CHAPTER 3

Care Transitions—Fractured or Flowing?

CHAPTER OBJECTIVES

After completing this chapter readers will be able to:

- Identify types of care transitions
- Describe the scope and impact of high-risk care transition gaps
- List care transition consensus standards and measures
- Describe evidence-based care transition programs
- Explain key elements of effective care transitions
- Assess the effectiveness of the reader's own organizational care transitions
- Identify evidence-based transition tools and techniques for use in the reader's own organization
- List common failures in care transitions

Introduction

In the course of writing this book I have spoken to many nurses and other health professionals about their perceptions of high-risk gaps and cracks in the healthcare system. One of these conversations was with a nurse population health director for a large medical practice, who dryly asked, "How many volumes will the publisher let you write?" Here, we will explore an area of care where care gaps are particularly prevalent and problematic—transitions of care from one healthcare setting to another.

In this chapter, we will explore the dimensions of care transitions and their impact on patients and the healthcare system, explore nurse care transition roles and competencies, examine evidence-based best practices, list available

tools and the links for finding them, and describe measures and distill guidelines that can be applied to the reader's own practice setting.

Because care transitions are all about teamwork, we will frame this chapter with observations about care coordination from Sharon Wood, RN, MSN, the director of Population Health for Community Medical Group in New Haven, Connecticut: "I think the vast majority of people who work in health care work too independently; not in silos, but on parallel pathways towards a goal. We do not or cannot see who is to the left and right of us moving toward the same goal, so we spend too much time, too much effort and too much money trying to attain an outcome that is only achievable if we work in collaboration with one another. We in health care talk a lot about safety nets for our patients. We need to broaden that concept and think about safety nets for systems" (Wood, 2017, personal communication).

Is a Care Transition Always the Best Answer?

Before considering the types of care transitions, it is important to remember that fewer or no transitions can be the best option for patients. This point is made in a document from the American Medical Directors Association (of long-term care facilities): "[I]t is well established that transferring a patient from a familiar environment (e.g., the SNF/NF where s/he resides) to a new, unfamiliar, and potentially bewildering location like an emergency room can cause severe and sometimes permanent decompensation and lead to medical errors. Hence, avoidance of unnecessary transfers should be a primary goal, but when transfers are necessary, we support implementation of processes that optimize efficient and well-orchestrated patient transitions" (American Medical Directors Association, 2010, p. 2).

Care Transitions Overview

The National Transitions of Care Coalition (NTOCC) defines care transitions as "leaving one care setting (i.e. hospital, skilled nursing facility, assisted living facility, primary care physician practice, home health care, or specialist care) and moving to another" (NTOCC, 2010a, p. 2). Care transitions are a potential care gap area and have been extensively studied and reported in the healthcare literature.

Transitions are notorious for causing patient harm and increasing costs. Transitions from acute care to home have produced the most evidence-based best practices and tools for improvement. Transitions to and from long-term care facilities, emergency rooms, and ambulatory surgery have been less studied, but they also have a significant impact on patient outcomes, especially for patients with multiple chronic illnesses and high care needs. Transitions to and from home health care have received very little research attention.

Care Transition Basics

Types of Care Transitions

In the American healthcare system there are five major types of care transitions (**FIGURE 3-1**):

- **Home to acute or postacute care** (emergency room, skilled nursing facility [SNF], or acute care hospital)
- **Acute care to postacute care** (to skilled nursing, long-term acute care hospital [LTACH], inpatient rehabilitation, and home health care)
- **Ambulatory care to home** (outpatient surgery, chemotherapy, outpatient procedures such as colonoscopies to home)
- **Transitions between postacute settings** (SNF to home care, home care to SNF, LTACH to SNF, LTACH to home care, assisted living to home care)
- **Acute care directly to home** (acute care hospital, emergency room to home)

In the white space between these facilities is a "mini transition" (e.g., transport by ambulance

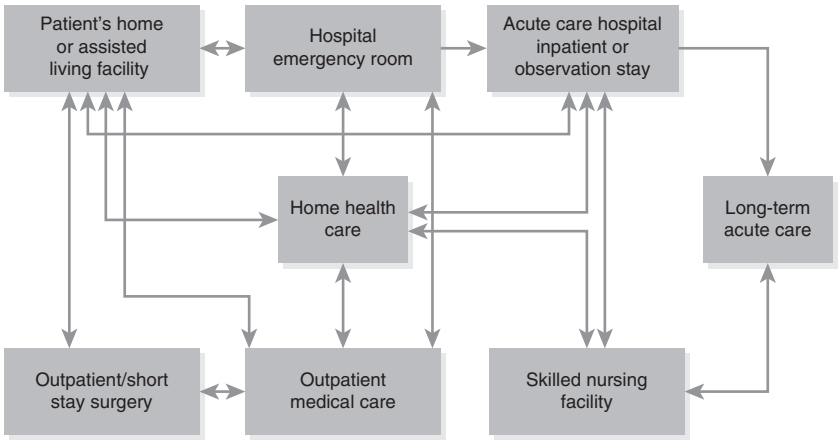

FIGURE 3-1 Types of Care Transitions

CASE STUDY

Interview with Beth Hodshon, JD, MPH, RN, Project Director of the CHIRAL Project 3—Transitions in and out of the Hospital

Yale University researchers at the Center for Healthcare Innovation, Redesign and Learning (CHIRAL), a joint partnership of the Yale Medical School and Yale New Haven Hospital, studied transitions between hospitals and SNFs. The project sites for this research included a 28-bed teaching service, a 14-bed general medicine hospitalist unit, and local SNFs. Project Director Beth Hodshon, JD, MPH, RN, shares her insights and impressions from the research.

Framing the Work of the Study

- Nationally 1:4 older hospitalized patients are discharged to an SNF and 1:4 are readmitted within 30 days.
- There is a national focus on reducing readmissions; and in 2018 SNFs and hospitals will receive readmission penalties.
- Because of the lack of SNF transition studies, one positive aspect of this project has been to "give SNFs a voice."

Impressions from Interviews and Observations

- Hospital staff lack knowledge about SNFs (when and how often a patient is seen by provider, differences in care provided by SNF vs. hospital).
- There is considerable variation in facilities in terms of their processes and the services they provide.
- There is a high volume of turnover among SNF clinicians. At various points in the study, researchers have had difficulty contacting facilities because the clinician who had originally participated in the research was no longer employed there.

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CASE STUDY *(continued)*

- Patients discharged from SNFs are very sick, and don't look much different from hospitalized patients. Yet, SNFs are structured very differently from hospitals in terms of staffing and ability to care for patients. Capabilities vary considerably between facilities.
- SNF providers have a much different relationship with patients than do inpatient providers. Because patients often stay in SNFs longer than they do in hospitals, clinicians have a closer bond with patients and families. Some researchers wonder (this has not yet been studied) if this close bond lessens objectivity that may impact SNF staff being more willing to send patients to the hospital when the patient's condition deteriorates.
- The attitude "when in doubt send them out" often prevails at SNFs when a patient has acute changes in condition. Some SNFs are trying to change this.

Hospital Versus SNF Views of Transitions

- The process of preparing the patient for a discharge from a hospital to an SNF is a complex and time-consuming process that must be performed by hospital medical residents, nurses, and care coordinators preferably before 11 a.m.
- An effective hospital-to-SNF process requires the transfer of complex information; and follow-up on tasks begun in the hospital may need to be completed by the SNF.
- Preparation work includes:
  - Completing a discharge summary
  - Reconciling patient medications for discharge
  - Providing orders for specialty services and equipment
  - Booking follow-up appointments
  - Making a "warm handoff" from the hospital clinician to the SNF clinician
  - Arranging transportation
- Because care transition is just "part of the work" of hospital and nursing staff and not a separately defined and measured process with specific best practices, it is often sandwiched in with other responsibilities. This can lead to incomplete transfer information being provided and leaves the SNF scrambling to get the right supplies and medications when the patient is admitted. These disconnects create fertile ground for mistakes.
- On the SNF side, the process of accepting a patient from the hospital is complex and can be intense and frustrating for both hospital and SNF staff. A key driver of making a decision to accept/not accept a patient is cost. A patient's care plan and the SNF's capacity to care for a patient may depend on the patient's insurance and/or willingness to pay for care privately. For example, patients who have been in observation and need SNF level care may not qualify for Medicare coverage in the SNF post discharge. This is a huge barrier to SNFs who are put in the position of having to accept a patient who cannot pay and potentially incurring large financial losses over time.
- On the hospital clinician side, SNF rules and constraints are not well understood. A delay in accepting a patient or a refusal to accept causes hospital clinical staff to express frustration and anger because, as they see it, after all their work, the patient is not going to get the level of service that is expected. Often refusals are seen as "unfair" and the SNF is labeled as "uncooperative" when this occurs.

Crossing the Gap Between SNFs and Hospitals

In conversation, Ms. Hodshon wonders if some future work might be done on improving communication and joint expectations between SNFs and hospital staff. Having clinicians from one facility visit the other would be ideal but not practical due to staffing constraints. Some type of videotaped interviews might be another option.

CASE STUDY (continued)

Summary

Some SNFs with a broader view of care transitions and higher level capabilities to manage complex patients are making serious attempts to reduce readmission. A high volume of staff turnover in SNFs and the lack of consistent best practices complicate the problem of effective transitions. SNF transitions can be smooth, but many of these transitions are fraught with potential errors and mistakes due to hospital staff overload and a transition process that focuses on quickly moving patients to the next setting in care. Another factor in less than ideal transitions is the difference in priorities and a lack of understanding and communication between hospital and SNF staff. In the future work of the project some improvements to address these root causes of poor transitions may be tested.

or other means). The quality and timeliness of transport between settings can be a significant factor in achieving a successful care transition.

Standards for Effective Care Transitions

A 2007 policy statement by the Transitions of Care Consensus Conference (TOCCC) tackled the daunting task of creating standards for care transitions.

This consensus group included key medical organizations such as the American College of Physicians, the Society of General Internal Medicine, the Society of Hospital Medicine, the American Geriatrics Society, and the Society for Academic Emergency Medicine. The TOCCC adopted 9 principles for effective care transitions: "1.) Accountability, 2.) Communication, 3.) Timely interchange of information, 4.) Involvement of the patient and family member, 5.) Respect the hub of coordination of care, 6.) All patients and their family/caregivers should have a medical home or coordinating clinician, 7.) At every point of transitions the patient and/or their family/caregivers need to know who is responsible for their care at that point, 8.) National standards, 9.) Standardized metrics" (Snow et al., 2009). These standards have been embedded into the evidence-based care transition programs that will be described later in this chapter and they provide guidelines for the development of organizational level care transition efforts.

Core Care Transition Activities

A review of the literature indicates that there are a core series of specific activities that achieve the TOCCC standards for effective care transitions (American Medical Directors Association, 2010; NTOCC, 2010a; Naylor, 2008; The Joint Commission [TJC], 2012).

- A predischarge assessment of patient risk and caregiving support
- A discharge plan focused on expressed patient and family needs
- Multidisciplinary communication and collaboration
- Clinician accountability for patient support across transition points
- Patient and family engagement and self-management education
- Follow-up after a patient leaves a care setting
- Effective transfer of information between settings, preferably in electronic form

FIGURE 3-2 summarizes the essential elements of effective care transitions.

When these activities occur consistently and in concert, the patient experience is good; when one or more of these activities is faulty or

FIGURE 3-2 Essential Elements of Effective Care Transitions

missing, care transitions fail or create adverse events and poor outcomes for patients.

Care Transitions Roles and Responsibilities

The complexity of care transitions has fueled the development of a number of specific roles and responsibilities. Nurses, physicians, social workers, and support staff trained as "transition coaches" or "patient navigators" may all play a part in helping patients safely transition from one setting to another. Nursing roles dominate in care transitions, although in postacute settings, social workers also play a prominent role in discharge planning and execution. Nurses who arrange care transitions have a variety of titles (Agency for Healthcare Research and Quality [AHRQ], 2016).

Care Manager

"Care manager" is one of the most common titles, but others are "discharge planner," "care coordinator" or "transition coach." "Case manager" is a common title for nurses who organize care transitions and discharge planning, although some experts see case management as a more long-term, intense relationship with a population of seriously ill patients and transitional care as the work of linking care across settings (Lamb, 2014). According to the Case Management Society of America (CMSA) one of the guiding principles for case managers is to "[a]ssist with navigating the health care system to achieve successful care, for example during transitions" (CMSA, 2016).

Care Coordinator

The care coordinator title is commonly used in ambulatory care settings, behavioral health, and medical offices. These positions may be responsible only for episodic coordination of care and transitions or the role may evolve into a more long-term case management.

One advertisement for a medical office nurse care coordinator describes the transition role of the care coordinator: Coordinates care across the inpatient/outpatient/community continuum to assure appropriate utilization of clinical and community resources.

Utilization Management

Utilization management is a type of care transition management that focuses on the optimal use of healthcare resources for patient care. Using standardized guidelines, utilization managers determine medical necessity, recommend the use of evidence-based clinical guidelines, and determine optimal time frames and lengths of stay for care (URAC, 2017).

Clinical Liaison Nurses in Skilled Nursing Facilities and Home Health Care

Nurses in these roles evaluate whether patients in inpatient settings are appropriate for referral to the next step in care such as the SNF or home health care. They may participate in discharge planning. They educate patients and families

about the type of services they can expect in the SNF or home health care agency. Liaison nurses may also identify barriers and obstacles to effective transitions and communicate these to the admitting or intake staff at the SNF or home care agency.

Social Work Discharge Planners

The National Association of Social Workers (NASW) defines the social work role in SNF transitions as: "Facilitating residents' safe integration into the community through interdisciplinary discharge planning and follow-up services" (NASW, 2003, p. 15). In most SNFs, social workers collaborate with nursing and therapy staff to design a discharge plan and to facilitate both admissions and discharges from facilities.

Physician Hospitalists

Since the late 1990s physicians who specialize in inpatient care, called hospitalists, have supplanted the role of community physicians in managing patients who are admitted to acute care facilities.

Most health professionals agree that the hospitalist role has improved the quality of acute care, but many believe that it has created more complexity in care coordination. Clear accountability for patient care across the transition from hospital to home has been lost since the community physician no longer manages care in both settings. In one study, some hospitalists felt a strong responsibility to communicate their findings to community physicians through timely transmission of discharge summaries. Some go much further and contact the community physician directly. Others stated that "once the patient is out the door, they are not my responsibility" (Hongmai, Grossman, Cohen, & Bodenheimer, 2008, p. 1321). In some settings, hospitalists actually take the lead in identifying patients who are at risk for readmissions and in developing strategies for avoiding these readmissions in concert with community providers (Johnson, 2016).

Extensivists

According to a 2016 article in the online journal, *HealthLeaders Media*, yet another new specialty, "the extensivist," has been developed to address the fragmented nature of inpatient to outpatient care coordination: "Extensivists typically take their scope of practice beyond the hospital and into the home or other settings, with a focus on keeping patients healthier and reducing readmissions" (Freeman, 2016). These roles are filled by either physicians or nurse practitioners. This new role has been received with some skepticism by health professionals who wonder if it usurps the role of the primary care physician in coordinating care. Others feel that the extensivist role is ideally suited to the management of high-need, high-risk patients who may not get an adequate level of care coordination and intense medical management in a busy primary care practice.

Technology and Care Transitions

Technology often plays a role in improving care transitions. Interoperable electronic medical records are the main area of focus, but emerging technologies such as electronic tracking of patients across the continuum of care and electronic communication with patients after a transition are other aspects of technology being applied to transitions.

Health care professionals almost universally acknowledge that the lack of health information systems interoperability (computer systems that can exchange information) is a huge barrier to effective care transitions. While some transitions are communicated via interoperable electronic medical records (EMRs), communication is still likely to be done by fax or phone, and forms mailed and occasionally emailed via secured servers. Lack of standardized communication templates or forms and a variety of communication methods often results in care transition information being missed or misinterpreted. Even when the facility or agency that receives the patient from an acute care institution has

access to the hospital EMR, information is not always condensed into a usable form.

Another problem that lacks sufficient study in the literature but is often reported in conversations with health professionals is that transition information may contain considerable clinical information but fails to "tell the patient's story." One example of this is not informing the next step in care about palliative care or hospice patient and family conversations that may have been started at the referring facility. A second example is not providing information about socioeconomic barriers to care or the patient's caregiving support situation to health professionals who provide care to the patient at the next step in the continuum.

One nursing informatics study describes a hospital-based project that did create a "patient story" portal with constantly updated patient information (Struck, 2013).

In a position paper about the use of health information technology to improve transitions of care, the NTOCC (2010b) explores the issues of barriers to effective transition communication at length. This paper identifies five significant barriers to effective care transition communication:

- **Lack of connectivity.** This issue concerns the lack of interoperability, partially due to a focus on technology as a revenue generator and not a method of improving patient care.
- **Lack of shared goals related to care transitions.** The root cause of this problem is a "silo mentality" in which each part of the care continuum focuses only on its own transition goals and tasks.
- **Misaligned incentives.** Payment for volume fosters disconnected transition communication, but pay for results fosters better communication.
- **Consumer knowledge and demand for a continuing care plan.** Low levels of health literacy and information that are not patient friendly contribute to lower levels of consumer use of healthcare information through care transitions.
- **Issues of trust.** Fears about data breaches, misunderstanding of the Health Insurance Portability and Accountability Act (HIPAA) laws, and patient fears about who can access the personal health information inhibit sharing of important clinical information between professionals and patients.

The paper goes on to propose solutions including standards, better quality measures, aligned incentives, and team-based care within and across provider groups (NTOCC, 2010b).

Electronic systems that track patients through the continuum of care are a new innovation in care transition technology. Some of these systems are internal to an organization and use the organization's EMR. For example, a home care agency used its "patient status report" capabilities to gather and document data from clinicians and families about the patient's current site of care (emergency room, observation, hospital, or SNF). By continually entering status data and running reports on patient status, clinical managers were better able to identify and manage transitions to and from home care.

An example of an external tracking system that is used by accountable care organizations (ACOs) is PatientPing. Ping is a system that "relies on feeds of admission, discharge and transfer data commonly exchanged among healthcare IT systems. PatientPing's partners provide the company with a list of their patients and the networks they use. PatientPing takes that information and connects it to those facilities' feeds. PatientPing then filters through both the list of patients and the registration system looking for matches. When a match is identified, the providers are notified" (Castellucci, 2016). The data are used in a practical way by medical groups, SNFs, and home care agencies to track the location of patients in value-based payment programs. When patients are identified as being in a different care setting, each involved provider can communicate with ACO care managers about a new transition care plan.

Middlesex Hospital in Middletown, Connecticut, uses an interactive voice response (IVR)

system to communicate with patients after hospital discharge. The system calls patients within 48 hours of discharge and asks a series of questions about the patient's health status. Using a set of triage protocols and an analysis of the responses, the system provides "trigger alerts" to care managers to triage and manage the patient's changing health situation (Mackinnon & Mansfield, 2015).

Patient portals are another electronic tool that can improve the quality of care transitions. According to HealthIT.gov, "A patient portal is a secure online website that gives patients convenient 24-hour access to personal health information from anywhere with an Internet connection. Using a secure username and password, patients can view health information such as: recent doctor visits,discharge summaries, and medications" (HealthIT.gov, 2015). Patient portals are often used to provide patients with continuing access to discharge instructions. In an innovative project, one Veterans Administration hospital used a patient portal to manage postdischarge medication reconciliation with patients. The program resulted in avoiding 108 medication discrepancies and 23 potential adverse drug events, 50% of which were classified as serious (Heyworth et al., 2014).

As time goes on and these electronic systems evolve and become more widespread and more interoperable, we can expect them to make a positive impact on the quality of care transitions.

Care Transition Measures

The National Quality Forum (NQF) has included a number of care transition measures in its Endorsement Summary of Care Coordination Measures (NQF, 2014). These measures include:

- **Timely initiation of home health care** within 2 days of the referral or patient discharge date
- **Medication reconciliation for older adults** (age 66 and older) within 30 days of discharge
- **Reconciled medication list received by discharged patients** or caregivers at the time of discharge
- **Transition record received by discharged patients** or caregivers at the time of discharge
- **Transition record received by the facility, primary physician, or other health professional** designated to provide follow-up care within 24 hours of discharge
- **Transition record received by patients discharged** from an emergency department

In 2014, the Care Transitions Measure (CTM-3®), a three-item question set developed by the Care Transitions Program (Coleman et al., 2002), was incorporated into the publicly reported Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The new CAHPS measures include three new questions that assess patient perceptions of care transitions:

1. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my healthcare needs would be when I left the hospital.
2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
3. When I left the hospital, I clearly understood the purpose for taking each of my medications. (Centers for Medicare and Medicaid Services [CMS], 2015)

The IMPACT Act of 2014 is a Medicare regulation that creates a unified measurement system across all postacute settings, including skilled nursing facilities, long-term care acute hospitals, inpatient rehabilitation facilities, and home health agencies (HHAs). The act mandates the use of several existing transition measures and it creates contracts for developing several additional care transition measures.

Within the context of the IMPACT Act, CMS Medicare Learning Network (2015) describes care transitions in this way: "Communicating

and providing for the transfer of health information and care preferences of an individual when the individual transitions" (p. 9). The universal measure for care transitions across all four postacute settings is a 30-day postdischarge, all-cause readmission rate.

In 2017, CMS began soliciting comments on two new measures for care transitions (CMS, 2017):

1. Transfer of information at postacute care admission, start, or resumption of care from other providers/settings
2. Transfer of information at postacute care discharge or end of care to other providers/setting

Commonsense Care Transition Measures

While the formal measurement of care transitions is a work in progress, most health professionals and most patients and their family caregivers know a good care transition when they see one. Good care transition processes incorporate the four key elements of connected care:

- It's all about them (patients and caregivers), not just about us (health professionals).
- We're all in this together (teamwork).
- We share relevant information to meet patient needs.
- We do the right things right (work processes produce desired results with the least amount of resources).

Both groups (professionals and patients) describe good transitions in terms like these:

- "Communication was good. I knew what was happening all the time."
- "Nothing fell through the cracks. All the right supplies and equipment arrived on time."
- "The patient and family stated they knew who to call for help during the transition."
- "Somebody from the hospital called to see how I was doing."
- "The patient is taking the correct postdischarge medications."
- "The facility that sent us the referral called to give us some additional information about the 'patient story.'"
- "The doctor called me back to give me the results of my tests."

In the absence of formal measures, health professionals should be asking patients and families such questions as "How do you feel we are doing on planning your discharge?" and "Do you know who to call if your condition gets worse?"

Organizational Level Care Transition Measures

In an era of value-based payment, all programs and activities must be built to achieve quadruple aim goals (i.e., improved outcomes for populations of patients, better patient experience, lower cost of care per capita, better clinician experience). Care transition processes are no exception. Most organizational care transition programs will focus on Medicare publicly reported measures, such as 30-day readmission rates, which carry penalties for low performance, and measures that are built into value-based payment programs.

Some of the common care transition measures include:

- **Care transitions outcomes.** The overriding goal for most transition programs is a reduction in patient readmissions to the hospital. Because of Medicare readmission penalties for both hospitals, and in the near future, for SNFs, most institutions are highly motivated to improve transitions to reduce their readmission rates. Another emerging outcome measure is the rate of emergency room visits for patients who have transitioned to a new care setting.
- **Patient experience measures.** Patient satisfaction goals and measures are an essential element in monitoring effective care transitions. The care transition questions in the CAHPS survey are the most commonly used type of patient satisfaction measures. Even if the facility is not mandated by Medicare to

do a CAHPS survey, it can still incorporate these measures into its own internal patient satisfaction surveys.

- **Operational measures.** Organizations that are serious about care transitions will also dissect their internal work processes and create goals and measures to determine their effectiveness. For example, home health agencies have hospital liaison programs, in which a nurse visits hospitalized patients who are ready for discharge. The nurse educates the patient about home care services and identifies discharge "red flags" that might alert the agency to work with the SNF more intensely to create a care plan or that might result in declining a referral in the case of serious patient safety issues.

  These "red flags" might include issues such as nonhealing wounds, inadequate caregiver support, financial issues, need for 24-hour care, inability to transfer safely, and need for a Hoyer lift in the home. The agency may measure effectiveness by surveying patients about how well the liaison prepared them for home care services. It may also measure the effectiveness of the liaison "red flag" screening process.

  Other organizational goals and measures may be dictated by ACO or insurer guidelines. For example, SNFs that participate in value-based payment programs try to have patients who decompensate at home return back to their facility rather than sending them to the hospital. The SNF might measure what percentage of total discharges end in a return to the hospital versus a return to the SNF.

- **Cost measures.** Another key internal measure is the cost of a care transition program. Organizations will measure the cost of maintaining a department or specialized functions to manage care transitions and should also monitor the average cost of each transition and the cost of transitions that fail. For example, in an SNF, the cost of a social work discharge planner, the cost of staff time for making patient follow-up calls, and the costs of patients who are readmitted to the facility within a specific time window might all be practical cost measures. The cost of buying or licensing computer programs required to take referrals or track patients through the continuum might also be calculated as part of a care transition program cost assessment.

CASE STUDY

A Good Care Transition

Consider the case of Mr. Washington, a 77-year-old inpatient in an acute care hospital. Mr. W, who has heart failure, chronic obstructive pulmonary disease, and diabetes, lives in his own home and receives caregiving support from his 74-year-old wife and his middle-aged daughter.

Soon after admission, Mr. W's hospital primary care nurse conducted a nursing assessment and identified the patient's goals, which were to return home, continue his regular activities, and be able to walk to his mailbox every day. The nurse also identified financial barriers to obtaining needed medications after discharge. She promptly made a referral to a social worker who was able to help the patient apply for a medication discount program.

During the course of the hospital stay, the unit secretary coordinated a follow-up medical appointment with the patient's primary care doctor and the patient's family. The hospital care coordinator referred Mr. W to a home care agency for patient teaching, physical therapy, and medication management.

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CASE STUDY *(continued)*

On the day prior to discharge, the home care liaison nurse visited Mr. W in the hospital to educate the patient and his wife about home care and to identify barriers to care. She also educated them about how to identify signs that Mr. W's condition was worsening and when to call the doctor. She learned that transportation to medical appointments would be a problem since the patient's adult daughter worked at the time of most appointments. She noted this in the agency medical record and made a recommendation for a social work referral after home care admission. The hospital care coordinator referred Mr. W to home care via an electronic referral system.

The home care agency was able to search the hospital EMR, retrieving the discharge summary, medication list, and social work notes for the care team.

One day after discharge, the home care nurse admitted the patient to service and conducted medication reconciliation using the hospital discharge medication list, the medications that his daughter had filled at the pharmacy, and the medications that were already in the home.

She called the physician to resolve medication discrepancies and verified that the patient would keep his follow-up medical appointment. After reading the liaison nurse's notes, she made a referral to the agency social worker who arranged for town transportation. After reviewing the hospital discharge summary, which contained information about patient goals, the home care nurse verified these goals with the patient and created a home care plan that incorporated those goals. She also reviewed the "when to call the doctor sheet" and used teach-back (having the patient repeat back what was learned) to ensure that the patient and his wife both understood when to call for help. She called the adult daughter to keep her updated on all care plan arrangements. Two days after discharge, the hospital care coordinator called both the patient and the home care nurse to ensure that the discharge had gone smoothly and to identify any problems.

By the end of the first week, the patient was taking the appropriate medications, was clear on when to call his doctors, had a follow-up appointment with the primary care physician, and had transportation to get there. He and his wife stated that they felt less stressed and more able to effectively cope with Mr. W's medical situation.

Case Study Review Question

Review the case study and identify the effective care transition activities that were used to achieve good results in this case.

The Impact of Poor Care Transitions

Hospital readmissions are the most visible, measured, and costly of postacute care discharge adverse events. A 2014 report by HCUP (Healthcare Cost and Utilization Project of the AHRQ) noted that "In 2011, there were approximately 3.3 million adult 30-day all-cause hospital readmissions in the United States, and they were associated with about $41.3 billion in hospital costs" (Hines, Barret, Jiang, & Steiner, 2014, p. 1).

In 2012, in response to these huge costs, Medicare instituted a readmission reduction program that penalized hospitals for unnecessary readmissions. A recent study that analyzed data from 3,387 hospitals found that from 2007 to 2015, readmission rates for targeted conditions declined (from 21.5% to 17.8%) and rates for nontargeted conditions declined (from 15.3% to 13.1%) (Zuckerman, Sheingold, Orav, Ruhter, & Epstein, 2016). Despite this decline in readmissions, the problem continues with over half of the nation's hospitals receiving readmission penalties (Rau, 2016).

Adverse Events after Hospital Discharge

A classic older study found that nearly 20% of patients experience adverse events within 3 weeks of discharge, many of which are preventable. Some of the most common adverse events post discharge were:

- Hospital-acquired infections
- Worsening symptoms due to hospital treatment
- Procedure-related injuries
- Adverse drug events (Modified from Forster, Murff, Peterson, Gandhi, & Bates, 2003)

Post-Hospital Syndrome

Dr. Harlan Krumholtz, Yale University School of Medicine, describes the post-hospital syndrome as "an acquired, transient period of vulnerability resulting from a hospital stay" (2013, p. 100). This syndrome—which results from patients experiencing inadequate sleep, poor nutrition, the stress of change and a challenging environment, multiple new medications, and deconditioning from bed rest—produces adverse events on discharge such as falls and injuries. In practical terms, the impact of this post-hospital syndrome for patients who transition home or to a postacute setting is profound. An example is postdischarge patient functional limitations or falls that result from patient deconditioning during the hospital stay.

A hospital readmissions collaborative group attacked this issue when home health agencies complained that too many patients were being sent home unable to ambulate. This lack of functional ability was not being assessed prior to discharge or the assessment was not being communicated to the home health agency. A typical scenario described by the home health agencies was that when the home health nurse came to the patient's home to conduct the admission visit the nurse would find that the patient could not get up out of a chair. This necessitated a call to emergency services, transport to the hospital emergency room, and a subsequent hospital readmission.

A review of readmission data by both the hospital and the home health agencies revealed that this was indeed a common cause of readmissions for that hospital. A deeper analysis revealed that hospital inpatient nursing and therapy staff felt that their schedules were too busy to allow for patient ambulation and patients were spending considerable time in bed or in a bedside chair. The inpatient nursing and therapy teams subsequently worked with management to create more time and a process for patient ambulation and strengthening exercises prior to discharge.

This intervention reduced the incidence of unnecessary transfers back to the hospital due to preventable patient functional limitations.

Wasteful Spending

"Researchers have estimated that inadequate care coordination, including inadequate management of care transitions, was responsible for $25 to $45 billion in wasteful spending in 2011 through avoidable complications and unnecessary hospital readmissions" (Burton, 2012, p. 1).

Caregiver and Patient Stress and Dissatisfaction

A family caregiver, who is herself a physical therapist with extensive healthcare experience, described her frustration with her father's hospital discharge and postdischarge transition: "You leave the hospital with 5 to 10 pages of paperwork and nobody explains it. You have a bag full of meds to deal with. You get a list of appointments for doctors you have never seen and a number to call. They don't tell you the location of the office. You finally find the address and you are driving around looking for a garage or parking with a sick person in the car. You are working and trying to do this. What are you really supposed to do in this situation?" (Mary Jane Fegan, PT, DPT, Personal communication, 2018)

ASK YOURSELF

- What are the most common patient transitions in and out of your practice setting (admission, discharge, transfer between units, etc.)?
- Do you know if your patients experience adverse events when they transition out of your practice setting to home or to the next setting in the care continuum?
- If the answer to the second question is "yes," at which points in the workflow do you think things fall through the cracks?

CASE STUDY

The Pieces Don't Fit Together for a High-Risk Patient and Caregiver

A patient with a history of mental illness and sporadic homelessness who was being treated for severe arthritis, chronic obstructive lung disease, and congestive heart failure was discharged from a hospital to home health care. He was living with his wife in public housing, from which they had periodically been evicted and allowed back. Neither the patient nor his wife had been able to muster the energy or organizational skills to apply for Medicaid.

The patient was being followed by multiple specialists, but communication was poor. The patient did not have a consistent, involved primary care physician. He was taking multiple medications prescribed by a number of specialists; some of them were duplicates of others that had been previously prescribed. Many postdischarge follow-up appointments were made, but the patient came to these appointments only occasionally. He was often transported to the emergency room by ambulance after missing appointments at the congestive heart failure diuretic infusion clinic.

Ultimately, after a series of missed phone calls (due to wrong phone numbers being exchanged between social workers at the hospital and home care agency), the home care social worker was able to help the patient complete an application for a transportation service. The application had been started by the hospital social worker, but never finished. The family caregiver (the patient's wife) who was highly stressed and ill herself, received little to no attention until the home healthcare team identified her distress and provided social work counseling.

Further complicating things, the hospital palliative care team had started a goals of care discussion with the family, but the notes were not part of the discharge summary that was sent to the home care agency, so agency clinicians were left to begin the conversation again, to the bewilderment of the family. The litany of disconnects in care in this case goes on and on and could fill a short story.

Some were eventually resolved as the result of a joint hospital/home health care agency case conference; many were not. In reading both the inpatient and outpatient hospital record and the home healthcare agency notes, one consistent theme emerged: Each setting and each professional acted in a vacuum, concentrating on each discipline's focus and needs, but not attempting to tie clinical actions to patient goals and not communicating to the next step in care. Considerable time, expense, and patient and family distress could have been alleviated by a broader view and better communication.

Evidence-Based Best Practices in Care Transitions

Since the start of the 21st century, there has been considerable research on best practices and tools to improve care transitions. Some of these new models have been proven to reduce patient harm, increase patient satisfaction, and improve clinical outcomes. Nurses are an integral part of many of these evidence-based care transition models. Nurses in nonspecialized care transition roles have also been able to adapt many of the care transition patient education and interdisciplinary communication tools as part of their daily practice. The most notable of the evidence-based care transition models are:

- **The Care Transition Intervention.** This approach, developed by Dr. Eric Coleman and colleagues, was tested in a large integrated delivery system in Colorado. The program utilized advanced practice nurses as "transition coaches" who coached patients on four "pillars" of self-management:
  - Medication self-management
  - Patient-centered record
  - Follow-up with patient's primary care provider
  - Identification of "red flags" that indicate a change in condition

  The program included a home visit and follow-up phone calls. The intervention reduced readmissions within 30 days by 30% (Coleman, Parry, Chalmers, & Min, 2006). Since the initial research, the Care Transitions Program has continued its research and has created new refinements such as standardized care transition measures and structured interventions for family caregivers.
- **The Transitional Care Model.** This model was tested in Philadelphia-area hospitals from 1997 to 2001 by Dr. Mary Naylor and colleagues. Advanced practice nurses provided eight home visits to high-risk patients using techniques such as risk assessment, self-management education, continuity of care, and fostering interdisciplinary communication and collaboration (Hirschman, Shaid, McCauley, Pauly, & Naylor, 2015; Naylor et al., 2004). Subsequent research revealed that this intervention resulted in a significant decrease in both cost of care and readmissions during the study period.
- **Project RED (Re-Engineered Discharge).** This intervention was conducted at the Boston Medical Center from 2003 to 2004. "A nurse discharge advocate worked with patients during their hospital stay to arrange follow-up appointments, confirm medication reconciliation, and conduct patient education with an individualized instruction booklet that was sent to their primary care provider. A clinical pharmacist called patients 2 to 4 days after discharge to reinforce the discharge plan and review medications" (Jack et al., 2009, p. 178). Participants had a lower incidence of hospital utilization after the intervention.
- **The BOOST (Society for Hospital Medicine) Program.** This program utilizes an extensive series of tools and processes to improve care transitions. Some program elements include an eight-question risk assessment, an assessment of preparedness for discharge, patient education tools, follow-up phone calls, and interprofessional rounds (Hansen et al., 2013).
- **INTERACT (Interventions to Reduce Acute Care Transfers).** This is one of the few postacute (after acute care) evidence-based care transition programs. INTERACT is a publicly available program that focuses on improving the identification, evaluation, and management of acute changes in condition of nursing home residents. The program was developed through a CMS contract to the Georgia Medical Care Foundation, the Medicare Quality Improvement Organization in Georgia. While the primary focus of the program is on identifying and taking action on resident changes in condition, there are also

evidence-based best practices to improve care transitions from SNFs to and from acute care hospitals.

Three key elements of this program are a facility capabilities list, standardized transfer forms for both hospitals and SNFs, and a medication reconciliation worksheet. The capabilities list is a formal document that details the capabilities of the SNF for hospital staff. These capabilities might include such things as whether the facility is IV certified.

The capabilities list helps hospital staff understand which facilities can provide the type of care their patients need after discharge. The standardized transfer forms help emergency room staff make informed decisions about the type of care needed by SNF residents who have been sent to the emergency room.

The forms sent by the hospital to the SNF ensure that time-sensitive information necessary to deliver care in the first few days after a transfer from an acute care hospital is received. The medication reconciliation worksheet provides guidance to SNF staff about medications from the sending acute care facility. This worksheet ensures that SNF patients, especially those taking multiple medications, receive the right drugs in the right way (Ouslander, Bonner, Herndon, & Shutes, 2014).

Common Elements of Evidence-Based Care Transition Programs

Each of these care transition program models, while quite variable in length, cost, staffing, and resources required, includes common elements:

- The programs are highly focused on patient needs. They pay less attention to utilization or insurance issues, possibly because most were grant funded.
- There is one clinician or transition coach assigned to manage the transition and to act as the patient and family advocate.
- The program is designed to "close the loop" on care transitions by contacting the patient and family after the transition to ensure that all necessary tasks were completed.
- Patient education using health literacy principles is usually an integral part of the evidence-based programs.
- Patient education emphasizes practical self-management skills for the next step in care, especially about how to identify clinical warning signs and when to call for help.
- Patient education in evidence-based care transitions ensures patient mastery of key knowledge and skills by using *teach-back* (asking the patient to repeat what was taught) and *return demonstration* (actually practicing a skill that was just taught).
- The programs typically use simple, standardized forms for communication with patients and for communication with health professionals at the next step in care.
- The programs educate both the patient and his or her network of support people and family caregivers.
- The programs reestablish the patient's connection with the primary care practitioner who coordinates the patient's care.
- There is a process for identifying and managing socioeconomic barriers to care such as access to transportation to medical appointments or being able to afford needed medications. Evidence-based programs take some responsibility for managing these social determinants of health as well as managing the medical aspects of care transitions.
- There is an effective system for transmitting information from the sending to receiving provider with a means to verify that information was received.

While your organization may not have a formal evidence-based care transition program, you can and should apply the lessons learned from these programs in your own care transition program. Use the checklist in **BOX 3-1** to assess how many best practices you currently have in place and how many you need to develop.

BOX 3-1 Checklist of Evidence-Based Care Transition Best Practices

Review the list and check off all items that apply to your transition program. Fewer checkoffs indicate a weaker program.

1. ❑ The transition program balances patient needs with insurance, utilization, and value-based payment goals. Patient needs should predominate.
2. ❑ There is one clinician or transition coach accountable for managing the transition process and the patient and family know how to contact this person.
3. ❑ The accountable clinician ensures that all necessary care tasks related to the transition were completed (prescriptions were provided, equipment was ordered and delivered, test results were reported, etc.).
4. ❑ The transition team provides patient education that is based on health literacy evidence-based best practices.
5. ❑ Patient education emphasizes practical self-management skills for the next step in care, with special emphasis on "clinical red flags" and when to call for help.
6. ❑ Patient mastery of self-management skills and knowledge are verified by using teach-back and return demonstration.
7. ❑ The program uses simple, standardized forms for communication with patients and for communication with health professionals at the next step in care.
8. ❑ The accountable clinician assesses family caregiver willingness and capability for providing patient support at the next step in care.
9. ❑ Family caregivers and other patient support people are included in all transition education, communication, and support activities.
10. ❑ The program connects the patient back to the primary care practitioner who coordinates the patient's care. This is done by notifying the primary care provider of the care transition and by facilitating follow-up primary care appointments.
11. ❑ There is a process for managing financial, social, and other barriers to care such as having transportation to medical appointments or being able to afford needed medications.
12. ❑ There is an effective system for transmitting information from the sending to receiving provider with a means to verify that information was actually received.

Tools and Techniques for Care Transitions from Evidence-Based Programs

Care transition programs employ a variety of tools and techniques that can easily be adopted in other settings. These tools are both part of the evidence-based models described earlier and available from other sources. Many tools are free and most are available on the internet. The most common types of tools and forms are:

- Assessments of patient and caregiver capability and readiness for discharge or self-care
- Patient medication lists
- Patient personal health records
- Patient discharge planning checklists
- Transition information transfer checklists
- Provider communication forms

TABLE 3-1 contains a list of tools, descriptions, and sources. Many of these tools are freely available for use in your own transition program, although some require written permission or payment for use.

TABLE 3-1 Evidence-Based Care Transition Program Tools and Techniques

Tool	Description	Source	Location
After Hospital Care Plan	Patient medication, appointment, and follow-up activities forms, questions for doctor in English and Spanish	Project RED	https://www.ahrq.gov/sites/default/files/publications/files/redtoolkitforms.pdf
Personal Health Record	Patient medications, appointments, questions for doctor in English, Spanish, and Somali	Care Transitions Intervention	http://caretransitions.org
Patient Activation Assessment®	Scores patient ability to manage medications, red flags, personal health record, medical follow-up	Care Transitions Intervention	http://caretransitions.org
Patient Activation Assessment® Guidelines	Instructions for scoring the Patient Activation Assessment	Care Transitions Intervention	http://caretransitions.org
The Family Caregiver Activation in Transitions Tool©	Assessment of family caregiver transition skills; requires permission of Eric Coleman MD, for use	Care Transitions Intervention	http://caretransitions.org
Medication Discrepancy Tool (MDT)®	A form for assessing patient level and system level medication discrepancy factors and documenting resolution of these issues	Care Transitions Intervention	http://caretransitions.org
8P Risk Assessment Screening Tool	A checklist of factors that might contribute to risk of adverse events after discharge	Project BOOST	http://www.hospitalmedicine.org/
The General Assessment of Preparedness (GAP)	A checklist that helps identify patient concerns prior to transitions out of the hospital	Project BOOST	https://store.hospitalmedicine.org/PersonifyEbusiness/Store
BOOST Teach-back Curriculum and Video	A video and curriculum that teaches providers the patient teach-back method to improve patient understanding and adherence	Project BOOST	Available for purchase from Society of Hospital Medicine eStore

Tool	Description	Source	Location
Patient PASS: A Transition Record Patient Preparation to Address Situations (after discharge)	A simple, one-page personal medical record for tracking patient medications, questions, follow-up information, and medical tests	Project BOOST	http://www.hospitalmedicine.org/
Taking Care of Myself When I Leave the Hospital	An extensive patient personal medical record	Project RED	www.ahrq.gov/sites/default/files/publications/files/goinghomeguide.pdf
Interventions to Reduce Acute Care Transfers (INTERACT) Tools for Nursing Home to Hospital Communication	■ Skilled nursing facility capabilities list ■ SBAR (situation, assessment, background, result) communication form ■ Medication reconciliation worksheet ■ Transfer forms for use between hospitals and postacute settings ■ Other forms and checklists are available from the INTERACT website	INTERACT	Interact Implementation Guide http://www.pathway-interact.com/wp-content/uploads/2017/04/INTERACT-V4-Implementation_Guide-Dec-10.pdf
National Transitions of Care Coalition (NTOCC)	Multiple educational tools and checklists for both providers and patients; most notable is the *Transitions of Care Checklist*, which contains instruments for assessing medication management capability and continuity of care status	NTOCC	http://www.ntocc.org/Portals/0/PDF/Resources/TOC_Checklist.pdf

Current Challenges and Problems in Care Transitions

While the healthcare research literature is primarily focused on transitions from hospital to home, there are a huge number of other patient care transitions in other settings, each with its own unique challenges. These challenges are especially acute for frail elderly patients, those with mental health problems, and patients with dementia.

It is important to know that unless you are functioning as a case manager with ongoing patient contact and accountability for patient care, you probably only see and manage one or two types of transitions. Patients may experience many more types of transitions. It is vital for nurses to have some understanding of care transitions in other settings so that they can educate and advocate for patients.

Observation Status and Its Aftermath

One of the most problematic transition situations for frail older adults is an inpatient stay in "observation status." The Center for Medicare Advocacy defines observation status in this way: "CMS describes the issue as outpatients receiving 'observation services.' In reality these patients are patients in hospitals who receive medical, physician and nursing care, tests, medications, overnight lodging and food, but who are called outpatients" (Center for Medicare Advocacy, 2016).

The key impact of the observation status designation is that it is not considered a real inpatient stay and thus does not meet the Medicare "two midnight" requirement (a patient requires inpatient hospitalization in an acute care hospital for at least two midnights) for coverage of an SNF rehabilitation stay. This situation results in many frail older adults, who cannot afford to pay privately for rehabilitation or temporary assisted living care, being discharged home without the functional capability for self-care. The responsibility then falls to family members and possibly a home care agency to provide intensive and expensive in-home care. In many cases it creates extreme pressure on families to hire in-home personal care assistance that would have been provided in an SNF before the observation status rules were implemented. Many professional organizations have mounted lobbying campaigns to eliminate or mitigate the observation status rules, but at the time of this writing, it remains in force.

Shorter Skilled Nursing Facility Care Transitions

With the advent of the Affordable Care Act and value-based payment programs, SNFs are under considerable pressure to both reduce lengths of stay and reduce readmissions.

Observation stays and value-based payment pressures have completely changed the nature of SNF transitions in the last few years. Patients are typically admitted to SNF short-term rehabilitation after surgery, such as joint replacement, or after an acute hospital stay for an exacerbation of a chronic condition. Previous to changes in the healthcare system, patients receiving rehabilitation services stayed in SNFs for relatively long periods of time. At the time of discharge, most of these patients had regained their previous level of function after weeks of nursing care and rehabilitation. Now, while the Medicare benefit actually allows for up to 100 days of SNF care, most patient stays are far shorter. Patients still receive nursing care, patient teaching, and therapy, but are not always rehabilitated to their previous level of function before discharge, nor are the patient or family always fully competent in self-management skills. As in the observation stay scenario, this situation has created considerable pressure on families and home care agencies to take care of much more acutely ill patients.

SNFs that participate in bundled payment programs or are ACO preferred providers have a huge financial incentive to readmit their recently discharged patients back to their own facilities rather than to an acute care facility as a readmission to acute care triggers financial penalties to the SNF. This new impetus for shorter stays and lower readmissions has led to new strategies and new partnerships between SNFs and home health care.

Some of these strategies include mutual agreement on high-risk patient discharge criteria, home care staff involvement in discharge planning meetings at SNFs, home care nurse liaison visits to SNF patients to evaluate patient capacity for functioning at home to educate patients about home care, and to identify barriers to a safe discharge. In addition, SNF staff make follow-up phone calls to determine the patient's postdischarge status and to report to the home care agency or physician if problems are occurring. Home care staff periodically meet with the SNF clinical team to report on patient readmissions and to jointly debrief the situation and identify opportunities for future improvement.

Transition from Home to Emergency Care

Transitions from home to urgent or emergency care can be problematic when they are delayed too long. One nursing study found that 93% of patients with heart failure delayed seeking treatment, in some cases up to 2 weeks after the onset of symptoms, because they did not identify that the symptoms were serious or related to their heart problems (Reeder, Ercole, Peek, & Smith, 2015). In other cases, patients report delays in seeking treatment due to "the hassles involved," wanting to try self-care first, denial that the problem is serious, and "not wanting to bother anyone." In most of the evidence-based care transition programs mentioned in this chapter, patient education about "red flags" and when to report an exacerbation of symptoms are important educational elements. Programs often use colored "stoplight" charts to indicate the seriousness of symptom clusters with green, yellow, and red stoplight graphics. This type of patient education can make the difference between a patient seeking treatment promptly and potentially lethal treatment delays.

Another potentially highly traumatic transition to an inpatient hospice facility is, unfortunately, a common last-minute, end-of-life transition (Vig, Starks, Taylor, Hopley, & Fryer-Edwards, 2010).

Medication Reconciliation—A Transition Problem That Spans All Settings

Medication reconciliation, the process of ensuring that the patient is taking all currently prescribed medications correctly, is a universal patient safety problem in care transitions across the continuum of care. An article from the Cleveland Clinic states: "As many as 70% of patients may have an unintentional medication discrepancy at hospital discharge, with many of those discrepancies having potential for harm. Indeed, during the first few weeks after discharge, 50% of patients have a clinically important medication error, and 20% experience an adverse event, most commonly an adverse drug event" (Sponsler, Neal, & Kripalani, 2015, p. 352). These adverse events occur as a result of multiple complex variables that originate from patients, providers, and systems.

In some cases, the medication reconciliation process simply requires ensuring that prescribed drugs are available to be given to the patient. In other settings, such as in home care, where drugs have been prescribed by multiple providers the health professional must ensure that the current drug list contains no duplicates, contraindicated medications, or drug interactions. Differences in facility drug formularies may create problems by creating inconsistency in the drugs that patients receive in different settings. In the home setting, patients often have medications that were prescribed before the inpatient stay. If not told specifically to stop taking them, they may just add the old medications to the newly prescribed ones. Another problem is driven by drug costs. In home care and primary care settings, patients sometimes refuse to switch to drugs newly prescribed during an inpatient stay because they "paid for the old ones and intend to finish them."

Among the more common care transition problems are getting an accurate account of the medications that were actually prescribed at the previous step in care from referral documents or facility EMRs. Patients' inability to self-manage medications is another huge problem in transitions from inpatient care to home.

Some techniques that have proved useful to prevent medication reconciliation problems are:

- The involvement of a pharmacist in post-discharge medication reconciliation phone calls
- The use of EMR software that evaluates medication lists for duplicate or contraindicated drugs and potential drug interactions
- Patient education about medications and supporting patients to create and maintain a current medication list

- Encouraging patients to bring all their current medications to medical visits for review
- Ensuring that recently discharged patients are seen by their primary care physician within 7 days of discharge so the primary care physician can evaluate inpatient prescribed drugs and develop a current and effective drug regimen for the patient
- Ensuring that over-the-counter medications (OTCs) are listed on the patient's master drug list
- The use of prepackaged "bubble pack" medications to avoid medication errors
- The use of electronic medication dispensers for patients with cognitive impairment
- Comparing the list of drugs prescribed at discharge with the list of drugs that the patient is currently taking
- Asking patients about financial barriers to filling prescriptions and finding benefits or entitlements that can help (Data from AHRQ, 2012)

Other problematic care transitions are those that occur at the end of life, mental health–related care transitions, and transitions for people with dementia.

ASK YOURSELF

- What types of problem care transitions do your patients experience?
- What causes the problems in these transitions?
- What can be done to alleviate or compensate for these problems?
- Can your organization forge an alliance with other providers to improve the quality of care transitions for patients?

Tuning Up Your Care Transitions

Every healthcare organization has work processes that include patient transitions. Some are internal, such as the transfer of a patient from the hospital emergency room to an inpatient unit. Many others involve movement of the patient from one care setting to the other. Effective internal transfers are essential elements in patient safety since it is at these handoff points that many medical errors occur. Our focus is on transitions that occur when patients move between care settings or from a care setting back to home. A good care transition system in a healthcare organization requires three key elements:

- Goals and measures
- A structure that supports effective transitions
- Transition workflows that are efficient and effective

Building a Structure That Can Achieve Care Transition Goals

To achieve care transition goals, health organizations must pay serious attention to the structures and processes that support transition outcomes. Care transition structural elements include:

- Senior management oversight and attention to care transition processes
- Functions and roles that manage care transitions
- Resources and time allocated to care transitions
- Policies and procedures that support effective care transitions
- Computer information systems and other tools for care transitions communication
- Forms and patient education materials that foster effective care transitions
- Negotiated relationships, expectations, and contracts with other providers who send patients to the facility or agency

FIGURE 3-3 uses a fishbone diagram to detail the various elements of a care transition program structure.

Assessing Your Care Transition Structure

The effectiveness of your care transitions will be strongly influenced by how well your transition structure is built and maintained.

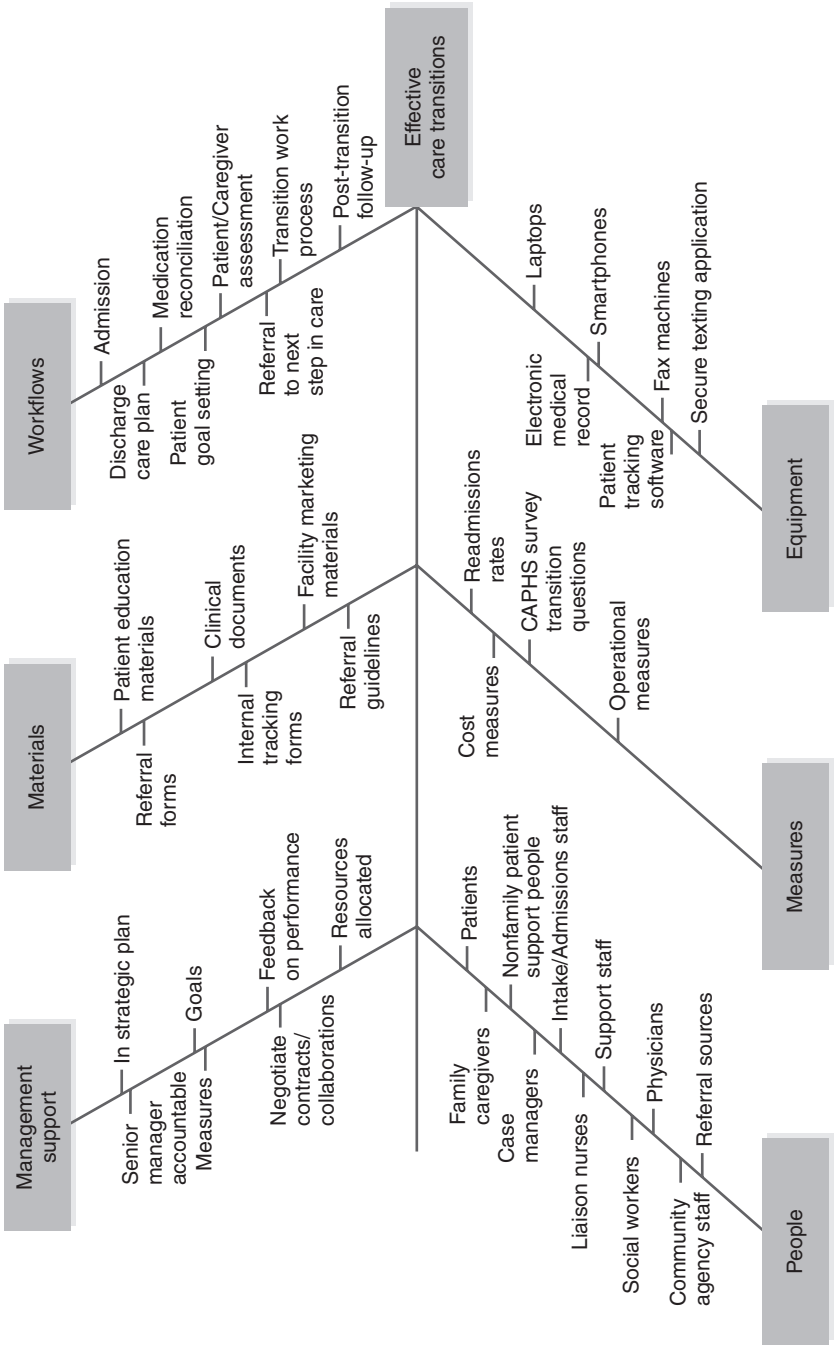

FIGURE 3-3 Fishbone Diagram—Elements of an Effective Care Transitions Program

ASK YOURSELF

After looking at the fishbone diagram:

- How many essential structural elements does your transition program have?
- Does senior management give transition programs the support they need?
- How many elements are missing or ineffective?
- Are you clear about transitions goals and measures?
- How many of these missing elements are you in a position to control?

If you can control elements of the care transitions process, it may be time to create an improvement team and an action plan. If accountability for the missing elements (such as goals, measures, and adequate resources) lies at the senior management level, it may be necessary to assemble data about the problem, list the organizational and clinical benefits of effective care, and propose alternative solutions.

Using a Quality Framework to Analyze and Improve Care Transitions

Quality improvement principles and tools can be particularly helpful in improving care transition processes. The Institute of Medicine defines health care quality as "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (AHRQ, 2017). Quality improvement efforts focus on achieving better outcomes through improving work process efficiency and effectiveness.

Care transitions are ideal targets for quality improvement efforts because they so often involve complex, multistep work processes with multiple handoffs and a variety of communication elements. In care transitions "the devil is most definitely in the details."

Processes with this level of complexity cannot be improved just by talking about them. Improvement typically requires a formal meeting between all members of the care team—those departments or organizations that send patients and those that receive patients in the course of the transition. It is also necessary to use specific quality diagnostic and improvement tools to make the elements of the transition process visible and to identify possible gaps and cracks.

We have already used a fishbone diagram to illustrate the structure of a transition process. We will use two new quality tools to analyze and improve a transition process: flowcharting and a SIPOC (supplier input process output customer) chart. A flowchart is an illustration of the work tasks, information, handoffs, and computer entries that are linked together to produce a product or service in a work process. The AHRQ Health Information Technology website (AHRQ, 2017) offers detailed instructions for flowcharting and examples of healthcare process flowcharts. In its simplest form, flowcharting involves assembling a group of people who do the work, drawing the steps of the process in sequence, and then putting in directional arrows (Mind Tools, 2018).

Once the flowchart is complete, the team reviews the steps of the process and looks for missing pieces; problems at handoff points between individual employees, patients, and departments; redundant actions; unclear decision points; and excessive variation. It is very important to use the discipline of actually creating a paper picture of the workflow through flowcharting. Most participants in flowcharting exercises are amazed at what they learn about their own work when they see it made visible. Variation is a subtle but very important process problem. When everyone who performs parts of a process "does their own thing" in the way the work is performed, results are typically poorer because some methods are more effective than others. For example, if an admissions or intake department in a SNF or a home care agency has multiple people processing admissions, some people will inevitably perform more efficiently and effectively.

The key is to determine what the "best practice" in managing the transition should look like. An important outcome of a flowcharting process should be to create a draft "common process" for performing the transition process and testing to see if it works to produce better results.

FIGURE 3-4 provides simple instructions for creating a flowchart.

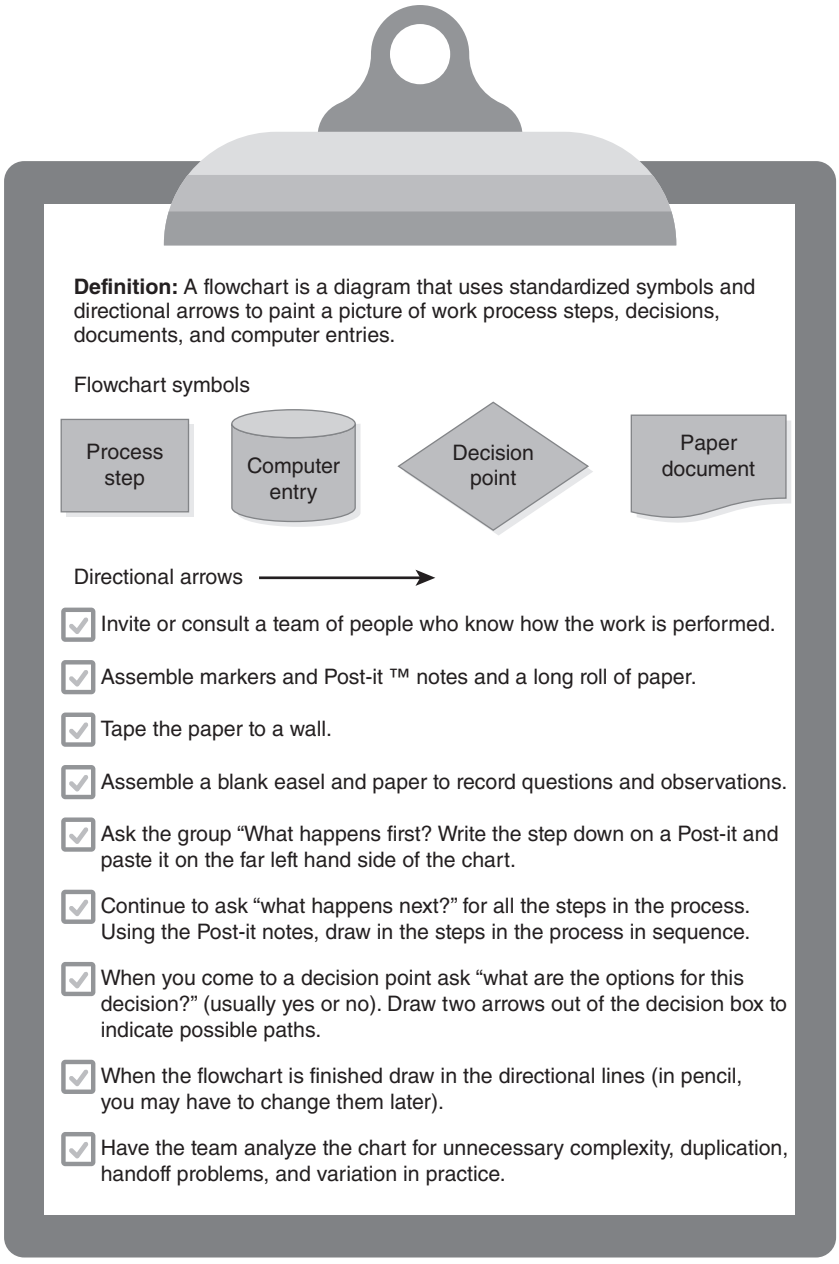

FIGURE 3-4 Flowcharting Instructions

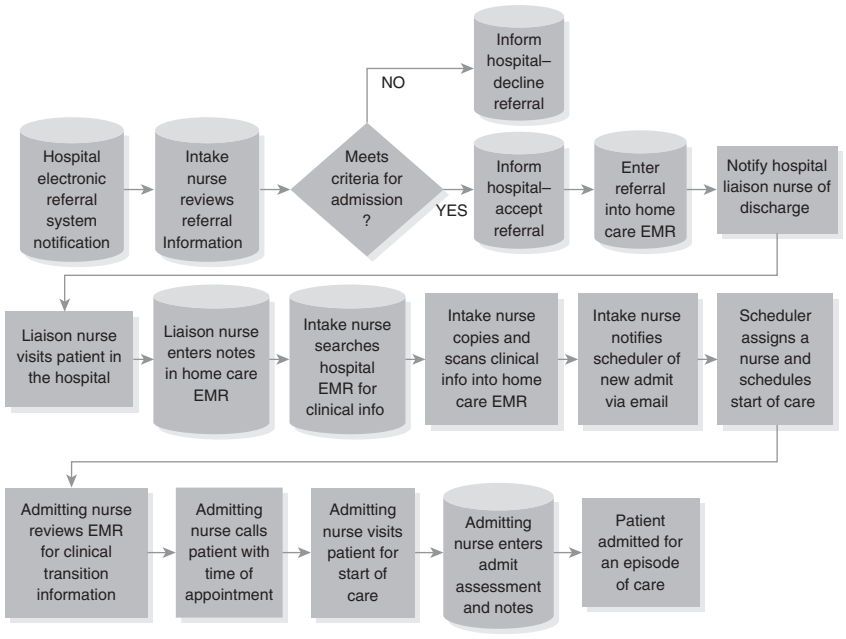

FIGURE 3-5 A Hospital to Home Health Care Transition

FIGURE 3-5 gives an example of a hospital to home care transition process workflow.

A SIPOC chart is a tool for dissecting the essential elements of a work process. This chart is used in the Six Sigma type of quality improvement projects (that seek to improve results by reducing variation) to dissect and analyze the elements of a work process, to map relationships, and to determine which resources are required and which are missing (Simon, 2018) (**TABLE 3-2**). By combining a SIPOC chart with a flowchart, members of an improvement team can visualize the key elements of a care transition process and can begin to identify what is missing and where things go wrong.

TABLE 3-2 Essential Elements of a Work Process—SIPOC Chart Definitions

Quality Term	Definition	Care Transition Example
Input	Information, tools, materials, and resources we need to do our job.	Computer programs patient information, transition guidelines, insurance authorizations, measures, forms, resource guides, etc. that are needed for care transitions.
Supplier	The people, department, or organization that provides us with the inputs we need to do our work.	Agencies or departments that refer patients to us for care. The people within the organization who do work that contributes to the care transition process.

Quality Term	Definition	Care Transition Example
Process	Linked activities that produce a product or service for a customer.	The steps in the transition process from patient assessment to checking on the results of the transition.
Customer	The people, departments, or organizations that use, regulate, or pay for the work outputs that we produce. The patient is the primary customer. Regulators, insurers, case managers, and other professionals are secondary customers.	Patients, families, insurance companies, regulatory agencies, organizations that receive patients from us.
Output	The end product or service that the customer receives and that is produced by our work processes.	The patient and his or her clinical information has been transitioned to the next step in care.
Requirements	The way the customer expects the product or service to look, feel, behave; standards for measures.	The patient and family expect a smooth transition with nothing "falling through the cracks." The next step in care expects accurate clinical information, specific requests for services, and information about the "patient's story." Regulatory agencies expect outcomes like limited readmissions.

Data from ASQ (American Society for Quality) quality glossary. https://asq.org/quality-resources/quality-glossary/o, accessed Jan 27, 2017; Baldridge Glossary, 2017.

FIGURE 3-6 shows a combined SIPOC chart and flowchart.

Here is how a SNF/home team might analyze the SIPOC chart and flowchart in Figure 3-6:

- The nursing home gets an electronic record from the patient's hospital stay when the patient is admitted to the facility. Unless we in the home care agency ask them to send us a discharge summary we won't have that information for our start of care.
- During the patient discharge planning meeting, if the patient and family are not involved, the care plan may not be realistic or reflect patient goals and needs.
- When the discharge plan is developed, if the social worker does not understand the capabilities and limitations of home care, he or she may assume that care at home will be safe when it is not or may plan a premature discharge.

Looking at the flowchart and SIPOC chart, see if you can identify other potential care transitions problems.

ASK YOURSELF

- Would flowcharting or a SIPOC chart help my organization improve care transitions?
- If the answer is yes, try these tools and use the insights to improve your transition processes.

Suppliers	Inputs	Processes	Customer	Output
Discharge social worker Director of nursing Floor nurse Therapists (physical, occupational)	• Hospital discharge record (before patient was admitted to SNF) • Patient assessment • Family caregiver capability assessment • SNF care plan • Clinical notes from team members • Results of care team meetings with family • Patient discharge medication list • Referral form with medical history and services requested	• SNF assessment and care planning • Care delivery while patient is in the facility • Discharge planning meetings • Home care clinical liaison onsite visit and predischarge evaluation • Prepare discharge documents and patient instructions • Patient discharge instruction • Patient transported home • Patient and family at home for 24 hours • Home care start of care second day after discharge • Phone call from SNF to assess status of patient transition • Home care orders sent from primary care physician	• Patient • Family • Home care clinical liaison nurse • Home care admission nurse • Home care intake dept • Insurer • Primary care doctor • Case manager, if any • Pharmacy • Durable medical equipment company	Patient and family given discharge instructions Home care agency decision to accept patient Patient and family understand home care services Home care agency receives clinical information from the SNF Home care agency receives initial orders for services from SNF Patient prescriptions sent, DME orders, follow-up appointments in place

FIGURE 3-6 SIPOC/Flowchart of a Skilled Nursing Facility (SNF) to Home Care Transition

Here is a hint for looking at care transition flowcharts: Problems and gaps usually occur in the handoffs between individuals, disciplines, departments, and organizations. When results are poor, look in the "white space" between parts of the process. The tips and techniques that follow provide some potential solutions to transition workflow problems.

Tips and Techniques for Better Care Transitions

- Analyze the types of care transitions that your organization manages and that your patients experience in other settings.
- Identify high-risk gaps and cracks in your care transition workflow. Where might patients become confused or where could follow-up tests "fall through the cracks?" For example, home care agencies do not admit patients until 24 hours after inpatient discharge. During this period patients are still theoretically under the care of the discharging institution but have not yet seen a new clinician.
- Use data to identify care transition results and opportunities for improvement. If your organization has a patient tracking system or participates in one, find out where your patients are going. If you are getting "problem" referrals from some sources, explore the process, have a discussion with the "sending" providers, and try to improve the process.
- List your key suppliers (places and people that send you patients) and your key customers (places and people that receive your patients). List their key requirements. If you don't know their requirements go to the next bullet.
- Have a customer/supplier conversation and negotiation with your referral sources and the providers who typically receive patients from your setting. Discuss roles, responsibilities, information needs, and accountabilities. Find out more about the capabilities and admission criteria for other healthcare organizations that you work with. Obtain brochures, marketing materials, and capabilities lists from your referral partners. When possible formulate written agreements or at least exchange emails that clarify roles and responsibilities.
- Develop a robust network of relationships. Organizations that have a marketing/community outreach function often develop relationships with other organizations that can be leveraged to improve care transitions. When members of the sales team attend networking functions or make sales calls, they often get to know discharge planners and clinical staff. These relationships can be very useful in negotiating workflows or resolving transition problems. In integrated delivery systems, preferred provider partners often work together in a formal way to develop joint workflows, participate in case conferences, and perform patient tracking and outcomes monitoring. These close working relationships typically result in better transition outcomes and fewer readmits.
- Visit other care settings that send or receive patients from your facility or organization. If you are in an SNF then go on a home visit with a home care nurse case manager. If you are in home care then tour an SNF and talk to the nurses and discharge planners. If you are in a hospital or medical office then visit an SNF, home care, or assisted living facility. Go with a visiting nurse on a home visit. This can be an eye-opening experience for inpatient clinicians who don't really know what happens to patients when they go home (e.g., all prescribed medications dumped into a single bowl, a Hoyer lift that is used only as a swing by grandchildren, no hospital or other healthcare organization literature or phone numbers to be found anywhere in the home).
- Talk to clinical staff who perform formal care transition functions. Ask them what obstacles they see, what questions patients ask, and where they see potential transition failures.
- Interview patients and their families about their care transition experiences. Focus on

what it was like when they entered your care setting and what happened when you transferred them to the next step in care.
- Improve written and electronic communication using templates, standardized forms, and communication tools. Using a standardized template in your medical record helps everyone understand what has occurred during a patient transition. Templates should include a checklist of standardized items such as medications, transportation, food, follow-up medical care, and knowledge of red flags.
- Ask someone from outside your organization to read your discharge or patient transition instructions and identify inconsistencies, unclear communications, and things they don't understand.
- Learn from the best. Call or visit providers who have care transition best practices in place. Learn about problems they have solved, obstacles they have overcome, and tools they have successfully used. Consider adopting an evidence-based care transition program.
- Develop community resource lists for patients and staff. With shorter stays, patients and families are left to their own devices to find resources after care ends. Make it easier for them and for your staff with good information about services that may be available.

When Things Go Wrong—Why Care Transitions Fail

Poor care transitions can take a terrible toll in human suffering and in wasteful expenditures. Care transition failures are a problem with multiple root causes. Laurie Page, DPT, a clinician, educator, and consulting physical therapist, describes some of the factors that contribute to care transitions and connection failures:

- I find many clinicians working in one setting (hospital, SNF) have a disconnect with the reality of patients' safety in a non-clinic setting (i.e. standard use of wall grab bars for transfers in bathrooms in hospitals and SNFs).
- Patients (and their families /caregivers) would benefit from a case manager who crosses settings including the home to improve safety and reduce unnecessary rehospitalizations. Even a true case manager within settings would help.
- Many different staff instruct in many different ways in part due to their own experiences and knowledge base. (This is very confusing to patients.)
- I still see/hear/read documentation that is single discipline specific. Productivity demands, a linear hierarchy amongst disciplines, which creates barriers to true 'INTERDISCIPLINARY' care where we all respect and learn from each other." (Laurie Page, PT, DPT, 2016, personal communication)

ASK YOURSELF

- Do you really know what goes on in settings other than your own? How does your knowledge or lack of it affect the way you plan patient care transitions?
- Who is coordinating care across the continuum for your patients—the primary care physician, a case manager, the family, or nobody? If nobody, how can you help the patient achieve a safe transition?
- Are you communicating with your colleagues about how you each educate patients?
- Is your patient education consistent? Could you do more to collaborate with your colleagues on key education points, terminology, and materials to reduce patient confusion?
- Is the care you are delivering truly interdisciplinary? Are all disciplines represented in discharge planning?

Root Causes of Transition Failures

Any process that involves multiple organizations, multiple disciplines, competing expectations, and incentives is fraught with potential for failure points (Greiner, 2017). Some of the most common causes of imperfect care transitions are discussed next.

Lack of Communication or Miscommunication Between Care Providers

Health facility and provider communication is a huge root cause of poor care transition outcomes. The dimensions of this problem include:

- Little to no relevant information is transmitted to the next step in care.
- Mismatch of expectations between sending and receiving clinicians about what information is important to share.
- Lack of a common language. Each provider uses his or her own industry jargon to the confusion of other providers in the transition chain.
- No incentive to share information—the discharging provider is unaware of the next step in care or sees no reason to share information.
- Lack of standardized information checklists for postdischarge communication.

Faulty clinical data exchange between providers is one of the key reasons that transitions fail. In most cases these disconnects are honest misunderstandings of what the next step in care needs. In rare instances the communication disconnect is conscious: "If I tell the truth about this patient's insurance gaps, lack of caregiver support or functional deficits, I may not be able to get, them discharged." Situations like these require immediate conversation and issue resolution to ensure that safe care is provided to patients. **FIGURE 3-7** illustrates the difference between flowing and "throw it over the wall," care transitions.

Failure to Identify and Engage Family Caregivers

Most of the literature on care transitions addresses the engagement and education of each specific patient. Much less attention has been paid to the role of the family caregiver. In reality, successful discharges to home or between settings for seriously ill patients are often dependent on the existence and willingness of a dedicated family caregiver or other support person.

The few existing studies indicate that family caregivers often feel ignored or left out of communications and education for and about the family member they are caring for. While the healthcare system expects family caregivers to take responsibility for complex medical tasks

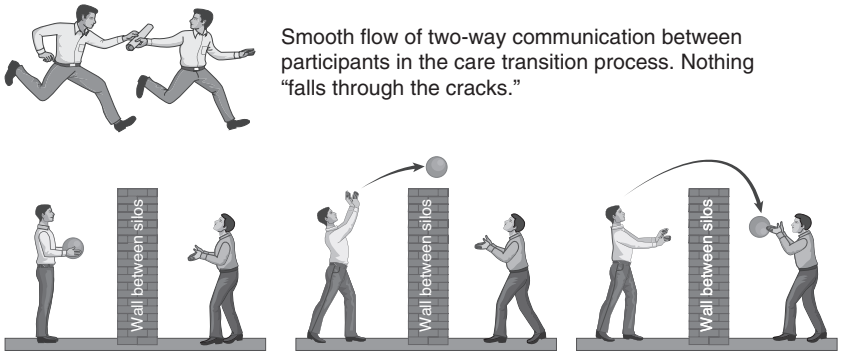

FIGURE 3-7 Care Transitions—Connected and Flowing or "Throw It Over the Wall"

and care coordination after discharge they typically don't receive the type of in-depth education necessary to manage these tasks (Reinhard, Levine, & Samis, 2012).

Another complicated aspect of family caregiver support is determining the roles of various family caregivers. While there is often one "lead" caregiver, other family caregivers may take responsibility for various aspects of care such as finance and insurance management and household maintenance. Without a purposeful conversation with family members, health professionals may not identify the caregiver whose role it is to manage care transitions and may mistakenly give information to the wrong person.

Another problem is the lack of availability of family caregivers to attend key patient-related meetings or to be present at discharge due to other work or family obligations. For long-distance caregivers who live away from their loved one, this lack of availability can become a real barrier to good care planning.

Eric Coleman, the architect of the *Care Transitions Intervention*, described the positive impact of an enhancement to the CTI model that better incorporated the concerns of the family caregiver into transitional care. These enhancements included simulations and role-playing communication with health professionals, enhanced caregiver medication management education, and phone call follow-up specifically with the caregiver (Coleman, Roman, Halt, & Min, 2015). Even when present in the patient's life, a caregiver may not always agree with the recommendations of health professionals involved in the patient's care.

Disputes over what services are actually needed, the best place for the next step in care, the type of care that will be provided, who will be responsible for what aspects of care coordination, and how to pay for care can all be areas for conflict. A common example of this is a recommendation for 24-hour care in the home after discharge from an SNF or home health care. Health professionals, in pursuit of a "safe discharge," will often insist on this requirement for functionally disabled patients. Families who may not have the means or the willingness to pay for such services will often either dispute the need or agree and simply not arrange for the service.

Lack of an Adequate Caregiver Support System

Of even more concern than fragmentary communication to caregivers is the lack of an adequate caregiving support system for seriously ill patients.

A Harris Poll survey of 1,000 seniors commissioned by CareMore (Caffrey, 2016) found that a third of chronically ill elderly patients stated that no one coordinated their medical care. For many nurse care coordinators, this lack of caregiving support creates a nightmare scenario for effective care transition planning. Elderly patients, especially those with mild to moderate dementia, who live alone or with an inadequate or disengaged caregiver, are at the greatest risk. Another area of high concern is a caregiver who is mentally ill, physically ill, a substance abuser, or neglecting or abusing the patient unbeknownst to the care team. Situations like these usually require intensive effort, creativity, strong knowledge of community benefits and resources, and the expertise of a cross-functional team of experts, usually including an experienced nurse care coordinator, social workers, and therapy clinicians.

Preexisting relationships with community benefit programs and agencies can make these difficult cases much easier to manage. A good example is the Interagency Council developed by an Agency on Aging in one community. This group which includes local nonprofits, community geriatric care managers, home healthcare agencies, SNFs, and hospital care managers meets bimonthly for networking and informational sessions. On months when there is no educational meeting the group holds "M" team meetings during which members bring difficult

cases for discussion and get advice and support from other members.

Lack of Knowledge or Misperceptions About the Next Setting in Care

Health professionals must educate themselves about the organizations and professionals in their continuum of care—learning what these organizations do, what their capabilities are, what requirements they must meet, and what they need from the step in care before theirs.

For example, if you work in a hospital, do you know whether your patient meets the requirements for admission to an SNF, what care looks like in that setting, or what information the staff in the SNF need from you? Sometimes there is simply a failure of knowledge and imagination on the part of the sending clinician.

For example, a young, white physician or nurse from a middle-class family may have no idea of the types of problems and obstacles that an older black woman faces who has little caregiving support, is being discharged to subsidized housing, and has limited financial means for transportation, purchasing medications, and obtaining food. Clinicians who have never made a home visit or never visited an SNF may have no idea of the types of patient care capabilities and limitations that exist in these settings. As one admission liaison for an SNF commented, "Some of the residents in the hospital think that a nursing home is just like a hospital with multiple RNs available around the clock to do all the things that hospital nurses do. It isn't like that and some of the things they expect us to do after discharge aren't reasonable."

Patient Resistance to Discharge Plans

Like family caregivers, patients may not always agree with discharge plans. Many patients who have been acutely ill see a discharge as a "get out of jail free card" that enables them to escape the discomfort of the inpatient facility and return to a familiar home setting where they assume that things will go along much as they always have. These patients may not be aware of the impact of the hospitalization on their functional abilities, especially if they have some degree of dementia, have had delirium, or are simply still feeling the effects of surgical anesthesia.

A well-educated, 79-year-old man insisted on going home despite recommendations for an SNF stay because, as he put it, "I am feeling much better and I know that I will do better in my own environment." Unfortunately, his prediction was not correct and he fell at home soon after discharge and had to be readmitted.

In other circumstances, patients may refuse home health care for privacy reasons ("I don't want anybody in my house,") or because they are concerned that the home health nurse may consider the home environment unsafe and "put me in a nursing home." People with hoarding issues frequently fall into this category.

Cost is often a factor in patient and family decisions to disagree with health professional recommended discharges. While professionals may see a clear need for a short respite stay in assisted care or good reasons to hire live-in help for a period of time, patients and families who cannot afford to pay will dispute the recommendation or simply not follow it.

While patients have a clear right to follow their discharge preferences in these circumstances, and in many cases actually have no choice, these are precarious transitions that all too often end in a readmission.

Rushed Discharge Planning

When the focus is on productivity and shortening inpatient stays and not on effectiveness, discharge planning can be hurried and fragmented, leaving loose ends for both patients and providers who will care for the patient after discharge.

This is especially true in facilities that do not value effective care transitions and simply add the responsibility onto the work of an already harried clinician.

Lack of an Accountable Clinician to Oversee the Handoff of Care

This is one of the most common care transition failures, especially in settings that have an "assembly line" mentality about care and assume that once the patient leaves their setting, their care is no longer the responsibility of the sending clinician. Typically, attention is more focused on patients being admitted or coming into the setting than leaving it. All the evidence-based programs described in this chapter have a specific mechanism for closing this gap in care by having a clinician call or sending a clinician or patient advocate to visit the patient after he or she leaves the care setting to ensure that the patient is doing well or to identify problems. Families and patients experience a high level of distress when they are caught in the "white space" between two organizations without a clear idea of who to call for information or help.

Cultural Competence Barriers

Complex care transitions require clear communication to all parties involved. When language barriers and cultural misunderstandings occur, transitions can become problematic. For example, caring for a frail elder at home may be a strong value in a particular culture. A care manager's insistence on a nursing home stay for a frail elder after a hospital admission might be seen by the family as a way of questioning the family's caregiving capabilities.

Language barriers and assumptions about patient and family perceptions can create nightmare transition situations. Issues of sexual orientation and gender identity can also complicate care transition efforts if they are not properly understood by clinical staff.

CASE STUDY

Anna told the story of her mother's impending, and almost disastrous, hospital discharge. Her mother, whose native language is Spanish, had had a stroke and needed total care. She was aphasic, but could understand spoken Spanish. The family was caring for her at home and had been involved in her care, but the nurses who were coordinating her care did not seem to understand the family role. They communicated only to the patient through an interpreter. Although the patient understood what was being said, she couldn't respond. The nursing staff made arrangements for the patient to be transferred "to a facility" by ambulance, not knowing that the facility was the family home. The patient's family members were at work on the planned discharge day, so if the discharge had gone as planned. no one would have been at home to receive their mother when the ambulance arrived. Luckily, one of the patient's daughters called the hospital and was able to work with the hospital nurses on an appropriate discharge plan. The family was angered by this experience, and 5 years after their mother's death, they were still telling this story.

Patient Education Failures

Patients must leave a care setting knowing what to expect at the next stop in the care continuum and, if they are going home, how to self-manage. All too often, patient education consists of handing out a checklist or brochure and a hurried review of the items on it, without any attempt to verify patient or family understanding.

Because patients in inpatient settings are often stressed, not feeling well, and anxious to get home, patient teaching at discharge is not the ideal "teachable moment."

Teaching in this situation seldom includes "teach back" or a "return demonstration" in which the patient or family member demonstrates that he or she understands the instructions that have

been given and can perform necessary self-care tasks at home.

A good example of this is outpatient cataract surgery. After surgery, patients are expected to receive several types of eye drops multiple times per day. Administering eye drops correctly actually involves a relatively high degree of manual dexterity, which many patients lack. Few facilities demonstrate the procedure and then watch the patient demonstrate proper administration. Managing the complex schedule of multiple drops requires organizational skills as well, a fact that should be checked through "teach back" by asking the caregiver or family to explain exactly how and when they plan to administer the drops. In a rushed environment, it is seldom easy to have the facility nurse incorporate this type of patient education into his or her daily routine, but doing so avoids unnecessary call backs and adverse events.

Chapter Summary

Effective care transitions are an essential element in connected care. Readmissions and patient safety failures are serious consequences of poor transitions. Nurses play a key role in care transitions as care coordinators and case managers. Key measures for care transitions are 30-day readmission rates, medication reconciliation measures, costs of transitions, and CAHPS questions about patient care transition experiences. New cross-organizational measures are an integral part of the 2014 IMPACT Act implementation. There are many evidence-based best practices in care transitions, primarily for patient transitions from acute care to home.

Essential best practices for all settings include accountability across handoff points, verifying that information sent was received and understood, planing for primary care medical follow-up, completing all postdischarge follow-up tasks, and proving patient self-management support. Good transitions require an understanding of and communication with the next step in care. Technology plays a key role in communications through medical records interoperability, electronic patient tracking, and in some cases interactive voice response systems post discharge. There are significant gaps and challenges in care transitions, including insurance gaps, medication reconciliation, observation status, end-of-life transitions, and mental health–related patient discharge issues. Readers can use the tools and techniques of quality improvement including flowcharts and SIPOC charts to identify and eliminate flaws in care transitions processes.

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