Hot Topics in Transitions of Care

nThrive Speakers Bureau // Sample Presentation

Agenda

- What is “Transitions of Care”?
- CMS Conditions of Participation – Transitions of Care
- Does Transition of Care Impact the Patient?
- How does Transitions of Care Impact Quality?
- Are there financial implications of Transitions of Care?
- Key Indicators of an Effective Transitions of Care Program
- Does my hospital have an Effective Transition of Care Program?

What is Transitions of Care?

Key Risks in Transitions of Care:

Increase the risk of adverse events:

- Potential for miscommunication
- Responsibility transferred (“transitioned”) to a new care provider / party

Hospital discharge is a complex process

- Significant vulnerability for patients
- Length of Stay initiatives push “timeliness” of discharge
- Requires effective provider communication
- Requires patient/family/caregiver comprehension of discharge instructions

Key Elements of Transitions of Care

- ✓ Medication reconciliation
- ✓ Follow-up tests and services
- ✓ Changes in plan of care
- ✓ Involvement of team during hospitalization, discharge, follow-up, etc.
- ✓ Communication
- ✓ Transfer of all information when site of care changes
- ✓ Education of the patient and family

Transitions of Care and Quality

National Quality Strategy* Six Key Priorities

1. Making care safer by reducing harm caused in the delivery of care
2. Ensuring that each person and family is engaged as partners in their care
3. Promoting effective communication and coordination of care
4. Promoting the most effective prevention and treatment practices for leading causes of mortality, starting with cardiovascular disease
5. Working with communications to provide wide use of best practices to enable healthy living
6. Making quality care more affordable to individuals, families, employers, and governments by developing and spreading new health care delivery models

Two of the Six Priorities are Directly Related to Transitions of Care

* The National Quality Strategy (NQS) was first published in March 2011 as the National Strategy for Quality Improvement in Health Care, and is led by the Agency for Healthcare Research and Quality on behalf of the U.S. Department of Health and Human Services (HHS).

Transitions of Care and Quality

The National Quality Strategy has identified three long-term goals related to Care Coordination and Transitions of Care:

Improve the quality of care transitions and communications across care settings.

Improve the quality of life for patients with chronic illness and disability by following a current care plan that anticipates and addresses pain and symptom management, psychosocial needs, and functional status.

Establish shared accountability and integration of communities and health care systems to improve quality of care and reduce health disparities.

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