Minnesota Hospital Association

Transitions in Care Road Map

MHA's road maps provide hospitals and health systems with evidence-based recommendations and standards for the development of topic-specific prevention and quality improvement programs, and are intended to align process improvements with outcome data. Road maps reflect published literature and guidance from relevant professional organizations and regulatory agencies, as well as identified proven practices. MHA quality and patient safety committees provide expert guidance and oversight to the various road maps.

Each road map is tiered into fundamental and advanced strategies:

- **Fundamental strategies** should be prioritized for implementation, and generally have a strong evidence base in published literature in addition to being supported by multiple professional bodies and regulatory agencies.
- **Advanced strategies** should be considered in addition to fundamental strategies when there is evidence the fundamental strategies are being implemented and adhered to consistently and there is evidence that rates are not decreasing and/or the pathogenesis (morbidity/mortality among patients) has changed.

Operational definitions are included to assist facility teams with road map auditing and identifying whether current work meets the intention behind each road map element.

Resources linked within the road map include journal articles, expert recommendations, electronic order sets and other pertinent tools which organizations need to assist in implementation of best practices.

Transitions in Care - A patient's journey of moving from one part of the continuum of care to another within the health care system.

Road map sections	Road map questions (if not present at your hospital or answering no, please see next column for suggested resources)	If specific road map element is missing, consider the following resources:
Safe transition teams/ culture	**FUNDAMENTAL** *(check each box if "yes")* ☐ The facility has an established interdisciplinary team involved in implementing and maintaining the safe transitions of patients with representation from across the facility and meets on a routine basis. - Develop a structured, tailored and multifaceted approach to overcome barriers and enhance protocols. ☐ Interdisciplinary team has defined roles and expectations. - Team includes a designated coordinator to lead/oversee transitions work and representatives involved in transitions work.	• Joint Commission Sentinel Event 58 Alert • Clear communication between team members is crucial in ensuring patient safety. Consider the AHRQ TeamSTEPPS pocket guide for communication templates and overall TeamSTEPPS resources. AHRQ TeamSTEPPS Pocket Guide

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Safe transition teams/ culture, cont.	**ADVANCED** *(check each box if "yes")* ☐ Team is empowered to implement safe transitions through Just Culture policies and expectations. - Leadership sets expectations and accountability for established culture of safety to support patient transitions in care. ☐ Develop and maintain active partnerships with organizations in the community. - Facilitate ongoing communication and engagement of organizations from across the continuum of care in hospital transition process improvement work, including long-term care, home health care and community and social service organizations.	• Joint Commission Sentinel Event 58 Alert • Minnesota Alliance for Patient Safety Just Culture Road Map
Quality improvement guidelines	**FUNDAMENTAL** *(check each box if "yes")* ☐ The facility has a process in place to audit the completion of transitions of care. ☐ The facility has a process in place to review and analyze data on a regular basis for learning and improvement opportunities. - Organization identifies metrics to analyze, focused on reducing readmissions. Options include: ○ all-cause readmissions ○ potentially preventable readmission ○ stratification by diagnoses ○ days to readmissions	• IHI Model for Improvement • AHRQ Designing and Delivering Whole Person Transitional Care Tool Overview Oct. 2016
	ADVANCED *(check each box if "yes")* ☐ Learnings and improvement opportunities are shared and distributed across the system regularly. - Goals for readmissions and safe transitions are clearly defined and reviewed by senior leaders and feedback is incorporated into process changes.	• AHRQ Designing and Delivering Whole Person Transitional Care Tool Overview Oct. 2016

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Comprehensive discharge planning	**FUNDAMENTAL** *(check each box if "yes")* ☐ The facility begins discharge planning within 24-48 hours of admission and includes evaluation of the ability of the patient/family to provide self-care.	• CMS Discharge Planning Checklist – Patient • Strategy 4: Care Transitions from Hospital to Home: IDEAL Discharge Planning. Dec. 2017. AHRQ • Care Transitions from Hospital to Home: IDEAL Discharge Planning Implementation Handbook. AHRQ
	ADVANCED *(check each box if "yes")* ☐ The facility has a pre-screening process to assure post-acute facility has capacity to care for the patient (exclude acute care transfers).	
Medication management	**FUNDAMENTAL** *(check each box if "yes")* ☐ The facility's medication reconciliation process includes communicating to the pharmacy to confirm that the pharmacy received the same medication orders that are listed on the patient discharge orders.	• MHA Medication Safety Road Map • MHA Medication Reconciliation Road Map
	ADVANCED *(check each box if "yes")* ☐ The facility's medication reconciliation process includes obtaining the best possible medication history from at least two sources. - Patient can be one of the sources, if alert and oriented.	• Institute for Health Care Improvement Medication Reconciliation Data Collection Form Sample • Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation
Patient and family education	**FUNDAMENTAL** *(check each box if "yes")* ☐ A section on the transfer record is devoted to communicating a patient's preferences, priorities, goals, and values.	• CMS Discharge Planning Checklist – Patient • Care Transitions from Hospital to Home: IDEAL Discharge Planning Implementation Handbook. AHRQ
	ADVANCED *(check each box if "yes")* ☐ Patients have access to their transfer information in their preferred language. ☐ Health literacy and teach-back principles are used to create and update patient and family education and materials (i.e., using plain language).	• MN Health Literacy Partnership resources • MN Health Literacy presentations and training materials • AHRQ Health Literacy

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Staff education	**FUNDAMENTAL** *(check each box if "yes")* ☐ Expectations and supporting education regarding transitions of care have been incorporated into orientation. ☐ Identified practitioners and staff involved in transitions of care. - Physicians, nurses, social services, pharmacy	• Transitions of Care Standards. American Case Management Association (ACM)
	ADVANCED *(check each box if "yes")* ☐ Continuous education is provided to staff based on process changes, new tools and resources, leadership decision-making, in support of process improvement transition goals. - Education is based on process changes.	
Transition communication	**FUNDAMENTAL** *(check each box if "yes")* ☐ Core transition safety elements are included in the patient's medical record. - Refer to list of best practice elements. ☐ Core safety elements are communicated to the receiving facility for transitions out of hospital (i.e., forms, electronically, phone calls). ☐ A contact from the sending facility is designated for follow-up questions following a patient transition. ☐ The facility completes a verbal hand-off for all transitions (i.e., nurse-to-nurse tool).	• MHA Safe Transitions of Care Transfer Form with Core Safety Elements • Member example: Winona Health Intra-Agency Transfer • Institute for Health Care Improvement (IHI) SBAR Tool
	ADVANCED *(check each box if "yes")* ☐ Core safety elements are received by the hospital for patients transitioning into the hospital. - Core safety elements are documented in the patient's electronic medical record.	• MHA Safe Transitions of Care Transfer Form with Core Safety Elements

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Transition coordination of care	**FUNDAMENTAL** *(check each box if "yes")* ☐ Facility completes post-discharge follow-up for high-risk patients who discharge to home within a designated amount of time. - Suggested within three days. ☐ Hospital/referring facility completes pre-discharge planning with facility/provider (i.e., for discharge to home health care and as soon as possible).	• Readmission Risk Assessment • Tool 5: How to Conduct a Postdischarge Followup Phone Call. Mar. 2013. AHRQ • Resources and Tools to Improve Discharge and Transitions of Care and Reduce Readmissions. Jul. 2022. AHRQ • Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. 2017 National Academy of Medicine • Patient Engagement Strategies for Post-Discharge Follow-up Care. Patient Engagement HIT
	ADVANCED *(check each box if "yes")* ☐ The facility has a process to assess patients who are at high risk for readmissions, such as behavioral health, pediatric and others (i.e., heart failure, sepsis, chronic obstructive pulmonary disease). ☐ The facility connects with community resources to coordinate services for high-risk populations (i.e., transportation, limited access to food).	• Social Determinants of Health. Guide to Social Needs Screening. 2019. American Academy of Family Physicians (AAFP) • Social Needs Screening Tool. 2018. AAFP