| Care Transition Bundle<br>Seven Essential Intervention Categories | | |
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| **Essential Intervention Categories** | **Description** | **Examples of Transition of Care Interventions** |
| **1. Medications Management** | Ensuring the safe use of medications by patients and their families and based on patients' plans of care<br><br>a. Assessment of patient's medications intake<br><br>b. Patient and family education and counseling about medications<br><br>c. Development and implementation of a plan for medications management as part of the patient's overall plan of care | a. Assessment of patient's medications intake<br>• Medication review including over-the-counter medications, herbals, vitamins, allergies, and drug interactions<br>• Identify problem medications<br>• Identify polypharmacy<br>• Adherence and medication schedules<br><br>b. Patient and family education and counseling about medications<br>• Teach back method to establish understanding of medication plan<br>• Explain what medications to take, emphasizing any changes in the regimen<br>• Review each medication's purpose, how to take each medication correctly, and important side effects to watch out for<br><br>c. Development and implementation of a plan for medications management as part of the patient's overall plan of care<br>• Medication Reconciliation including pre-hospitalization and post-hospitalization medication lists<br>• Be sure patient has a realistic plan about how to get the medications<br>• Confirm the medication plan - pharmacist follow-up telephone calls after intensive nurse-based patient education upon hospital discharge or transfer<br>• Coordinated and integrated team approach to medication management, involving pharmacists and/or physicians |
| **2. Transition Planning** | A formal process that facilitates the safe transition of patients from one level of care to another including home or from one practitioner to another. | a. Clearly identified practitioner (or team dependent on setting) to facilitate and coordinate the patient's transition plan<br>• Use of a Transitional Care Nurse (TCN) or Advance Practice Nurse (APN), who conducts a comprehensive assessment of patient and family/caregiver needs, coordinates the patient's discharge or transition plan with the family and healthcare provider team |

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| | a. Clearly identified practitioner (or team dependent on setting) to facilitate and coordinate the patient's transition plan<br><br>b. Management of patient's and family's transition needs<br><br>c. Use of formal transition planning tools<br><br>d. Completion of a transition summary | • Assessment of patient's and family/caregiver's post-episode of care needs, by a specific member of the healthcare team in collaboration with the others on the team<br><br>b. Management of patient's and family's transition needs<br>• Performing an enhanced assessment, including hospital assessment and comprehensive home assessment to ensure safe transition<br>• Provision of coaching, counseling and support to patients and their families/caregivers regarding healthy lifestyle and health regimen<br>• Education of patients and families/caregivers about self-care management skills<br>• Consideration for the patient's and family/caregiver's literacy level<br><br>c. Use of formal transition planning tools<br>• Universal Discharge or Transition Checklist<br>• Standard Plan of Care<br>• Electronic transfer of information from one level of care, setting or provider to another<br><br>d. Completion of a transition summary<br>• Expedited transmission, preferably an electronic transfer, of the Discharge or Transition Summary to the physicians (and other services, such as the visiting nurses) accepting responsibility for the patient's care after discharge<br>• Give the patient a written Discharge or Transition Plan at the time of discharge/transition, written at the patient's appropriate literacy level and assess the patients' degree of understanding by asking them to explain the details of the plan in their own words |

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| **3. Patient and Family Engagement / Education** | Education and counseling of patients and families to enhance their active participation in their own care including informed decision making.<br><br>a. Patients and families/caregivers are knowledgeable about condition and plan of care<br><br>b. Patient and family-centered transition communication<br><br>c. Developing self-care management skills | a. Patients and families/caregivers are knowledgeable about condition and plan of care<br>• Patient is knowledgeable about indications that their condition is worsening and how to respond using knowledge of "red flags"<br>• Provision of education using appropriate health-literacy materials and language<br>• Use of patient and family education and counseling guides<br><br>b. Patient and family-centered transition communication<br>• "Translating" information between the provider and patient to ensure that each really understands what the other has communicated<br>• Conducting real time patient- and family-centered handoff communication<br><br>c. Developing self-care management skills<br>• Improving patient and family education practices to encourage use of the teach-back process around risk specific issues<br>• Assess the patients' degree of understanding by asking them to explain the details of the plan in their own words |
| **4. Information Transfer** | Sharing of important care information among patient, family, caregiver and healthcare providers in a timely and effective manner.<br><br>a. Implementation of clearly defined communication models<br><br>b. Use of formal communication tools | a. Implementation of clearly defined communication models<br>• Communication infrastructure, that will enhance communication with other healthcare providers about a patient (or resident in certain settings) change of status<br>• Timely feedback and feed-forward of information by utilizing specific communication models that support consistent and clear communication among healthcare practitioners and caregivers<br><br>b. Use of formal communication tools<br>• Use of personal health record |

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| | c. Clearly identified practitioner to facilitate timely transfer of important information | • Implementation of specifically designed tools, i.e. Transfer Tool, Transition Record, Transition Summary<br>• Utilization of an integrated electronic medical record and a Web-based care management tracking tool, i.e. electronic transfer of the Discharge or Transition Instruction Form to the receiving healthcare provider<br><br>c. Clearly identified practitioner to facilitate timely transfer of important information<br>• Timely transfer of critical patient information, preferably within 24 hours<br>• Care coordinators actively facilitating communications among providers and between the patient and the providers<br>• Conduct real time patient and family handoff communication with accepted handoff communication techniques |
| **5. Follow-Up Care** | Facilitating the safe transition of patients from one level of care or provider to another through effective follow-up care activities.<br><br>a. Patients and families timely access to key healthcare providers after an episode of care as required by patient's condition and needs<br><br>b. Communicating with patients and/or families and other healthcare providers post transition from an episode of care | a. Patients and families timely access to key healthcare providers after an episode of care as required by the patient's condition and needs<br>• Confirmation of Primary Care and Specialist Follow-Up<br>• Make appointments for clinician follow-up and post-discharge testing prior to discharge<br>• 24 hours a day, seven days a week access to Health Services Access Line.<br>• Post-acute care follow-up, including a face-to-face visit at home and/or with a doctor, within 48 hours of discharge<br>• Enhanced access and not having long wait times to get in to see a provider<br>• Appointment within first 5-10 days post an acute care episode<br><br>b. Communicating with patients and/or families and other healthcare providers post transition from an episode of care<br>• A primary-care RN to call the patient by the next business day to monitor his or her condition<br>• Telephone re-enforcement of the Discharge or Transition Plan and problem |

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| | | solving 2 to 3 days after discharge/transition from an episode of care<br>• One in home follow up visit to assess safety<br>• Telephone calls or face to face contacts with the patient and family<br>• Healthcare provider teams have frequent contacts with their patients and their families/caregivers (or enrollees in payor-based settings). This helps them to detect subtle changes in their patients' or enrollees' conditions and they can react quickly to changing medical, functional, and psycho-social problems |
| **6. Healthcare Provider Engagement** | Demonstrating ownership, responsibility and accountability for the care of the patient and family/caregiver at all times.<br><br>a. Clearly identified patient's personal physician (primary care provider)<br><br>b. Use of nationally recognized practice guidelines (evidence-based guidelines)<br><br>c. Hub of case management activities<br><br>d. Patient and family education and counseling activities<br><br>e. Open and timely communication among healthcare providers, | a. Clearly identified patient's personal physician (primary care provider)<br>• Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care (Patient-Centered Medical Home Model)<br>• Enhanced access to services and provision of follow up appointments without long wait times<br><br>b. Use of nationally recognized practice guidelines (evidence-based guidelines)<br>• Reconciliation of the Discharge or Transition Plan with national guidelines and critical pathways<br>• Implementation of evidence-based care tools or plans<br><br>c. Hub of case management activities<br>• Improve documentation around change in patient's (or resident's) condition<br>• Improve flow of information between hospital and outpatient physicians and access to timely information on hospital and emergency room admissions<br>• Being a communications hub<br>• Reconcile pre-hospitalization and post-hospitalization medication lists<br><br>d. Patient and family education and counseling activities<br>• Coaching patients on self-care management with attention to "red flags" |

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| | patients and families | • Giving the patient and family/caregiver a written Discharge or Transition Plan and Instructions at the time of discharge/transition<br><br>e. Open and timely communication among healthcare providers, patients and families<br>• Enhanced communication with other health care providers about change in a patient's (or resident in some settings) status<br>• Close interaction between care coordinators and primary care physicians<br>• Care is coordinated and/or integrated by coordinating patient care in a team based approach |
| **7. Shared Accountability across Providers and Organizations** | Enhancing the transition of care process through accountability for care of the patient by both the healthcare provider (or organization) transitioning and the one receiving the patient.<br><br>a. Clear and timely communication of the patient's plan of care<br><br>b. Ensuring that a healthcare provider is responsible for the care of the patient at all times<br><br>c. Assuming responsibility for the outcomes of the care transition process by both the provider (or organization) sending and the one receiving the patient | a. Clear and timely communication of the patient's plan of care<br>• Sending healthcare provider must communicate plan of care to patient and to receiving provider before handoff is completed<br>• The sending provider must be available to the receiving provider for any questions and clarifications regarding the patient's care after the handoff<br><br>b. Ensuring that a healthcare provider is responsible for the care of the patient at all times<br>• Sending healthcare provider must remain responsible for patient's care until the receiving provider has acknowledged that he/she can effectively assume the care of the patient<br>• The receiving provider has to acknowledge the receipt of transferred information in a timely manner, understand the plan of care for the patient and be prepared to assume responsibility for patient's care<br><br>c. Assuming responsibility for the outcomes of the care transition process by both the provider (or organization) sending and the one receiving the patient<br>• If the provider who has assumed care of the patient determines that the patient should go to another level of care than that provided, the provider is |

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| | | responsible for communicating with the receiving provider before handoff<br>• Post-transition patient's safety and outcomes report |