Healthcare Transitions

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Objectives

- Explore healthcare transitions, common issues, & connections to person-centered care
- Review healthcare transition practice standards
- Identify strategies for self-advocacy, engagement, & activation in healthcare transitions
- Examine tools and tips for healthcare transition planning and implementation

What is a Healthcare Transition?

- The safe transition between, within, or across care settings or providers that ensures continuity of care
- Care continuity is based on cooperation and collaboration between providers, settings, and the consumer/caregiver
- A safe transition is one that:

  Is without interruption or delays

  Prevents negative outcomes

  Has shared accountability between settings, providers, consumer/caregiver

(McGilton et al., 2021)

Person-Centered Care

Person-Centered Care

- Includes the consumer and caregiver
- Responds to individual preferences, needs, values, and goals of care
- Offers integrated and responsive healthcare
- Empowers the consumer and caregiver to make healthcare plans together

Involves assessment of your educational or training needs related to the transition and includes this in your transitional care plan

Common Issues With Healthcare Transitions

Most issues with care transitions relate to:
Lack of communication between settings
Lack of clear communication with consumer/caregiver
Lack of person-centered care
Lack of education for consumer/caregiver
Lack of teach-back *Asking consumer/caregiver to explain education given in their own words*

What can go Wrong in Healthcare Transitions?

- Medication Errors
- Lack of Follow-Up
- Readmissions
- Emergency Room Visits
- Increased Costs/Resource Use
- Decreased Consumer/Caregiver Satisfaction
- Start of Care Delays
- Poor Outcomes

  Falls

  Injuries

  Infections

(Josephson, 2016)

Have you Experienced Other Issues with Healthcare Transitions Not Mentioned?

Brief Check-In

Healthcare Transition Standards

Healthcare Transition of Care Standards

(Transitions of Care, 2019)

Risk Identification

- *Polypharmacy*
- *Cognitive or Functional Impairment*
- *Frequent Inpatient Admissions or Emergency Room Visits*

Comprehensive Assessment

- *Advanced Care Planning*
- *Instrumental & Activities of Daily Living Needs*
- *Designated Decision-Maker*
- *Ability to Self-Manage Health*

Medication Reconciliation

- *Prescribed and Non-prescribed*
- *Verification of Medications with Consumer/Caregiver*
- *Assessment of Medication Issues (side effects, administration, etc.)*

Healthcare Transition of Care Standards Continued

(Transitions of Care, 2019)

Care Plan

- *Referrals and Consults*
- *Resource Connection*
- *Review of Goals of Care*
- *Care Plan Sharing*

Cross-Setting Communication

- *Essential Transition Information*
- *Medications*
- *Appointments*
- *Follow-up Needed*
- *Timely and Relevant*

Essential Information & Cross-Setting Communication

(AHRQ, 2013;Kind et al., 2012)

- Follow-up appointments, Labs needed, etc.
- Notification of transition to Primary Care Provider
- Any pending results identified with a plan for who is accountable for follow-up
- Medical equipment needed, arrangement plans
- Medication reconciliation, new medications, and changes in medications identified
- Allergies
- Discharge Summary (purpose of visit, treatments or procedures received, results, follow-up appointments, diet, activity level or restrictions, discharge condition, information provided to consumer/caregiver, etc.)
- “Red Flags” & who to contact
- Additional information, such as who the decision-maker is, resource needs, and any follow-up needed for items not completed with the identification of an accountable person

Self-Advocacy & Healthcare Transitions

You Are Your Own Best Advocate

- If you need time to talk to the provider, when making the appointment, let the person know you will need a longer appointment.
- Use the patient portal messaging system and send questions ahead of the appointment.
- Bring the questions you have written down
- Bring another person to the appointment who can take notes

Healthcare Transition Self-Advocacy

Understand	Ask	Choice	Aware	Use	Inform	Keep
What you need for a successful transition of care	Ask questions	Right to choose •You have the right to refuse	Non-verbal & verbal language	Use good listening and communication skills	Become informed about the recommended transition •Why is this the recommendation •How do you access CMS ratings •Visit facilities •Set up a get-to-know-you visit	Keep an open mind & documents •Try to understand a different perspective •Ability to refer back, ask further questions, and clarify when you have time to internalize information given

(Medical Home Portal, 2020)

How to be Activated and Engaged

Have
- Have access to health summaries (electronic in portal or copy)

Keep
- Keep your team of providers informed of important events or changes

Learn
- Learn about diagnosis, conditions, treatments, medications, and recommended transitions to differing care levels

Learn
- Learn about community resources, support groups, etc.

Recognize
- Recognize signs of caregiver burnout and proactively address

Seek
- Seek out needed education and training
  - Conflict Management
  - Managing Behaviors

Let
- Let your care team know about barriers to a successful transition
  - Lack of money for medications
  - Lack of transportation to appointments
  - Caregiver Burnout
  - Housing Insecurity

Develop
- Develop a good relationship with our PCP – your go-to person for health issues and questions.
  - Ask for Help if Needed

Ensure
- Ensure you understand your healthcare
  - Ask questions
  - Ask for clarification
  - Ask for someone you can follow up with if questions arise later on

(Anderson, 2023)

Brief Check-In

What other self-advocacy tools have worked for you?

Healthcare Transition Planning & Checklist

(Josephson, 2016)

A Good Healthcare Transition

- Includes

  Collaborative Transition Planning

  Effective and Complete Communication

  Clear and Timely Information

  Medication Safety

  Consumer/Caregiver Education

  Resource and Community Support Connections

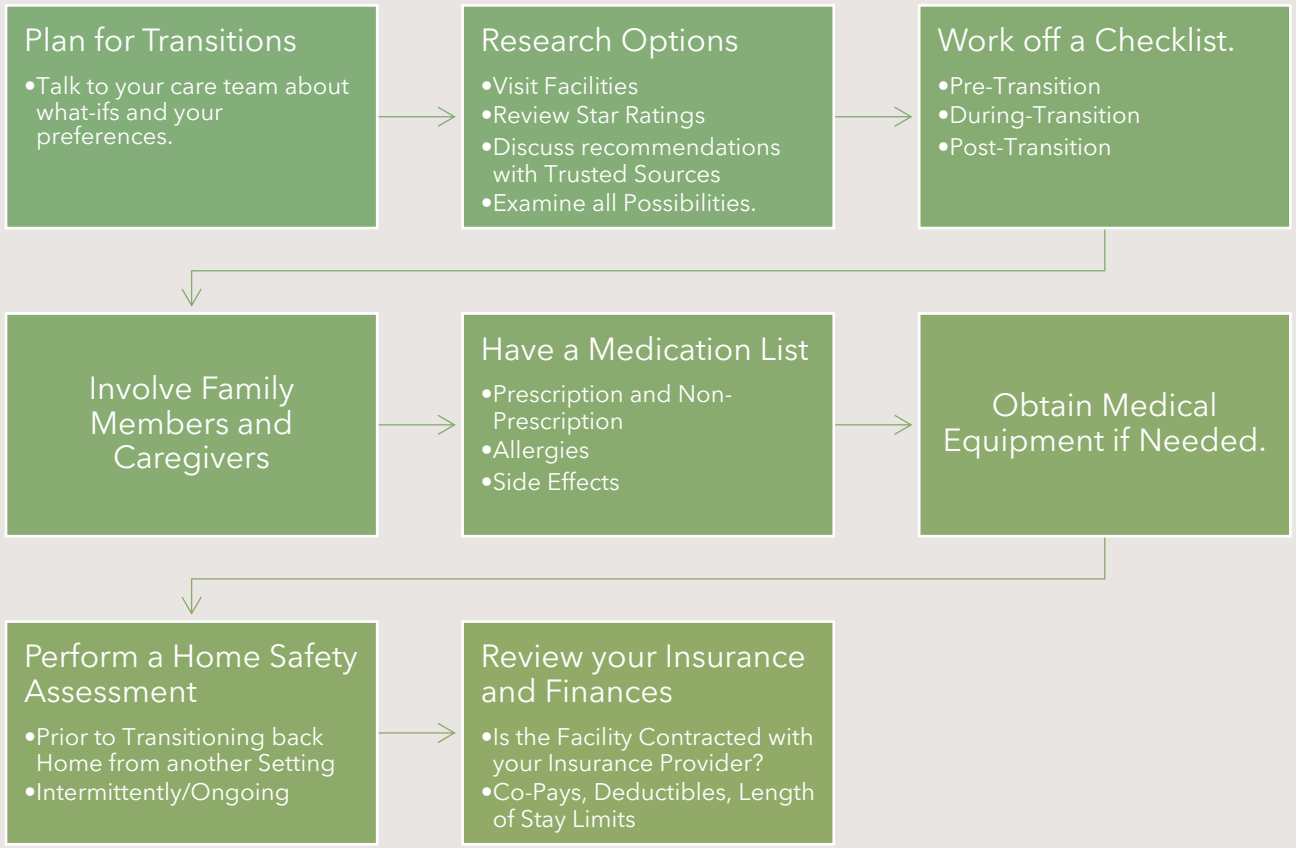
  Advanced Care Planning

  Interprofessional and Person-Centered Care

  Symptom/Condition Monitoring & Management

  Follow-Up

Healthcare Transition Planning Tips

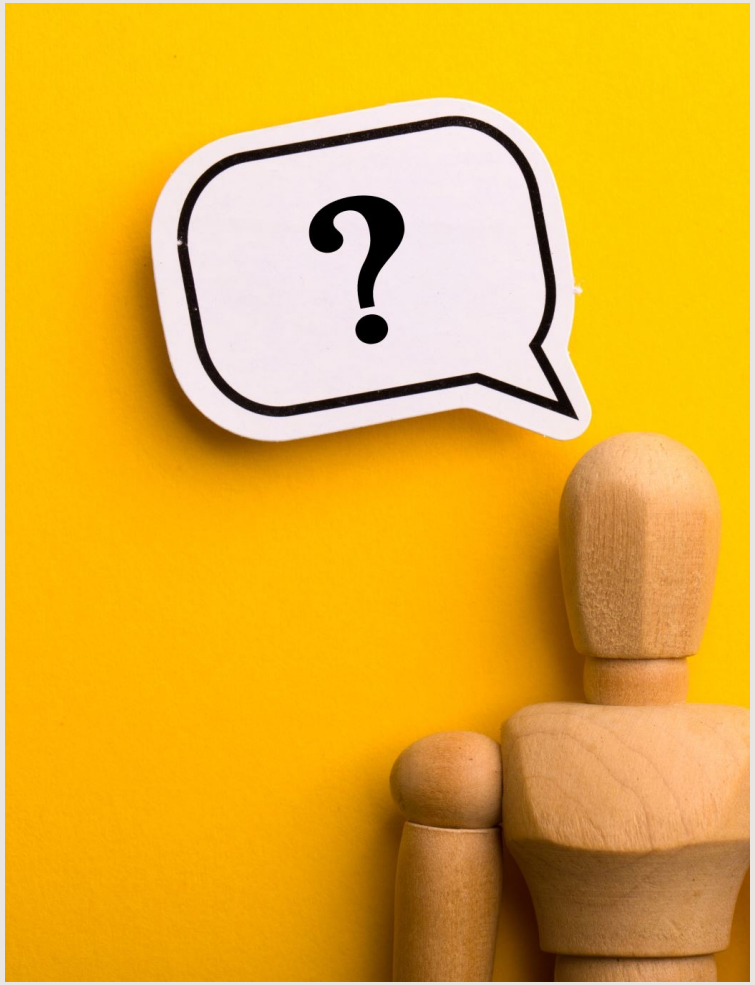


(Woodruff, n.d.)

Healthcare Transition Checklist

- ❑ Clear explanation of condition, diagnosis, and reason for transition
- ❑ Medications Reviewed
  - ❑ *Plan in place to pick up medications.*
  - ❑ *You understand how to take the medication.*
  - ❑ *You understand why it is being given.*
  - ❑ *You understand potential side effects or "red flags."*
  - ❑ *Interactions with current medications have been reviewed.*
- ❑ Barriers to the transition plan or other concerns have been addressed.
- ❑ Your needs and goals have been addressed in the transition plan.
- ❑ Resources needed have been arranged,
  - ❑ *Or you have been given contact information on obtaining the resources needed and are comfortable arranging them.*
- ❑ The transition plan has been given to you and your PCP in a documented format.
  - ❑ *You are clear on the timeline of the transition.*
  - ❑ *You know who will be involved,*
  - ❑ *You understand the next steps in the transition or care to be delivered.*
  - ❑ *The who, what, when, where, why, and how*
- ❑ You understand the next care setting or referral.
  - ❑ *What to expect from them,*
  - ❑ *If there is anything you need to do to prepare for the transition*
- ❑ Equipment is in place before the transition.
  - ❑ *Or there is a plan with a timeline for equipment delivery that works for you.*
- ❑ Questions are addressed to your satisfaction.
- ❑ Follow-up appointments are scheduled, or you are comfortable doing this.
  - ❑ *You know when they are and have a way to get to the follow-up appointment.*
  - ❑ *If tests are needed, you know when to get them, where, what they are for, and who to contact if you have a question.*
- ❑ You know what "red flags" or problems to be aware of and what to do if they occur.
- ❑ You know whom to contact if you have general questions, such as your PCP, care coordinator, or patient navigator.

What Questions Do You Have?



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