Development of a Community Transitions of Care Program

by

Katherine Barmer

A Master’s Paper submitted to the faculty of the
University of North Carolina at Chapel Hill
in partial fulfillment of the requirements for the degree of
Master of Public Health
in the Public Health Leadership Program.

December 2012

Approved by:

__________________________________
Susan A. Randolph, Advisor

__________________________________
Eleanor Everett, Reader
ABSTRACT

When patients suffer an acute health event in a community, they may enter multiple care settings and have several health care providers. As healthcare continues to evolve, patients are moved in and out of hospitals at a much faster pace, often leaving room for information to get lost and discharge plans to be inadequate. Hospitals are also encouraged financially to provide their patients with quality care and to do everything possible to prevent them from being readmitted soon after discharge.

To ensure that patients transition smoothly from the hospital into the community, a collaborative, multidisciplinary effort is crucial. A public health nurse can help build and strengthen transitional care programs within the hospital and establish partnerships outside of the hospital to improve care transitions across the community.

Key words: care transitions, patient-centered care, readmission
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapters:</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. INTRODUCTION</strong></td>
<td>1</td>
</tr>
<tr>
<td><strong>II. LITERATURE REVIEW</strong></td>
<td>4</td>
</tr>
<tr>
<td>Scope of the Problem</td>
<td>4</td>
</tr>
<tr>
<td>Centers for Medicare and Medicaid Services</td>
<td>4</td>
</tr>
<tr>
<td>Patient Protection and Affordable Care Act</td>
<td>5</td>
</tr>
<tr>
<td>Community-Wide Multidisciplinary Issues</td>
<td>6</td>
</tr>
<tr>
<td>Factors Affecting Transitions of Care</td>
<td>6</td>
</tr>
<tr>
<td>Discharge planning</td>
<td>7</td>
</tr>
<tr>
<td>Patient and Caregiver Education</td>
<td>7</td>
</tr>
<tr>
<td>Communication</td>
<td>8</td>
</tr>
<tr>
<td>High Risk Patients</td>
<td>8</td>
</tr>
<tr>
<td>Early Follow Up</td>
<td>9</td>
</tr>
<tr>
<td>Patient and Caregiver Engagement</td>
<td>9</td>
</tr>
<tr>
<td><strong>III. COMMUNITY PARTNERSHIPS</strong></td>
<td>11</td>
</tr>
<tr>
<td>Federal Level</td>
<td>11</td>
</tr>
<tr>
<td>State Level</td>
<td>12</td>
</tr>
<tr>
<td>Local Level</td>
<td>12</td>
</tr>
<tr>
<td>Page</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td></td>
</tr>
<tr>
<td>Resources .................................................................................................................. 13</td>
<td></td>
</tr>
<tr>
<td>IV. ROLE OF THE PUBLIC HEALTH NURSE .................................................................. 14</td>
<td></td>
</tr>
<tr>
<td>Collaboration ............................................................................................................ 14</td>
<td></td>
</tr>
<tr>
<td>Education and Best Practices ................................................................................. 14</td>
<td></td>
</tr>
<tr>
<td>V. CONCLUSIONS AND RECOMMENDATIONS .............................................................. 17</td>
<td></td>
</tr>
<tr>
<td>References ................................................................................................................ 20</td>
<td></td>
</tr>
<tr>
<td>Appendices ............................................................................................................... 23</td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER I
INTRODUCTION

Hospitals nationally are constantly being pressured by regulatory agencies to meet increasingly difficult quality improvement measures and standards of care that are tied directly to their financial reimbursement (Siegel, 2011). The focus of many healthcare organizations, with the support of The Joint Commission, has shifted to a more patient-centered approach by ensuring that patients are involved with their plan of care (Hughes & Clancy, 2007). This can be complicated by an equal push for a decreased length of stay. It is critical that patients can successfully move from the acute, hospital setting to the next care setting to reduce preventable readmissions, increase patient satisfaction, and provide quality care. Care transitions can be improved by establishing best practices that are collaborative, community oriented, and multidisciplinary.

Unsuccessful transitions, where critical information is not transferred or a patient’s needs are not met, often lead to frequent readmissions that occur just days or weeks after discharge from the hospital. It is estimated that approximately 18-24% of all Medicare patients who are hospitalized are readmitted to a hospital within 30 days of discharge (Siegel, 2011). Section 3026 of the Patient Protection and Affordable Care Act along with the Centers for Medicare and Medicaid Services states that hospitals will no longer be reimbursed at the same rate for preventable 30-day readmissions, beginning with the few key diagnoses of pneumonia, acute myocardial infarction, and heart failure (Siegel, 2011). Hospitals with excessive, preventable readmissions will also be impacted financially through hospital value based purchasing, thus furthering the need for improved care transitions.
Many communities strive to improve the patient’s experience while cutting costs and promoting the health of the population as a whole. This goal has been supported by the Institute for Healthcare Improvement, the Partnership for Patients, the Institute of Medicine, The Joint Commission, National Quality Forum, the American Board of Internal Medicine Foundation, and the National Transitions of Care Coalition, among many others (Coleman & Williams, 2007).

Coleman and Berenson (2004) define transitions of care as “a set of actions designed to assure the coordination and continuity of healthcare as patients transfer between different locations or different levels of care in the same locations” (p. 533). Over the course of one acute event, an individual can transition between several settings prior to going home independently. Communication between providers is critical to ensure these handoffs are successful (Coleman & Williams, 2007). In addition, the patients and their families may not be aware of the plan of care. According to Coleman and Boult (2007), patients who have multiple providers throughout the course of one acute event may have poor clinical outcomes and the patients and family members may be dissatisfied with care. With shrinking reimbursements on the horizon and more focused quality initiatives, hospitals must look at new ways to build programs within their own walls and partner with community resources to improve transitions of care for patients. Hospitals are realizing that their responsibility to patients extends far beyond the walls of their organization into the community.

To improve transitions of care for patients, communities must work together in a collaborative and multidisciplinary way to determine what processes and programs work best for their care team. While many recommendations have been described in the literature, the most frequently mentioned ideas are better communication between care settings for the sending and the receiving care team, adequate assessment of discharge needs, timely follow up post discharge
with a provider, better attention to health literacy levels, and a thorough medication reconciliation process (Tanner, 2010). Other suggestions include a transition coach within the hospital setting, telehealth programs, and programs such as INTERACT (Interventions to Reduce Acute Care Transfers) within the skilled care setting (Bonner, Herndon, Lamb, Ouslander, & Tappen, 2011).

Many of the above suggestions and programs have successfully improved care transitions for patients. However, there must be a community-wide, multidisciplinary approach that unites all care providers who interact with patients within a community. Commitment from all care partners within the community is vital to improving transitions of care. The focus of this paper is to develop an effective community care transitions program that offers patient-centered, quality care, while decreasing 30-day readmissions.
CHAPTER II
LITERATURE REVIEW

Scope of the Problem

According to the National Transitions of Care Coalition, approximately 20% of Medicare patients discharged from the hospital are readmitted within 30 days due to a fragmented health care system (2010). These 30-day readmissions account for about $15 billion in Medicare spending annually (National Transitions of Care Coalition, 2010). With many readmissions being potentially avoidable, the associated costs are also potentially avoidable. Patient and family satisfaction are also important when reviewing information regarding hospital readmissions and transitions of care. Often times, readmissions can cause patients to feel demoralized and can be an indicator of poor quality of care (Siegel, 2011).

Centers for Medicare and Medicaid Services

The patient’s and family’s perception of the quality of care as well as other clinical quality measures for heart attack, heart failure, pneumonia, and surgical care are publicly reported to the Centers for Medicare and Medicaid Services. These data will be available on the Hospital Compare Website for patients and families to view and, ultimately, determine where they wish to receive their care (U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 2008). When patients are satisfied with the care they received and perceive they received the right care at the right time, they are able to transition more smoothly to the next care setting.
The Patient Protection and Affordable Care Act has also identified poor care transitions as an issue to be addressed through its Readmission Reduction Program (Siegel, 2011). Beginning in 2013, hospitals with excessive readmissions will receive a 1% reduction in Medicare payments, potentially increasing to 3% by 2015 (Siegel, 2011). This holds hospitals accountable for these readmissions from a financial perspective and causes them to identify ways to reduce those that are deemed preventable. The Value Based Purchasing program is also an important part of the Patient Protection and Affordable Care Act that has a focus on care transitions. Through value based purchasing, hospitals will be rewarded for providing better quality, safer care. The Value Based Purchasing program will incorporate 17 clinical care measures within the categories of heart failure, acute myocardial infarction, pneumonia, surgical care improvement, and healthcare associated infections (Clark, 2011). This program also considers eight measures from the Hospital Consumer Assessment of Healthcare Providers and Systems survey, where patients comment on their healthcare experience (Clark, 2011).

After October 2012, patient’s perceptions of the care received coupled with the quality of care provided measured against best practice guidelines will determine how hospitals are reimbursed (Clark, 2011). Much of this care and many of these Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey questions that address communication regarding the plan of care could be improved through better transitions between care settings. By providing the right care at the right time, hospitals can reduce readmission rates and ensure that patients transition more smoothly.

Quality measures and readmission rates will affect hospitals financially and will also be available to the general public to view. Patient satisfaction survey results, quality measures for
patients with heart failure, pneumonia, heart attack, childhood asthma, and surgical care needs, readmission, complication, and death information can all be found on the Hospital Compare website. The accessibility of quality indicators will allow consumers to decide where they would want to receive care for themselves and their families.

**Community-Wide Multidisciplinary Issues**

Improving transitions of care for patients is a community-wide, multidisciplinary issue that extends beyond the walls of the hospital. While the hospital will be the first to feel many of the financial repercussions, other community partners will eventually gain from collaborating with hospitals, as they are able to provide better quality and safer care for the individuals within their shared community as they transition to the next care setting. Providing better hand-off from one care setting to the next reduces the risk to the patient and improves outcomes at the post-acute facility (To succeed, hospitals improve transitions of care, 2011). By working collaboratively to provide patient-centered care, health care providers are able to ensure that patients receive the care they need in the manner they desire at the time they desire (Coleman & Berenson, 2004). Community partners to be included in transitions of care improvement strategies are hospitals, home health agencies, hospice agencies, skilled nursing facilities, assisted living facilities, local Area Agency on Aging, transport agencies, and any others that provide needed services for the community.

**Factors Affecting Transitions of Care**

There are many different factors that affect transitions of care for patients and contribute to fragmentation of care. As patients transition through care settings, they interact with multiple care providers, which leaves opportunity for communication breakdowns. Throughout the course of one acute event, patients may receive care from their primary care physician, a hospital
physician during an inpatient admission, a different physician at a skilled nursing facility, and another care team from the home health agency (Coleman et al., 2002). Prompt and thorough communication is necessary, but many healthcare systems cannot support this type of information exchange (Lambrecht, 2012). Patients recently discharged were 25% less likely to be readmitted if their primary care physicians received a discharge summary prior to the follow up appointment (Powell, 2006).

**Discharge Planning**

Developing appropriate discharge plans is an essential skill for providers to master when they discharge patients from one care setting to another. According to Goins (2012), “Missing, inaccurate, and conflicting information can directly affect the quality and effectiveness of the care received” (p. 51). These communication breakdowns can increase overall costs to the healthcare system by causing duplication of tests and procedures as well as overutilization of services (Powell, 2006). Providers often lack training and understanding of their role in transitioning a patient to the next care setting and can be unfamiliar with other sites of care and the resources or skill level of the receiving facility (Coleman & Fox, 2004).

**Patient and Caregiver Education**

Educating patients and caregivers is also important when transitioning to another care setting (Coleman & Fox, 2004). Patients and caregivers are often the only constant throughout the healthcare continuum. They must be included in the plan of care to assume the care coordination role across care settings (Coleman & Fox, 2004). Populations at risk when transitioning between care settings are often the elderly as they are more medically complex and frail; those who transition frequently; or those who have very low literacy (Coleman & Fox, 2004). Some studies have shown that 30-40% of older adults lack health literacy skills which
may prevent them from understanding medications at discharge as well as instructions for follow up appointments (Coleman & Fox, 2004). Education would include medication management and instructions for patient specific follow up care such as provider appointments, labs, wound care, therapy, etc.

**Communication**

In moving forward, hospitals must have a greater focus on ways to improve care transitions for patients. Improved communication is consistently recommended in the literature as a means for providers to break out of their silos and ensure more smooth transitions for their patients (Coleman, 2003). For communication to be effective, it must be understood and valued as a 2-way activity, as “enhancing accountability begins with setting expectations for both the sending and receiving healthcare teams” (Powell, 2006, p. 236). When the various providers and disciplines collaborate, they are better able to develop a common plan of care (Coleman & Fox, 2004). There is also a push from the federal government for improved communication via electronic health records that connect all care providers involved with patients (Goins, 2012). Unfortunately, the shared electronic health record does not include skilled nursing facilities. Focusing more on transition planning as a collaborative activity between hospitals and skilled nursing facilities will ensure better handoff and thus, improved safety and quality of care.

**High Risk Patients**

Hospitals need to be able to identify admitted individuals who are at highest risk for readmission to reduce those readmissions that are potentially preventable (Lambrecht, 2012). Some hospitals have implemented programs that involve advanced practice nurses who will follow these high-risk individuals into the home, post discharge, and coordinate care with their primary care physician (Coleman, 2003). Other programs with proven success include Project
Re-Engineered Discharge (Project RED), Project Better Outcomes for Older Adults through Safe Transitions (Project BOOST), the Care Transitions Intervention, and the Transitional Care Model, which all focus on patients with complex needs and improving their transition back into the community (Lattimer, 2012).

**Early Follow Up**

Early follow up with the primary care physician is consistently identified in the literature as best practice for ensuring a successful transition. It is recommended that patients should have a follow up appointment with their physician within 7 days of discharge (Lambrecht, 2012). According to the Agency for Healthcare Research and Quality (2012a), approximately “40% of patients are discharged with test results pending, and a comparable proportion are discharged with a plan to complete the diagnostic work up as an outpatient” (p. 1). By providing early follow up, providers are able to intervene as early as possible and address any of these pending issues.

Medications are also the source of many issues that patients experience after discharge from the hospital. Many patients have multiple prescribers and are often confused about whether or not to resume home medications or take those found on their discharge orders (Coleman, 2003). To avoid this confusion, a medication reconciliation process should occur on admission, transfer, and discharge (Agency for Healthcare Research and Quality, 2012b).

**Patient and Caregiver Engagement**

Finally, engaging and including the patient and caregiver in the plan of care and education is essential. Health care organizations should engage these individuals in transition planning, provide them with the necessary resources, and educate them on their role in transitions as soon as possible (Coleman & Fox, 2004). By preparing and including these
individuals as valued members of the care team, they are more empowered to be active participants in their care and improve their transition to the next care setting.
CHAPTER III
COMMUNITY PARTNERSHIPS

Developing and strengthening community partnerships at the federal, state, and local levels is an important step in improving care transitions for patients within a community. Having an understanding of those partners, resources, and tools that currently exist and are in support of improved care transitions is also important.

Federal Level

At the federal level, Partnership for Patients, which is a public-private partnership sponsored by The Centers for Medicare and Medicaid Services, is dedicated to keeping patients from being harmed while in the health care system and improving transitions from acute-care hospitals to other care settings (HealthCare.gov, 2011b). There are many different stakeholders that have joined in this initiative, such as, hospitals, health plans, and employers. The Community-based Care Transitions Program is major part of this partnership created by the Patient Protection and Affordable Care Act, which funds communities in their efforts to better manage Medicare patient’s transitions (HealthCare.gov, 2011a). The Joint Commission, a nationally recognized accrediting agency for hospitals, also supports the need of improved care transitions. Through its Transitions of Care (TOC) portal on the website, various tools and resources are provided for patients and healthcare organizations (The Joint Commission, n.d.). Many of these tools are offered through the Institute for Healthcare Improvement including those focused on reducing avoidable rehospitalizations when moving from the hospital to the skilled nursing facility, home health care, and clinical office practice (Institute for Healthcare Improvement, 2012).
State Level

There are also many community partners at the state level who are also instrumental in this movement. The Community Care Plan of North Carolina is a public-private partnership that coordinates the care of North Carolina’s Medicaid population by bringing together a network of physicians, nurses, pharmacists, hospitals, health departments, and social services organizations (Community Care of North Carolina, 2012). Using the Medical Home model approach, all patients are assigned to a primary care provider in their community and more patient-centered care is provided which drives down unnecessary costs to the Medicaid system. By working closely with the Community Care Plan, hospitals and communities can ensure that Medicaid patients have smooth transitions from one care setting to the next.

The North Carolina Center for Hospital Quality and Patient Safety is also an excellent partner at the state level as it strives to improve the quality of care and safety among NC hospitals. By providing “educational, collaborative and performance measurement programs and services” (North Carolina Center for Hospital Quality and Patient Safety, n.d.b, p. 1), they connect hospitals across the state to determine best practices when caring for patients. Through the Readmission Collaborative, work is being done to improve care transitions and reduce preventable readmissions by bringing together healthcare facilities, the NC Center for Hospital Quality and Patient Safety, and The Carolinas Center for Medical Excellence (North Carolina Center for Hospital Quality and Patient Safety, n.d.a).

Local Level

Much of the work that focuses on improving transitions of care is performed at the local, community level. Hospitals must recognize these community resources and reach out to form strong and lasting partnerships to implement change. Hospitalized patients who are considered
too sick to be discharged home independently are often admitted to skilled nursing facilities or receive care from home health agencies. As these patients transition from the hospital setting, their entire care team changes and important information regarding their plan of care may not always be communicated clearly. By working collaboratively, as partners in the patient’s care, providers are more likely to ensure that patients transition smoothly. Other partners include assisted living facilities, transportation agencies, senior centers, caregiver agencies, faith organizations, and disease specific education centers. Each of these partners works within their associated communities to ensure that patients have all of the necessary resources to successfully manage their health in the outpatient setting. It is important for hospitals to recognize and use these resources so that they can connect the right patients to the right resources.

Resources

There are various toolkits and resources available to improve care transitions. The National Transitions of Care Coalition offers tools for the provider regarding medication reconciliation and health information technology. Tools also exist for consumers or patients to use about what questions to ask and checklists to use when moving from one care setting to the next. Another tool includes personal health records for patients to keep with them at all times and update as their health status changes.

The North Carolina Center for Hospital Quality and Patient Safety also provides a number of toolkits and resources to be used by organizations across the state in their improvement efforts. Appendix A lists various agencies and available resources for providers and patients. Appendix B is an example of a transition record to be used when moving from one setting to the next.
CHAPTER IV

ROLE OF THE PUBLIC HEALTH NURSE

“For over a century, public health nursing has significantly contributed to population-focused health through effective partnerships” (American Nurses Association, 2007, p. 1). Some of these partnerships include members of the public health team; local, state, and federal public health organizations; health care providers, community organizations and coalitions, and community service organizations. Public health nurses not only give nursing care but also have been doing “transition work” by referring their patients to both health care providers and community services, following up with providers, and smoothing communication between patients and providers.

Collaboration

The PHN plays an important role in improving transitions of care for patients. By collaborating across organizational and agency lines, the PHN can ensure that the patient receives safe, quality care to improve care transitions in a community. The PHN must also be able to educate the various agencies and professionals involved in caring for patients about the importance of care transitions to gain buy in and participation from these community partners. Being able to collaborate with community partners to promote the health of the population is one of the many roles that the public health nurse can play in assisting with transitions of care (Quad Council of Public Health Nursing Organizations, 2004).

Education and Best Practices

The public health nurse can present and implement best practice programs and processes.
The PHN must have excellent communication skills and be able to advocate for public health programs (Quad Council of Public Health Nursing Organizations, 2004).

Many hospitals and home health agencies are using telehealth, such as health technologies and remote monitoring, to ensure successful patient outcomes. Telehealth is defined as, “the use of technology to deliver health care, health information or health education at a distance” (Health Resources and Services Administration, n.d., p. 1). Telehealth is one way to follow patients beyond the hospital and increase compliance with the treatment plan to assist with symptom management (Schlachta-Fairchild, Elfrink, & Deickman 2008). These programs have decreased readmissions emergency room visits, successfully managed patients with chronic illnesses, reduced healthcare costs, and increased access to care (American Telemedicine Association, 2011).

Public health nurses can educate patients about their chronic health conditions. By using a teach-back method, patients can demonstrate understanding of their care by teaching the nurse (Hines & Barndt-Maglio, 2012). With reinforcement of knowledge over time, patients begin to retain the information (Hines & Barndt-Maglio, 2012). Teaching patients about their medications is also important, as many medications are changed or discontinued after an inpatient hospital stay. The PHN can compare hospital medications to home medications, address any discrepancy, and educate the patients and caregivers about the importance of adhering to the medication regimen.

In addition, the PHN should conduct a home visit shortly after discharge, particularly for those patients who are at high risk for readmission (Hines & Barndt-Maglio, 2012). During these visits, the PHN can review information regarding medications, early signs and symptoms of their chronic conditions, their action plan, and follow up care (Hines & Barndt-Maglio, 2012).
Transitional care programs, which utilize registered nurses as transition coaches, are also becoming increasingly popular in the hospital setting. These nurses must be experienced in providing care coordination services in both the acute care and community settings (Innovative Care Models, 2008). Through a screening process, patients who meet the eligibility criteria are identified and enrolled in programs that follow them post-discharge from the hospital. Transition coaches ensure that 1) critical information is transferred to the appropriate care providers; 2) patients and caregivers are prepared for the next care setting; 3) patients and caregivers are given support and education regarding successful self-management of their health; and 4) they feel empowered to advocate for themselves and their preferences (Parry, Coleman, Smith, Frank, & Kramer, 2003). By coordinating plans of care, the transitions coaches increase appropriate utilization of services and improve the patient’s overall health status (Innovative Care Models, 2008). The four pillars of the transitions intervention program include: medication self-management, a patient-centered personal health record, follow up after discharge, and knowledge of red flags related to the patient’s chronic conditions (Parry et al., 2003). By developing an individualized plan of care that includes strategies to accomplish achievable goals, patients and caregivers are more likely to be successful in managing their care in the outpatient setting (Innovative Care Models, 2008).
CHAPTER V
CONCLUSIONS AND RECOMMENDATIONS

As hospitals are pushed to reduce length of stay and preventable readmissions to remain financially viable in the future, it is imperative that a multi-level, community approach be taken to improve transitions of care for individuals. Since hospitals are often the largest provider of care within the community, it is recommended that they take the lead on this community-wide program.

One recommendation is for hospitals to establish a telehealth program to target specific chronic disease processes and manage that program so patients remain out of the hospital and have a better quality of life. Through a telehealth program, nurses within the hospital can continue to manage individuals in the outpatient setting and improve the transition from hospital to home.

Hospitals must also be able to identify those patients who are at high risk for readmission. By early identification, case management teams within the hospital can provide enhanced discharge needs assessments for those patients, thus providing them with the resources needed to transition smoothly to the next care setting.

It is also recommended that hospitals develop transitional care programs that utilize registered nurses to follow patients for a six to eight week period post-discharge from the acute care setting. This timeframe will allow patients to be followed beyond the 30-day period in which hospitals are at risk to be penalized for readmissions. This program will ensure that critical information such as primary diagnosis, problem list, sending and receiving provider contact information, treatment plan, and recommended follow up will be communicated to the next care...
providers in a timely manner. These nurses will educate patients about their medications and chronic conditions. They will also continue to identify and link patients with resources in the outpatient setting that will assist them in remaining healthy, and out of the hospital.

Another component of the recommended community transitions program involves the public health nurse serving as a liaison between the hospital and the local skilled nursing facilities and home health agencies. Often times, skilled facilities and home health agencies admit patients who are sicker and more medically complicated. Facilities and agencies must have the resources, processes, and programs in place to adequately care for these patients. The PHN should act as a liaison between the hospital and the next care setting to assess needs and develop action plans to address them. The PHN can also provide staff education regarding chronic disease management and ensure that the same protocols are used across care settings to provide consistency. A community-wide list of resources can be compiled to assist patients when transitioning from any care setting. As a result, everyone is aware of the services that are available and how to connect the patients with the service.

The public health nurse should work with facilities and home health agencies to assess readmission data on a quarterly basis to determine which patients are being readmitted. By having a better understanding of which patients are being readmitted and why they are readmitted, the members of the care team can develop focused improvement efforts to target those individuals. This collaboration among the hospital, the skilled facilities, and home health agencies will help develop better handoff communication when sending and receiving patients. A standardized communication tool adds consistency for all patients and providers of care.

Hospitals often have more available resources such as staff and finances. For this reason, it is recommended that the hospital employ the PHN to act as the leader for the community
transitions program to reassure other care providers that the hospital is available as a resource as concerns arise with patients.

As the healthcare system continues to change, providers of care must come together as community to address the needs of their patients. Their responsibility to patients extends beyond the walls of their individual organizations. By aligning goals and working together to transition patients more successfully within the community, care providers are able to provide the patient centered care that patients need.
REFERENCES


APPENDICES

A. Agencies and Resources .............................................................................................................24

B. Patient PASS: A Transition Record..........................................................................................25
# APPENDIX A

## AGENCIES AND RESOURCES

<table>
<thead>
<tr>
<th>Agency</th>
<th>Resources</th>
</tr>
</thead>
</table>
| **National Transitions of Care Coalition**<br/http://www.ntocc.org/> | • My Medicine List  
• Taking Care of My Health Care  
• How to Implement & Evaluate a Plan  
• Patient Bill of Rights During Transitions of Care  
• Informational Slide Deck  
• Informational Brochure  
• Transitions of Care Measures  
• Transitions of Care Checklist  
• Improving Transitions of Care with Health Information Technology  
• Issue Briefs: Improving Transitions of Care  
• Cultural Competence: Essential Ingredient for Successful Transitions of Care  
• Medication Reconciliation Essential Data Specifications  
• Policy Paper |
| **North Carolina Center for Hospital Quality and Patient Safety**<br/http://www.ncqualitycenter.org/> | • NC Prevent CLABSI Toolkit  
• NC Prevent CAUTI Toolkit  
• Medication Reconciliation Toolkit  
• NC Rapid Response Toolkit  
• NC Surgical Care Improvement Project Toolkit  
• The Color of Safety: NC Wristband Standardization Project |
| **Community Care of North Carolina**<br/http://www.communitycarenc.org/> | • Medicaid Tools and Information  
• Asthma Action Plan for Patients  
• Tobacco Cessation Quitline Fax Referral Form  
• Post Partum Depression: Edinburg Screening Questionnaire  
• ADHD: Parent Questionnaire (Vanderbilt Initial Assessment-AAP/NICHQ)  
• ADHD: Parent follow-up (Vanderbilt Followup-AAP/NICHQ)  
• Depression: Algorithm (icare/A2C Western NC/Western Highlands LME)  
• Alcohol: Tips for Cutting Down (NIAAA/NIH)  
• COPD: My COPD Checklist & Action Plan |
I was in the hospital because

If I have the following problems ...
1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

I should ...
1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

My Appointments:
1. ____________________________
   On: __/__/___ at __:__ am/pm
   For: ____________________________
2. ____________________________
   On: __/__/___ at __:__ am/pm
   For: ____________________________
3. ____________________________
   On: __/__/___ at __:__ am/pm
   For: ____________________________
4. ____________________________
   On: __/__/___ at __:__ am/pm
   For: ____________________________

Tests and issues I need to talk with my doctor(s) about at my clinic visit:
1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

Important Contact Information:
1. My primary doctor:
   __________________________________________________________
   (____) _________

2. My hospital doctor:
   __________________________________________________________
   (____) _________

3. My visiting nurse:
   __________________________________________________________
   (____) _________

4. My pharmacy:
   __________________________________________________________
   (____) _________

5. Other:
   __________________________________________________________
   (____) _________

I understand my treatment plan. I feel able and willing to participate actively in my care:

Patient/Caregiver Signature ____________________________

Provider Signature ____________________________

Date /____/_____