Transitions of Care: The Need for a More Effective Approach to Continuing Patient Care

Illinois Association for Healthcare Quality
April 24, 2015
Bridging the “gap” in care transitions
The “gaps” are everywhere....
Problems that Create the “Gaps”

- Study findings: 80 percent of serious medical errors/adverse events involve miscommunication between caregivers involved in care transitions

- Most common events include:
  - Medication errors (various types)
  - Wound infection
  - For elderly: falls/injuries, caregiver burden, nursing home placement and increased health care costs
  - Hospital readmissions (20% of all Medicare patients)
Top 10 Root Causes of Sentinel Events 2013-2014*

- Human factors (such as complacency or rushing)
- Communication (such as among staff, across disciplines, or with patients)
- Leadership (regarding, for example, lack of organizational planning and complaint resolution)
- Assessment (such as abuse/neglect assessments or clinical laboratory testing)
- Information management (for example, in the areas of medical records and data aggregation)
- Physical environment (such as fire safety and equipment management)
- Care planning (planning and/or interdisciplinary collaboration)
- Continuum of care (includes transfer and/or discharge of patient)
- Medication use (for example, preparing medications and monitoring patient use)
- Operative care (such as blood use)

(*Note: It is believed that only about 2% of actual Sentinel Events are reported to The Joint Commission)
ToC: Supported by the TJC Enterprise

Transitions of Care

- Strategic Planning: Primary Care Medical Home programs; NCC Post-Acute program
- Strategic Planning: Integrated Care Certification
- CTH: Hand-off Communications, Preventable Hospitalizations (CHF)
- Strategic Planning: Advanced Certification programs: Heart failure, CSC, PSC
- JCR: Publications and Consulting Services
In 2009, The CTH collaborated with 10 hospitals and health systems to begin a project focused on ineffective hand-off communications.

For this project, a successful hand-off is defined as a transfer and acceptance of responsibility for patient care that is achieved through effective communication.

- Involves “senders,” and “receivers” of patient information

Organizations examined the hand-off communications problems in their own facility, and identified their specific barriers and causes for failures.

- Identified, implemented and validated solutions that improved their performance
Process Improvement

Usual approach: best practices, toolkits, protocols, checklists, “bundles”

– Typical best practice is “one-size-fits-all”
– Can produce modest improvement
– Difficult to get to zero
– Difficult to sustain

The “one-size-fits-all” approach works well only for simple problems that do not vary

Toughest problems are not simple
A New Way of Delivering Results

- Complex processes require more sophisticated problem-solving methods
- Three crucial and consistent findings:
  - Many causes of the same problem
  - Each cause requires a different strategy
  - Key causes differ from place to place
- The CTH Hand-off Communications project used Robust Process Improvement (RPI™) and developed the Targeted Solutions Tool (TST®)
Hand-off Communications (HOC)  
Targeted Solutions Tool (TST)
The TST® is an innovative online application that guides health care organizations through a step-by-step process to:

- Accurately measure their organization’s actual performance
- Identify their barriers to excellent performance
- Direct them to proven solutions that are customized to address their particular barriers
# Validated Root Causes for Transition of Care: Hand-off Communications Failures

<table>
<thead>
<tr>
<th>Cause</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
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<tbody>
<tr>
<td>Culture does not promote successful hand-off, e.g. lack of teamwork and respect</td>
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<td>Expectations between sender and receiver differ</td>
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<td>Ineffective communication method, e.g. verbal, recorded, bedside, written</td>
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<td>Timing of physical transfer of the patient and the hand-off are not in sync</td>
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<td>Inadequate amount of time provided for successful hand-off</td>
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<td>Interruptions occur during hand-off</td>
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<td>Lack of standardized procedures in conducting successful hand-off, e.g. SBAR</td>
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<td>Inadequate staffing at certain times of the day or week to accommodate successful hand-off</td>
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<td>Patient not included during hand-off</td>
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<td>Sender provides inaccurate or incomplete information, e.g. medication list, DNR, concerns/ issues, contact information</td>
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<td>Sender, who has little knowledge of patient, is handing off patient to receiver</td>
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<td>Sender unable to provide up-to-date information, e.g. lab tests, radiology reports, because not available at the time of hand-off</td>
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<td>Sender unable to contact receiver who will be taking care of patient in a timely manner</td>
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<td>Inability of sender to follow up with receiver if additional information needs to be shared</td>
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<td>Sender asked to repeat information that has already been shared</td>
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<td>Receiver has competing priorities and is unable to focus on transferred patient</td>
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<td>Receiver unaware of patient transfer</td>
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<tr>
<td>Inability for receiver to follow up with sender if additional information is needed</td>
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<td>Lack of responsiveness by receiver</td>
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<tr>
<td>Receiver has little knowledge of patient being transferred</td>
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Note that not all of the main causes of failure appear in every hospital. The chart above represents the validation of the root causes across hospitals. This underscores the importance of understanding hospital-specific root causes so that appropriate solutions can be targeted.

Update: December 22, 2014
Ten hospitals involved in project; three looked at transitions from one setting to another.
The contributing factors to failed transitions of care were very similar between “internal” and “external” transitions.
Size of hospitals varied from less than 200 beds to more than 2200 beds.
Validated root causes for failed transitions:

**COMMON TO ALL ORGANIZATIONS IN CTH HOC PROJECT:**
• Sender provides inaccurate or incomplete information, e.g. medication list, DNR, concerns/issues, contact information.

Other major causes identified:
• Sender, who has little knowledge of patient, is handing off patient to receiver.
• Culture does not promote successful hand-off, e.g. lack of teamwork and respect.
• Expectations between sender and receiver differ.
Enterprise-wide Strategic Planning Project: Transitions of Care (2012-2014)

- Initial research of various models
- Review of current standards
- Development of ToC Portal
- Learning visits, expert panel
- Consideration of new standards, NPSG
- Publications
- Surveyor education across programs
- Customer education across programs
Project Research and Outcomes
- Leadership oversight
- Assigned accountability
- Resource allocation
- Collaboration with community partners
The team: all disciplines involved in patient/client care

- The team includes the provider at the next setting
- Patient/family is a member of the team
- The team develops care goals
Use of “triggers” to identify high risk patients/clients early in the admission/intake process

- Diagnosis
- Multiple co-morbidities
- Payor source (example: uninsured)
- Age
-Medication reconciliation
  - Engage family/caregivers
  - Call PCP
  - Contact pharmacy used by patient

-Patient/family education

-Consideration of financial resources

-Potential other barriers
  - Aging process: opening medication bottles, reading labels
  - Health literacy
- Should be proactive rather than reactive
- Early identification of those at risk
- Thorough psychosocial assessment
- Start discharge planning at admission/intake
- Interdisciplinary coordination
- Enhanced follow up care
  - Transportation, supplies, MD appointments, treatment appointments, home care, etc.
- Treatment team membership
- Learning style identification
- Knowledge deficit determined
- Educate! (“teach-back”)
- Patient/family commitment; responsibility/accountability for care
- Notification of high risk patient/client to the multidisciplinary team.
- Formalized processes for communication of information to next provider of care
- Clear discharge instructions
- Key information for next provider – diagnosis, treatment provided and response to care, medication information, support systems and resources, follow up care including appointments, treatments, outstanding labs/diagnostics, referrals given.
Project Outcomes

1) Development of ToC portal
   • Research and information gathered put in one place to share with customers and the public
Description

The Transitions of Care (ToC) Portal website is a source of information on the topic of care transitions from one setting to another.

One of the early “deliverables” from the ToC project team.
Purpose of the ToC Portal

The Portal was created to provide both our accredited customers and the public with a source of information on the topic of care transitions.

The website provides various types of information: written articles, JCR products (free/for sale), the CTH Hand-off TST, educational materials, links to numerous websites, etc.
Target Audience

The ToC portal is accessible by everyone!

Information/links are provided for all our accreditation and certification programs that address transitions of care: HAP/CAH, OME, BHC, NAR, AHC, DSC
Accessing the Portal: Front Page
Navigating the Portal
HOT TOPICS IN HEALTH CARE

Transitions of Care: The need for a more effective approach to continuing patient care
HOT TOPICS IN HEALTH CARE, ISSUE #2
Transitions of Care: The need for collaboration across entire care continuum
Page 4: Publications by Provider

Publications by Provider Type

TOC Portal Content

- TOC Portal Home
- Performance Measurement and TOC
- Articles and Publications
- Publications by Provider Type
- Other Sites to Visit
- Webinars and Education

New publications added as of March 2013.

**Ambulatory Health Care**
- There and Home Again, Safely (AMA)
- Failure to Follow-Up Test Results for Ambulatory Patients
- IHI Improving Transitions Guide: Clinical Office Practice

**Home Health Care**
- Optimizing Home Health Care (AHHQI Supplement, Cleveland Clinic Journal of Medicine)
- Optimizing Home Health Care CME Program (AHHQI/CCJM)
- Transitions of Care from Hospital to Home (ACHP)
- IHI Improving Transition Guides: Home Health Care

**Behavioral Health Care**
- Access to Recovery Implementation Toolkit (SAMHSA)
- Integrated Care and Why You Should Care (SAMHSA)
- Providing a Continuum of Care: Improving Collaboration Among Services (SAMHSA)
- Recovery Support: Collaboration, Coordination, and Recovery Management (SAMHSA)
- Bringing Behavioral Health into the Care Continuum
- A Plan to Reduce ER “Boarding” of Psychiatric Patients
- Screening, Brief Intervention and Referral to Treatment (SBIRT) in Behavioral Healthcare

**Hospital/Critical Access Hospital**
- Health Law’s Rules Help Hospitals Cut Readmission Rates
- Looking Beyond the 4 Walls of the Hospital to Reduce Readmissions
- Reduce Readmissions with Pharmacy Programs That Focus on Transitions from the Hosp. to the Community
- Community Liaison Programs to Decrease Hospital Readmissions (ISMP)
- Hospitals Hook Up With Drugstore Giants To Lower Readmissions
- Handoff communication between hosp. and outpatient dialysis units at patient discharge
- IHI Improving Transitions Guide: Hospital to Community Settings

**Nursing and Rehabilitation (Long Term Care)**
- AMDA Practice Guideline for Transitions of Care in the Long-Term Care Continuum
- Healthcare Providers’ Opinions on Communication between Nursing Homes and Emergency Departments
- Interventions to improve transitional care between nursing homes and hospitals: a systematic review
- IHI Improving Transitions Guide: Skilled Nursing Facilities

The Joint Commission Resources
## Page 5: Other Sites to Visit

### TDC Portal Content

- TDC Portal Home
- Performance Measurement and TDC
- Articles and Publications
- Publications by Provider Type
- Other Sites to Visit
- Webinars and Education

### Government Links

- Administration on Aging (AOA)
- Agency for Healthcare Research and Quality (AHRQ)
- National Quality Measures Clearinghouse
- CMS Innovation Center
- CMS Partnership for Patients
- Home Health Quality Improvement (HHQI)
- SAMHSA
- Administration for Community Living (ACL)
- AHRQ Health Care Innovations Exchange: Innovations and Quality Toolkit

### Professional Organizations

- American Case Management Association (ACM)
- The American Geriatrics Society (AGS)
- American Society on Aging
- American Society of Health-System Pharmacists
- ASHA
- Care Management Society of America (CMSA)
- Long Term Quality Alliance (LTQA)
- National Association of Case Management
- NTDOC (National Transitions of Care Coalition)

### Innovations of Care Models/Programs

- The Aging Network and Care Transitions
- The Care Transitions Program
- CareVigil
- Colorado Foundation for Medical Care Integrating Care for Populations and Communities (CFMC-IPC)
- Council on Aging of Southwestern Ohio (COA)
- Healthcare Transitions Initiative (University of FL)
- Hospital to Home (H2H)
- Innovative Care Models
- Project D2CST (2019)
- Project RCD
- Transitional Care Model

### Other Organizations

- Alliance of Community Health Plans
- Alliance Health, LLC
- Care Continuum Alliance
- CareVigil Connect
- Commonwealth Fund
- HealthCare
- Improvement Science Research Network
- Institute for Healthcare Improvement
- The John A. Hartford Foundation
- Multisource Medication Dispensing at Discharge (MMDAD)
- National Quality Forum
- National Quality Forum
- Quality Insights Pennsylvania Care Transitions
- The Bundling Report
- Robert Wood Johnson Foundation
- Care of Your Care Program (Robert Wood Johnson Foundation)
- Alliance for Home Health Quality and Innovation (AHHQI)
- QIN Health IT
Please visit!

www.jointcommission.org/toc
You Can Help Build the Portal!

Help us provide resources to everyone who accesses the ToC Portal:

• Share new articles, publications
  • Share helpful websites
• Share your organization’s ToC news
  • Share your comments

kclark@jointcommission.org
Project Outcomes

1) Development of ToC portal
   • Research and information gathered put in one place to share with customers and the public

2) Expert panel, focus group calls, and learning visits
   • Assisted us to develop publications, and education for our customers, central office and field staff
   • The research was used to further evaluate current standards as they relate to ToC
The Joint Commission Standards

Current Hospital standards that support the foundations of safe transitions of care

Standards meet or exceed the newest requirements at CMS Hospital CoP 482.43
Leadership Support

Allocation of resources

• LD.01.03.01 EP 5 - governing body provides resources

• LD.03.06.01 EP 3 - sufficient number and mix of staff

• LD.04.03.01 EP 2 - social work is an essential service

Provision of Qualified staff

• LD.03.06.01 EP 4,5 - those who work in the hospital are competent and adapt to change

• LD.04.01.05 EP 2 - programs/services are directed by qualified individuals

• LD.04.01.05 EP 5 - provide for the coordination of care, treatment, services among different … sites, services
Interdisciplinary Collaboration

MS.03.01.01 EP 1 and 3 - physicians and psychologists manage and coordinate the patient’s care and there is coordination among the practitioners involved in the patient’s care

PC.02.01.05 - care is provided in an interdisciplinary, collaborative manner

PC.02.02.01 - coordinating care based on the patient’s needs, receiving and sharing of information

PC.04.01.03 EP 3 - the treatment team (all involved in patient’s care, including family and patient) participate in planning d/c or transfer
Patient and Family Engagement

PC.02.01.21 - effectively communicating with patients

PC.02.03.01 - providing patient education and training based on assessed patient needs and abilities

PC.04.01.03 EP 3 - the treatment team (all involved in patient’s care, including family and patient) participate in planning d/c or transfer

PC.04.01.05 - before d/c or transfer, the hospital informs and educates the patient about follow-up care, tx, and services including written instructions in a manner the patient and family understand

RI.01.01.01 - right to effective communication

RI.01.02.01 - involving patient in care decisions

RI.02.01.01 - patient responsibilities in care
Medication Management/Reconciliation

MM.01.01.01 - collection of required patient information

MM.04.01.01 - medication orders are clear

MM.05.01.01 - pharmacy reviews all medication orders

NPSG.03.06.01 - maintain and communicate accurate patient medication information
Early Identification of Those at Risk

PC.01.02.01 - assess and reassess patients

PC.01.02.03 - assessments completed at defined timeframes

PC.01.02.09 - assessing risk of abuse or neglect

PC.01.03.09 - planning care based on assessments and reassessments, plans and goals revised based on changing needs

PC.02.01.01 - providing care based on the individualized plan of care

PC.02.03.01 - providing education and training based on assessed needs and abilities
Transfer of Information

PC.04.02.01 – at discharge or transfer, the hospital gives the next provider of care information about the care, treatment and services provided and the patient’s progress towards goals
Effective Transitional Planning

PC.04.01.03 - discharging the patient based on the assessed needs of the patient and the hospital's ability to meet those needs

- discharge planning begins early in the episode of care
- post discharge needs are identified
- prior to discharge, arrange or assist in arranging services required by the patient to meet the ongoing care needs

RC 02.04.01 - document the discharge information to facilitate continuity of care
Joint Commission Hospital Standards on Discharge Planning

- To test your process and compliance with Joint Commission standards and CMS requirements, use the CMS Hospital Discharge Planning Survey Tool, released 11/14:
Home Care Standards Related to Transitions of Care

Assuring a safe environment of care for transitioning patients:
EC.02.01.01, 02.03.01

Assuring that there are qualified, educated staff to provide care:
HR.01.01.01, 01.02.01, 01.02.07

Assuring that proper infection control procedures are used in “sending” and “receiving” patients:
IC.01.01.01, 02.01.01, 02.02.01, 02.03.01

Assuring that organizational leadership promotes and provides resources for safe, quality transitions of care:
LD.02.03.01, 03.03.01, 03.04.01, 04.03.01

Assuring safe medication management for patients being transitioned from one provider to another:
MM.01.01.01, 03.01.05, 04.01.01, 05.01.01, 06.01.03
Home Care Standards Related to Transitions of Care (cont’d.)

Assures patient safety throughout every patient transition of care:
NPSG.01.01.01, 03.06.01, 09.02.01, 15.02.01

Assuring safe provision and coordination of care, treatment, and services:
PC.01.01.01, 01.02.01, 01.03.01, 02.01.05, 02.02.01, 02.03.01, 04.01.01, 04.01.03, 04.01.05, 04.02.01

Assures that all patient care information is documented in the patient record:
RC.02.01.01

Assures that the patient’s rights and responsibilities are communicated and respected throughout every transition of care:
RI.01.01.01, 01.01.03, 01.02.01, 02.01.01
Project Outcomes

1) Development of ToC portal
   - Research and information gathered put in one place to share with customers and the public

2) Expert panel, focus group calls, and learning visits
   - Assisted us to develop publications, and education for our customers, central office and field staff
   - Led us to a decision to hold off on an NPSG, but further evaluate current standards as they relate to ToC

3) Development of new Integrated Care Certification (ICC) program
The Joint Commission
Integrated Care Certification Program

Integrated Care Certification (ICC):

- A new optional certification program that provides an evaluation of the integration of care across health care settings*

(*currently for hospitals, physician practices and ambulatory settings)
Integrated Care Certification: Program Standards

- Emphasis of requirements:
  - An organized integrated care program
  - Interdisciplinary team leadership whose members support the coordination of clinical care
Integrated Care Certification: Program Standards

- Emphasis of requirements:
  - Leadership endorsement and support of the program’s goals for providing care, treatment, and services
  - A special focus on patient and family engagement
  - Processes that support the integration, coordination of patient care among health care settings and providers
Integrated Care Certification: Program Chapters (3)

Program Alignment (ICPA) chapter:
- The structure and organization of the program

Program Characteristics (ICPC) chapter:
- Involvement of the patient and/or family
- Managing transitions of care
Integrated Care Certification: Program Chapters (3) (cont’d)

Quality, Safety, and Culture (ICQS) chapter:

- Performance improvement priorities and activities
Integrated Care Certification: Next Steps

- Initial ICC program with focus on integration of care between hospitals and physician practice(s) networks or ambulatory care organizations – completed and approved
- Currently pilot testing standards and review process
- Certification reviews to begin mid-year
- Next step: Expand program to evaluate the integration of care among hospitals, physicians and Home Care
Through these projects and activities, it is our goal to utilize the key concepts learned to assist our accredited organizations to develop successful methods for providing safe, quality care transitions.
Improving the Quality of Care through Improving the Transitions of Care Process

Centers for Medicare & Medicaid Services
Hospital Discharge Planning Worksheet

TJC ToC Portal

Powered by RPI™
Monitoring the Quality of your Organization’s Discharge Planning

Are discharge planning policies and procedures applicable to all inpatients?

Are staff following policy and procedure?

Does the process have a method for early identification of patients at risk for problematic care transitions?

Do staff, including physicians, know how to initiate discharge planning? Are patients aware they can request a discharge plan?

Are discharge plans re-evaluated based on a change in patient condition?

Is the discharge plan reviewed on an ongoing basis?
Monitoring the Quality of your Organization’s Discharge Planning (cont’d)

Are discharge planning staff competent and qualified?
Are discharge planning assessments documented and in the record?
Did the assessment include psychosocial factors?
Were the psychosocial factors considered in discharge planning?
Were the patient and family assessed in the ability to provide self-care/care?
Are community-based services considered based on assessed needs of the patient/family?
Did the patient choose the next provider or was the provider assigned? (home care, skilled nursing, etc…) 
Was the discharge planning assessment initiated early in the admission? 
Were assessments completed in a timely fashion? 
Was the patient/family advised of assessment results? Care options? 
Did the discharge plan match the needs determined by the assessment and the interdisciplinary team? 
Were the learning needs of the patient/family assessed and addressed?
Monitoring the Quality of your Organization’s Discharge Planning (cont’d)

Were written instructions provided to the patient/family in manner the clear to the patient/family?
Is there evidence of patient/family education in the medical record?
Is there evidence of referrals made?
Were arrangements made for DME, transportation, home care, follow up care?
Was necessary information sent to the next provider of care in a timely manner? (at time of transfer or before next appointment)
Monitoring the Quality of your Organization’s Discharge Planning (cont’d)

Are there delays in discharge due to failure to implement the discharge processes?

Are final results of tests that were pending at time of discharge sent to the patient and next provider of care?
For more information:

Transitions of Care Portal:  
www.jointcommission.org/toc

Contact: Kathy Clark, MSN, RN  
  kclark@jointcommission.org  
  630-792-5932
Questions?

Working Together to “Bridge the Gaps” in Transitions of Care