconciliation
- Follow-up tests
- Follow-up appointments
- Follow-up Consultations
HOW CAN WE IMPROVE TRANSITIONS OF CARE
Solution to Problem

- A set of actions designed to ensure the coordination and continuity of care as patients transfer between different locations or different levels of care in the same location – AGS definition of Care Transitions
Solution to Problem

- Tailored towards what will work best for the patients in different hospital settings

- Interventions
  - System related
  - Patient related
  - Provider related
Other Interventions

- Several programs developed aimed at improving transitions across settings

- Coordination of care by a “coordinating” health professional

- Interventions are divided into two groups based on intensity:
  - The “coach,” “guide,” approach
  - The “guardian angel” approach
### TABLE 1 Clinical Trials to Improve Outcomes for Elders Discharged From the Hospital

<table>
<thead>
<tr>
<th>Study</th>
<th>Setting</th>
<th>Population</th>
<th>Intervention</th>
<th>Sample Size (n)</th>
<th>Follow-up Period and Retention Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue et al. (2001)</td>
<td>A teaching hospital in England</td>
<td>Patients with heart failure</td>
<td>Home visits and telephone contact, education, support, liaison with other healthcare and social workers</td>
<td>IG: 84; CG: 81</td>
<td>99% for IG and 100% for CG at 12 months</td>
</tr>
<tr>
<td>Coleman et al. (2004)</td>
<td>A large integrated delivery system in Colorado</td>
<td>Community-dwelling adults aged &gt;65 years admitted to hospital</td>
<td>Tools for communication, encouragement to take an active role in their care, coach guidance</td>
<td>IG: 154; CG: 1235</td>
<td>100% for 6 months</td>
</tr>
<tr>
<td>Coleman et al. (2006)</td>
<td>A large integrated delivery system in Colorado</td>
<td>Community-dwelling adults aged &gt;65 years admitted to hospital</td>
<td>Tools for communication, encouragement to take an active role in their care, coach guidance</td>
<td>IG: 379; CG: 373</td>
<td>95% for IG and CG for 6 months</td>
</tr>
<tr>
<td>Debnik et al. (2004)</td>
<td>5 northern California hospitals in a large HMO</td>
<td>Patients with clinical criteria for heart failure</td>
<td>Structured telephone surveillance, and coordination of patients' care with physicians</td>
<td>IG: 228; CG: 254</td>
<td>87% for IG and 81% for CG at 12 months</td>
</tr>
<tr>
<td>Harrison et al. (2002)</td>
<td>2 medical units of a large urban teaching hospital in Canada</td>
<td>Patients with congestive heart failure</td>
<td>Standard discharge plus supportive care for self-management, linkages</td>
<td>IG: 92; CG: 100</td>
<td>80% for IG and 77% for CG at 3 months</td>
</tr>
<tr>
<td>Herilde et al. (2002)</td>
<td>2 health service centers in Australia</td>
<td>Patients with chronic obstructive pulmonary disease</td>
<td>Home visits by community nurse after discharge and preventive general practitioner care</td>
<td>IG: 84; CG: 93</td>
<td>80% for IG and 86% for CG at 3 months</td>
</tr>
<tr>
<td>Jaarsma et al. (1999)</td>
<td>A university hospital in the Netherlands</td>
<td>Patients with heart failure</td>
<td>Education and home visits to promote self-care</td>
<td>IG: 84; CG: 95</td>
<td>74% for 9 months</td>
</tr>
<tr>
<td>Kotteling et al. (2005)</td>
<td>A university hospital in the Netherlands</td>
<td>Patients with chronic heart failure</td>
<td>A 1-hour, one-on-one teaching session with a nurse-educator</td>
<td>IG: 102; CG: 116</td>
<td>100% for 6 months</td>
</tr>
<tr>
<td>Kwok (2004)</td>
<td>2 acute hospitals in Hong Kong</td>
<td>Patients aged &gt;60 years with a primary diagnosis of chronic lung disease</td>
<td>Nurses made home visits, telephone access, coordinated with specialists in hospital.</td>
<td>IG: 77; CG: 80</td>
<td>87% for the IG and 91% for the CG at 6 months</td>
</tr>
<tr>
<td>Lim et al. (2003)</td>
<td>4 university-affiliated urban hospitals in Australia</td>
<td>Patients aged &gt;65 years required community services after hospital</td>
<td>Nurse coordinators provided more time and expertise than usual practice — case management</td>
<td>IG: 311; CG: 287</td>
<td>91% for the IG and CG at 6 months</td>
</tr>
<tr>
<td>Naylor et al. (1999)</td>
<td>2 urban hospitals in Philadelphia, Pennsylvania</td>
<td>Patients aged &gt;65 years admitted to hospital</td>
<td>Comprehensive discharge planning and home follow-ups by advance practice nurses (APNs)</td>
<td>IG: 177; CG: 186</td>
<td>70% for IG and 74% for CG at 6 months</td>
</tr>
<tr>
<td>Naylor McCauley (1999)</td>
<td>University-affiliated hospitals in United States</td>
<td>Community-dwelling adults aged &gt;65 years</td>
<td>Same as above</td>
<td>IG: 311; CG: 287</td>
<td>100% for 6 months</td>
</tr>
<tr>
<td>Naylor et al. (2004)</td>
<td>6 Philadelphia academic and community hospitals</td>
<td>Community-dwelling elderly patients with a diagnosis of heart failure</td>
<td>A 3-month APN-directed discharge planning and home I follow-up protocol</td>
<td>IG: 118; CG: 121</td>
<td>69% for the IG and CG at 12 months</td>
</tr>
<tr>
<td>Riegel et al. (2002)</td>
<td>2 Southern California hospitals in United States</td>
<td>Patients hospitalized with congestive heart failure</td>
<td>Telephone calls and case management based on patient symptoms and needs</td>
<td>IG: 130; CG: 220</td>
<td>100% for Intervention group and 45% for Control group at 6 months</td>
</tr>
<tr>
<td>Sinclair et al. (2005)</td>
<td>3 district general hospitals in Birmingham, United Kingdom</td>
<td>Community-dwelling adults 65+ years with suspected myocardial infarction</td>
<td>Home visits; encouraged compliance with and knowledge of regimen, support, guidance</td>
<td>IG: 163; CG: 161</td>
<td>82% for IG and 83% for CG for 100 days</td>
</tr>
<tr>
<td>Young et al. (2003)</td>
<td>A hospital in Toronto, Ontario, Canada</td>
<td>Patients with post myocardial infarction</td>
<td>Home visits by a cardiac-trained nurse, communication with family physician, education</td>
<td>IG: 79; CG: 83</td>
<td>90% for IG and CG for a mean of 43.4±1.2 and 45.3±0.6 follow-up days</td>
</tr>
</tbody>
</table>

Note: IG = intervention group; CG = control group.
*Quasi-experimental design, all other were randomized controlled trials.
**This is a secondary analysis of a randomized controlled trial (Naylor, 1999).
***Physicians were randomized, all others were patient-randomized trials.

## Comparison of Care Transitions Models

<table>
<thead>
<tr>
<th>Author</th>
<th>Setting</th>
<th>Clinical Focus</th>
<th>Subjects per Group</th>
<th>Years</th>
<th>Duration</th>
<th>Intensity</th>
<th>Savings/ Patient ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naylor et al</td>
<td>2 university hospitals</td>
<td>Varied</td>
<td>180</td>
<td>1992–1996</td>
<td>6 months</td>
<td>High</td>
<td>$3,301</td>
</tr>
<tr>
<td>Naylor et al</td>
<td>6 urban hospitals</td>
<td>Heart failure</td>
<td>120</td>
<td>1997–2001</td>
<td>12 months</td>
<td>High</td>
<td>$4845</td>
</tr>
<tr>
<td>Coleman et al</td>
<td>HMO, 1 hospital, 8 NHs, 1 HHA</td>
<td>Varied</td>
<td>370</td>
<td>2002–2003</td>
<td>6 months</td>
<td>Low</td>
<td>$488</td>
</tr>
</tbody>
</table>
# Care Transitions Intervention Activities by Pillar and by Stage of Intervention

| Stage of Intervention | Four Pillars  
|-----------------------|---------------------------------------------------------------
|                       | **Medication** Self-management | **Patient-Centered Record** | **Follow-up** | **Red Flags** |
| Goal                  | Patient is knowledgeable about medications and has medication management system | Patient understands and uses PHR to facilitate communication and to ensure continuity of care plan across providers and settings; patient manages PHR | Patient schedules and completes follow-up visit with primary care provider or specialist and is prepared to be an active participant in interactions | Patient is knowledgeable about indications that condition is worsening and how to respond |
| Hospital visit        | Discuss importance of knowing medications and having a system in place to ensure adherence to regimen | Explain PHR | Recommend primary care provider follow-up visit | Discuss symptoms and drug reactions |
| Home visit            | Reconcile prehospitalization and posthospitalization medication lists; identify and correct discrepancies | Review and update PHR; review discharge summary; encourage patient to update and share PHR with primary care provider or specialist at follow-up visits | Emphasize importance of follow-up visit and need to provide primary care provider with recent hospitalization information; practice and role-play questions for primary care provider | Assess condition; discuss symptoms and adverse effects of medications |
| Follow-up telephone calls | Answer remaining medication questions | Remind patient to share PHR with primary care provider or specialist; discuss outcome of visit with primary care provider or specialist | Provide advocacy in getting appointment, if necessary | Reinforce when primary care provider should be telephoned |

*Abbreviation: PHR, personal health record.

**Coleman, E. A. et al. Arch Intern Med 2006;166:1822-1828.**
Intervention – Naylor Approach

Use of an Advanced Practice Nurse

- Initial APN visit within 48 hours of hospital admission
- APN visits every 48 hours during hospitalization
- 2 home APN visits (48 hours, 7-10 days after discharge)
- Additional APN visits based on patients’ needs with no limit on number
- APN telephone availability 7 days per week
- At least weekly APN initiated telephone contact with patients or caregivers
## Summary of Care Transitions Best Practices

### Table 1: During Hospitalization
- Risk screen patients and tailor care
- Establish communication with primary care physician (PCP), family, and home care
- Use “teach-back” to educate patient/caregiver about diagnosis and care
- Use interdisciplinary/multi-disciplinary clinical team
- Coordinate patient care across multidisciplinary care team
- Discuss end-of-life treatment wishes

### Table 2: At Discharge
- Implement comprehensive discharge planning
- Educate patient/caregiver using “teach-back”
- Schedule and prepare for follow-up appointment
- Help patient manage medications
- Facilitate discharge to nursing homes with detailed discharge instructions and partnerships with nursing home practitioners

### Table 3: Post-Discharge
- Promote patient self management
- Conduct patient home visit
- Follow up with patients via telephone
- Use personal health records to manage patient information
- Establish community networks
- Use telehealth in patient care