St Peter's Health Partners
Capital Region Health Connections

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Focus on Care Transitions

Care Transition Domain

"Transitions of care" refer to the movement of patients between health care practitioners, settings, and home as their condition and care needs change. For example, a patient might receive care from a primary care physician or specialist in an outpatient setting, then transition to a hospital physician and nursing team during an inpatient admission before moving on to yet another care team at a skilled nursing facility. Finally, the patient might return home under the care of their own PCP, where he or she may receive care from a visiting nurse or support from a family member or friend.

Joint Commission

PRESS GANEY

Why is the Care Transitions Domain important

- Within 30 days of discharge, approximately 2.6 million Medicare beneficiaries are re-hospitalized, at a cost of over $26 billion every year
- Direct communication between hospital physicians and primary care physicians occurred infrequently (in 3-20% of cases studied)
- A Study of Discharged patients found:
  - Only 41% were able to state their diagnoses,
  - Only 37% were able to state the purpose of their medications
  - Only 14% knew the common side effects of all their medications

Root Causes of Ineffective Transitions of Care

- Communication breakdowns
- Patient education breakdowns
- Accountability breakdowns

CRHC Chart Audit Tool Questions

Transition of Care	
Care Coordinator responded to alerts of hospitalizations and ED visits – and any other events calling for the provision of Care Transition services within 2 business days of receiving the alert.	
Was the care plan updated at the time of transitional events? (if needed)	Awareness
Care coordinator assists member in following their discharge plan when transitioning back to the community.	Awareness
• Discharge instructions from ER visits and hospitalizations are obtained and scanned into the chart. If not, does documentation show an attempt to obtain the discharge plan?	
• Documentation shows that the care coordinator notified/collaborated with the care team upon notification of member's transition to/from an ER/hospital/residential/rehabilitative setting (Providers/MCO)	
• Support resources and persons were identified with member to assist in the time of crisis and aide in preventing future crisis.	
• Documentation reflects care management team provided follow-up post discharge with member/family to ensure member care plan needs/goals are met. (Appointments kept, meds obtained, etc.)	
• Warm handoff was performed in transitioning members from criminal justice, to another Health Home, from ED and inpatient, rehab and other settings.(with/when proper consents were in place)	
[For detox] An in-person visit was conducted while the member was in detox. If not, is there clear documentation of why a visit could not be made. (i.e. Detox program was outside of our service area)	Awareness
[For detox] An in-person visit was conducted within 24 hours of the member being discharged from detox.	Awareness
Other issues present? (Mark N/A if no additional issues are present, mark a red/negative response if issues exist. Please leave details of the issue in the comments section.)	

Core Service Definition

- Follow up with hospitals/ER upon notification of a Member's admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting.
- Facilitate discharge planning from an ER, hospital/residential/rehabilitative setting to ensure a safe transition/discharge that ensures care needs are in place.
- Notify/consult with treating clinicians, schedule follow up appointments, and assist with medication reconciliation.
- Link Member with community supports to ensure that needed services are provided.
- Follow-up post discharge with Member/family to ensure Member Plan of Care needs/goals are met.