Standardized Care Transition Practices

Overarching Goal

To standardize an evidence-based process that will support timely, safe, appropriate and person-focused care transitions for patients who would benefit from coordinated care management.

What is coordinated care management?

Coordinated care management is an inter-professional, cross-sectorial approach (health and social) to the planning and coordination of care and services focused on the patient's goals. Using this approach, one provider takes on the lead role for care coordination including the development of a coordinated care plan. The goals of a coordinated care plan are to improve the patient's quality of life and to provide more effective and cost efficient care by identifying and carrying out clear roles and responsibilities for care team members built around the patient's identified priorities. Using warm handoffs at care transition points is a key component to providing coordinated care management.

Coordinated care management involves a standardized care process including:

- Real time identification
- Invitation and interview
- Initiation of a coordinated care plan
- Care conference and implementation of actions
- Care transition processes
- Ongoing management

What is a Care Transition?

A care transition is the transfer of a patient between different settings and health care providers during the course of an acute or chronic illness. *Transitions of Care – Health Quality Ontario- Best Path Recommendations – Refer to HQO Transition points Best Path document 3.2.*

A Care Transition may occur during:

- A referral from a person's family physician to a specialist
- Admission into a hospital
- Transfer between departments within a hospital
- Transfer of care between care providers
- Discharge from the Emergency Department or hospital
- Admission to a Long-Term Care facility from the person's home

Problems identified with incomplete and/or poorly coordinated care transitions includes such things as patient safety problems and poor patient experience. The most frequent outcomes of poor care transitions include:

- Patients returning to the hospital due to unclear or incomplete discharge plans and instructions
- Patients receiving follow-up plans and directions from multiple providers causing confusion
- Complications resulting from medication errors such as dangerous drug interactions, duplications or inability to get a prescription filled.

Recommended Steps to Ensure Seamless Transitions

Establish a standardized process to ensure the safe and effective coordination and continuity of care as patients experience a change in health status, care needs, health-care providers or location within, between or across settings. *RNAO Best Practice Guidelines, Care Transitions, March 2014.*

Suggested practices include the following:

- Implement a standard assessment/screening tool.
- Involve the patient and their caregivers throughout the transition planning process.
- Confirm understanding of information shared with patients and caregivers using "Teach Back" – a proven method to ensure patients understand the information shared by asking them to "teach back" or explain the information with their provider.
- Initiate a coordinated care plan that clearly explains the patient's specific issues, wishes, discharge plan and related actions.
- Establish practices to embed best possible medication reconciliation at points of care transition.
- Create collaborative care team partnerships through the development and implementation of robust communication practices inclusive of care conferences at key points of transition for patients to provide timely, safe, appropriate and person-centered care for the patient throughout their healthcare journey.

"A good discharge plan improves patient satisfaction and prevents readmissions." – Agency for Health Care Research & Quality

http://www.hqontario.ca/Portals/0/documents/qi/health-links/bp-improve-package-transitions-en.pdf
https://rnao.ca/bpg/guidelines/care-transitions

Adopted from North East LHIN