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CS 2012 ISSUE 3

Transitioning Residents: Reduce Hospital Readmissions by Improving Information Flow, Standardizing Procedures

Hospitalization is a routine occurrence for many aging services residents with complex and chronic illnesses. According to a retrospective study of 12 million fee-for-service Medicare beneficiaries who were discharged from a hospital, 20 percent were readmitted within 30 days, 34 percent within 90 days and 54 percent within a year.[1] Although discharges from an inpatient setting to a skilled nursing facility or assisted living community are frequent, they are not always simple, and a less than sound transition process can have a wide range of adverse consequences. These include unmet resident care needs, medication errors, resident confusion, conflict with families and avoidable rehospitalizations.

To protect residents, aging care providers must collaborate with their acute care partners and treat transitions as potentially risky, resident-centered events, rather than routine tasks. This edition of *CareFully Speaking*® presents four interventions designed to facilitate information exchange, which is fundamental to a safe and efficient resident transition. Consistent utilization of transition coordinators, standard care guidelines, transfer protocols and medication reconciliation tools can enhance communication and care planning, while reducing unnecessary readmissions, resident injury and consequent liability exposure.

I. COORDINATE DISCHARGE REPORTING

Hospital discharge summaries often fail to include information necessary for safe after-care, such as discharge medications, follow-up plans, pending diagnostic tests and even primary diagnoses. Thus, over-reliance on summaries can lead to serious lapses in transitional care. To enhance the transfer process and ensure that critical information is shared and documented, many aging services organizations now utilize specialized transition coordinators.

Coordinators are responsible for initiating the transition process well in advance of the resident's discharge from the hospital setting, minimizing the likelihood that relevant information will be overlooked. Advanced practice or geriatric nurses are generally the preferred choice to serve as transition coordinators.

1 See "Creative Interventions Reduce Hospital Readmissions for Medicare Beneficiaries," prepared by California Health Advocates, October 7, 2010. Available at **http://www.cahealthadvocates.org/news/basics/2010/creative.html**.

During their hospital pre-discharge visits, transition coordinators review patient care records and consult with treatment teams in order to secure vital patient data, including

- reason(s) for hospitalization
- primary and secondary diagnoses
- key diagnostic findings and test results
- consultant recommendations
- pending consultations, labs or tests, as well as arrangements for reporting results
- assessment of functional and cognitive condition at discharge
- primary language, educational level and degree of medical understanding
- discharge medications and long-term medication needs
- follow-up appointments needed and scheduled
- anticipated problems, if any, and appropriate responses
- contact numbers for hospital personnel
- resuscitation status and advance directives documentation

Pre-discharge visits by transition coordinators afford an opportunity for face-to-face communication with hospitalized residents and families, encouraging their active participation in the transition process. Knowledge gained through on-site interactions may additionally be used to personalize hospital care summaries, to the mutual benefit of aging services providers, residents and families.

II. ADOPT EVIDENCE-BASED MODELS

Standardized, evidence-based care models and guidelines can help reduce hospital readmissions by encouraging all parties to evaluate their transition policies, enhance procedures and clarify clinicians' roles. Available from a variety of sources, these tools offer tested protocols for each phase of the transfer process, focusing on such key strategies as electronic information exchange, shared discharge planning and medication reconciliation. The following programs and models are among the more widely used sources of transitional care guidelines and best practices:

- Best Practice Intervention Package (BPIP): Transitional Care and Coaching models, available to registered participants at **http://www.homehealthquality.org/Education/BPIPS.aspx** (Scroll down to "Cross Settings I BPIP.")
- BOOSTing (Better Outcomes by Optimizing Safe Transitions) Care Transitions from the Society of Hospital Medicine, at **http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm**
- The Care Transitions Program®, at **http://www.caretransitions.org/**
- INTERACT II (Interventions to Reduce Acute Care Transfers), at **http://interact2.net/**
- Transitional Care Model, at **http://www.transitionalcare.info/index.html**

III. DEVELOP HANDOFF PROTOCOLS

Close collaboration between hospitals and aging care facilities is especially critical during the physical transfer of an individual from an inpatient to a residential setting. Written handoff protocols ensure that roles and responsibilities are clearly defined and assigned, thereby safeguarding residents and preventing loss of key health information during transfer.

Safe handoffs require active communication between caregivers at each location starting at least 24 hours prior to transfer, especially for residents who are frail or not fully capable of expressing their needs. Off-hour transfers should be prohibited if they would result in a less than optimal staff-to-resident ratio, or the involvement of potentially less informed hospital or aging services personnel. Handoff agreements also should dictate that hospital discharge planners be readily available to address questions or concerns before, during and immediately after transfers.

For a checklist of the basic elements of an effective resident handoff protocol, see "Planning the Transition from Hospital to Aging Services Setting" on pages 3-5.

IV. RECONCILE MEDICATION STATUS

Lack of access to hospital-based medical records, drug ordering systems, formularies or pharmacies heightens the risk of medication-related discrepancies between hospital discharge summaries, residential referral forms and admission orders. Incorrect dosing or abrupt discontinuation of medications – especially opioid analgesics, anticoagulants, hypoglycemic agents and other high-risk medications – may result in serious injury and/or treatment setbacks for newly transitioned residents.

Discrepancies can be avoided through the standard practice of medication reconciliation, whereby a multidisciplinary team – comprising nursing, pharmacy and medical representatives – compares discharge medications with the pre-hospitalization medication administration record. (When patients have been admitted to the hospital from their home, rather than an aging services setting, the discharge medications list should be checked against their personal record of prescribed drugs.) If a group reconciliation process is impractical due to staffing levels, registered nurses and licensed practical nurses can be assigned responsibility for reconciling

medication orders and communicating changes or omissions to the resident's practitioner of record. Medication review should encompass not only prescription drugs, but also over-the-counter products, vitamin supplements, herbal compounds and other alternative remedies. The sample medication reconciliation form on pages 6-7 is designed to capture discrepancies that could precipitate drug interactions and other adverse drug-related events.

Drug list discrepancies also can be detected and addressed using the Medication Discrepancy Tool (MDT®).[2] This complimentary resource is designed to help providers capture a wide range of transition-related medication problems and initiate an intervention before residents experience harm. It may be accessed at **http://www.caretransitions.org/mdt_main.asp**.

2 The Medication Discrepancy Tool is made available by the Care Transitions Program, based in the Division of Health Care Policy and Research at the University of Colorado Denver School of Medicine.

Careful transitional planning is the key to maximizing the benefits of hospital treatment while significantly minimizing risks. By collaborating closely with hospitals, enhancing handoff procedures and adopting a team approach to medication reconciliation, aging services organizations can reduce unnecessary hospital readmissions and protect residents at a vulnerable point on the care continuum. To learn more about resident transitioning, and to access additional sample forms and tools, see *Transitions of Care in the Long-Term Care Continuum,* a 2010 practice guideline from the American Medical Directors Association. It is available at **http://www.amda.com/tools/clinical/TOCCPG/index.html**.

Planning the Transition from Hospital to Aging Services Setting

	INDICATOR PRESENT (PROVIDE NAME, NUMBER AND DATE IF A WRITTEN POLICY OR PROCEDURE EXISTS FOR THE INDICATOR)	REVISION NEEDED? (YES/NO)	COMMENTS
INTERVENTIONS PRE-TRANSFER			
A. HOSPITAL DISCHARGE PREPARATIONS			
1. *A transition team from the hospital – including a practitioner of record, hospitalist (if applicable), case/care manager, social worker and discharge planner – is assigned* and documented in the patient's health record, along with each team member's contact information.			
2. *A transition coordinator from the aging services setting is designated,* and contact information is provided to the inpatient team.			
3. *The patient's healthcare information records are reviewed by a transition coordinator* during pre-discharge visits.			
4. *Relevant issues are discussed by the patient/family and transition coordinator,* including diagnosis, the plan for transition to the aging services setting and the importance of patient involvement in the transition process.			
5. *A meeting is scheduled to discuss the patient's pending discharge,* attended by the transition coordinator, case/care manager, social worker and hospital clinicians.			
6. *A summary of the hospital stay is written by the transition coordinator,* to be used for purposes of aging services care planning.			

	INDICATOR PRESENT (PROVIDE NAME, NUMBER AND DATE IF A WRITTEN POLICY OR PROCEDURE EXISTS FOR THE INDICATOR)	REVISION NEEDED? (YES/NO)	COMMENTS
INTERVENTIONS PRE-TRANSFER (CONTINUED)			
B. INFORMATION EXCHANGE			
1. *A protocol is drafted regarding exchange of transitional care information between the hospital and the aging services facility,* in order to ensure shared accountability.			
2. *Patient heath information is transferred electronically whenever possible,* in order to expedite the process and enhance documentation.			
3. *A medication reconciliation process is completed,* documenting any change and/or discrepancy in medication orders from hospital admission through discharge.			
4. *Pending laboratory tests are noted,* and responsibility for follow-up is assigned to a designated staff member.			
5. *Follow-up appointments are documented using an established format,* which includes provider name, date and contact information.			
6. *A discharge planner is assigned,* who ensures that a bed is available in the receiving aging services setting.			
7. *A discharge summary is prepared by the hospital's attending practitioner,* which includes - primary diagnosis - treatments received during the hospital stay - consultations and recommendations - medications list, including last dose and stop dates for new medications - pending test results and follow-up appointments - vital signs - hospital contact name(s) and telephone numbers			
8. *Discharge orders are prepared* and transmitted to the aging services setting during the patient transfer.			
C. TRANSFER PREPARATIONS			
1. *At least 24 hours prior to the planned transfer, a verbal confirmation of the pending move is secured* from a hospital transition coordinator by a discharge planner/social worker/case manager/care manager.			
2. *Family members/caregivers are notified of the pending transfer* by a discharge planner/social worker/case manager/care manager.			
3. *A discharge summary and relevant diagnostic reports are sent by the hospital to the patient's physician(s),* in order to ensure continuity of care.			
4. *An ambulance or other carrier is procured* by the aging services facility to transport the resident.			
5. *Transfer activities and resident status are documented* by ambulance staff/emergency medical technicians.			

	INDICATOR PRESENT (PROVIDE NAME, NUMBER AND DATE IF A WRITTEN POLICY OR PROCEDURE EXISTS FOR THE INDICATOR)	REVISION NEEDED? (YES/NO)	COMMENTS
INTERVENTIONS DURING AND AFTER TRANSFER			
A. INTAKE PROCESS			
1. *A practitioner and/or medical director from the aging services setting is assigned to the resident,* and is prominently identified in the resident's healthcare information record.			
2. *An admissions coordinator is identified* and alerted to the pending transfer.			
3. *The resident is received by a unit nurse,* who also accepts and reviews pertinent transfer documents.			
4. *The transfer is verbally confirmed by a transition coordinator,* who is in contact with a hospital discharge planner.			
B. RECORDS REVIEW			
1. *The discharge summary, medication records and other transfer documents are reviewed by a registered nurse and/or transition coordinator,* who requests additional information, if necessary, from the hospital discharge contact.			
2. *The hospital's medication administration record is reviewed by a multidisciplinary team or nurse,* who completes a medication reconciliation form and documents any previously prescribed medications that are not resumed and/or other discrepancies.			
3. *The attending practitioner and/or medical director is contacted by a registered nurse,* who requests approval of the hospital practitioner orders and relays back to the hospital any previously prescribed medications that were omitted from the discharge orders or other discrepancies in prescribed orders or medications.			
4. *A registered nurse transcribes the practitioner orders* into the resident healthcare information record.			
C. TRANSITIONAL CARE PLANNING			
1. *A case/care manager and/or social worker are alerted to the resident's admission* by the admitting nurse or coordinator.			
2. *Hospital findings, resident health status, care needs and other high-priority topics are reviewed* by the admissions and transition coordinators and the resident/family.			
3. *A resident care plan is compiled by a multidisciplinary team,* which focuses on, among other issues, advance directive status, pending results of laboratory and diagnostic tests, needed follow-up appointments, medications and highlights of the hospital discharge.			

Sample Medication Reconciliation Form

The following format, which can be adapted to suit organizational needs, is designed to facilitate comparison of past and present medication regimes, thus revealing discrepancies and minimizing the possibility of drug interactions and other preventable problems.

Resident name: _____ Record number: _____

Date of birth: _____ Sex: _____

Date of hospitalization: _____ Transferred on: _____

Today's date: _____

ALLERGIES
(INCLUDING FOOD AND MEDICATION) – IF NONE, CHECK HERE ■

ALLERGEN	REACTION
1.	
2.	
3.	

ITEMS ON PRE-HOSPITALIZATION MEDICATION ADMINISTRATION RECORD
(INCLUDING OVER-THE-COUNTER PRODUCTS, NUTRITIONAL SUPPLEMENTS AND HERBAL REMEDIES)

NAME	STRENGTH	DOSAGE	FREQUENCY	ROUTE	LAST DOSE TAKEN
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

CURRENT MEDICATIONS PRESCRIBED (INCLUDING OVER-THE-COUNTER PRODUCTS, NUTRITIONAL SUPPLEMENTS AND HERBAL REMEDIES)					
NAME	STRENGTH	DOSAGE	FREQUENCY	ROUTE	VALIDATION – I.E. SIGNATURE OF PRESCRIBING MD PLUS DATE (YES/NO)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

NEW MEDICATIONS			PREVIOUS MEDICATIONS OMITTED FROM DISCHARGE ORDERS		
NAME	REASON FOR USE	MONITORING PARAMETERS AND STOP DATE	NAME	LAST DOSE TAKEN	PRIMARY MD NOTIFIED (YES/NO)
1.			1.		
2.			2.		
3.			3.		
4.			4.		
5.			5.		

Prepared by: _____

This sample form is for illustrative purposes only. As unique situations may arise and statutes may vary by state, consultation with a retained professional prior to use of this or similar forms is recommended.

RESOURCES

- Agency for Healthcare Research and Quality (AHRQ) Innovations Exchange, at **http://innovations.ahrq.gov/content.aspx?id=2577**
- The Care Transitions Program®, at **http://www.caretransitions.org/**
- National Transitions of Care Coalition (NTOCC), at **http://www.ntocc.org** (See also the NTOCC's 2008 study, "Improving on Transitions of Care: How to Implement and Evaluate a Plan," available at **http://www.ntocc.org/Portals/0/PDF/Resources/ImplementationPlan.pdf**.)

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