Strategies for Effective Transition Care Management:

Practices good for your patients and good for your business

Ann Loeffel, RN, BSN

Objectives for today

You will be able to:

• Evaluate systems and processes related to transition planning in your own center, identify strengths and opportunities and take steps to improve

• Recognize the importance of engaging patients and families in an effective and efficient transition-planning process to achieve successful patient transitions and desired business outcomes
Objectives for today

You will be able to:

• Describe desired objectives and key considerations for writing a comprehensive person-centered discharge summary and discharge plan
• Apply principles of Quality Assurance and Performance Improvement (QAPI) to your quality-improvement efforts related to transition planning

THE CARE TRANSITIONS INTERVENTION
Results of a randomized controlled trial

• Elderly patients transitioning to SNF/home from hospital
• Randomized: Intervention group paired with “Transition Coach” vs. standard care
• Empowerment and education: 4 pillars
  – Facilitate self management/adherence
  – Maintain a personal health record
  – Timely follow-up
  – Knowledge and management of complications
• Education during hospitalization
  – Including meds and med reconciliation
• Phone calls and personal visits by TC post D/C
• N=750

THE CARE TRANSITIONS INTERVENTION
The Effects

• Improved self-management knowledge and skills
  – Medication management
  – Condition management
• Improved patient confidence about what was required of them during the transition and beyond
• Fostered a sense of caring, safety and predictability about the transition
• Contributed to greater patient investment

Eric A. Coleman, MD, MPH; Carla Parry, PhD, MSW
Sandra Chalmers, MPH; Sung-joon Min, PhD

"You can't know where you're going until you know where you've been."

Taking an honest look at your organization's transition care management
AN EXERCISE

The 7 Key Drivers of Successful Patient Transitions

- Post-transition follow-up
- Patient readiness to self-manage
- Timely, relevant patient education
- Identification of expectation gaps
- Early and active patient engagement
- Clear post-transition instructions
- Patient feedback in the moment

AN EXERCISE
Align™

Strategies for Effective Transition Care Management

Are the patient and family engaged early and actively in the planning and decision-making that goes into effective transition planning?
**Identification of expectation gaps**

Are patient expectations discussed, understood and integrated into transition planning?

**Identification of Expectation Gaps**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-4 days Length of stay</td>
<td>21 days</td>
</tr>
<tr>
<td>Myself Preparing meals</td>
<td>Need support</td>
</tr>
<tr>
<td>Need support Showering</td>
<td>Need support</td>
</tr>
<tr>
<td>Kids will take me Transportation</td>
<td>Kids work; needs service</td>
</tr>
</tbody>
</table>

**In the Moment patient feedback**

Do you measure the patient’s experience while they are with you, when you still have time to do something about concerns?
Managing the Patient Experience

Do the patient and family have the necessary knowledge needed to safely monitor health conditions after transition?

Timely, relevant patient education
Align™

Strategies for Effective Transition Care Management

**Lessons:**
- Short in length
- Short paragraphs
- Bulleted lists
- Simple words
- 14-point type

**Patient readiness to self-manage**

Are the patient and family confident at the time of transition that they are prepared to self-manage? And when do you want to know that? After they leave, or when you still have an opportunity to do something about it?

**Clear post-transition instructions**

At the time of transition, does the patient and family receive clear and comprehensive instructions on self-monitoring and self-management?
Is the patient successfully monitoring and managing after they leave you?

Value of post-transition follow-up

- Provide patients with continued support to lower risk for rehospitalization
- Identify and follow up with unmet needs
- Answer questions and fill any gaps in understanding
- Improve patient experience

Provider of choice

<table>
<thead>
<tr>
<th>Transition Planning</th>
<th>VS</th>
<th>Discharge Summary/POC</th>
</tr>
</thead>
<tbody>
<tr>
<td>A process</td>
<td></td>
<td>A document; output of the process</td>
</tr>
<tr>
<td>Starts on or before admission; continues throughout stay</td>
<td></td>
<td>Content begins to develop on admission; continues throughout stay</td>
</tr>
<tr>
<td>Engages patient/family</td>
<td></td>
<td>Patient communication tool; staff guide for patient education</td>
</tr>
<tr>
<td>Involves discussion, assessment, referrals, patient education, resolution of expectation gaps</td>
<td></td>
<td>Record of planning activities</td>
</tr>
<tr>
<td>Activities to meet patient’s post-transition needs</td>
<td></td>
<td>Communication tool for next-level caregivers</td>
</tr>
</tbody>
</table>
Engaging patients in transition planning

"Over and over, patients with a new diagnosis said they did not receive or understand information about everything from taking their medications to potential complicating factors. They talked about rushed discharge processes and lack of follow-up care."


Discharge Summary & Plan of Care

Why?

- To engage the patient in his/her own healthcare by providing him/her with a clear summary of significant events and progress made during his/her stay at your center
- To assist patient/family in taking an active role in his/her healthcare management by providing him/her with a detailed list of post-discharge needs, and care recommendations, instructions and resources to ensure his/her needs will be met

(continued)

Discharge Summary & Plan of Care

Why? (continued)

- To facilitate a safe and orderly transfer or discharge from your center
- To communicate to next-level health care providers so they can continue timely quality care and follow-up
- To meet regulatory requirements for discharge summary (483.20 (1)) and discharge planning (483.20 (1)(3)).
Just a note about the regs...

Per February 2013 DHHS Office of Inspector General report addressing substandard care-planning and discharge planning in SNFs:

"We recommend that the Centers for Medicare & Medicaid Services (CMS):

1. strengthen the regulations on care planning and discharge planning,
2. provide guidance to SNFs to improve care planning and discharge planning,
3. increase surveyor efforts to identify SNFs that do not meet care planning and discharge planning requirements and to hold these SNFs accountable,
4. link payments to meeting quality-of-care requirements, and
5. follow up on the SNFs that failed to meet care planning and discharge planning requirements or that provided poor quality care.

CMS concurred with all five of our recommendations."

Effective transition planning

- More patient/family involvement in self-care and self-monitoring
- Reduced length of stay
- Increased consumer satisfaction
- Fewer unplanned avoidable rehospitalizations
- Cost savings across the healthcare continuum
- Strengthened relationships with HCP across care continuum

Preparing a quality person-centered discharge summary and discharge plan
Engage the patient and family by addressing the patient. Talk TO him, rather than ABOUT him. Write in second person.

Use You ... instead of He...

EXAMPLE: “While you were at ABC Rehab Center, you had physical therapy 5 days a week to work on your balance and walking skills.”

Use Take this medication with something to eat instead of This medication should be taken with food.

Use active voice.

Use Your skin is very dry and thin, and could tear easily instead of You have poor skin turgor that could lacerate easily.

Write at a 3rd- to 5th-grade level.

Use short sentences and words.

Use Get up and walk at least every 2 hours instead of It is critical that you ambulate frequently to facilitate strengthening of your muscles and joints.

Write in conversational-style.

Use When you are at home, Jane, don’t be afraid to call us at 000-000-0000 if you have any questions or problems.

Avoid all uppercase text. Use bold or capitalize text carefully to emphasize a key term or phrase.

Use Take ALL medications as directed instead of TAKE ALL MEDICATIONS AS DIRECTED.
Eliminate medical/nursing home jargon and acronyms. Use lay terms. Give explanations and definitions of terms as needed.

Use tailbone instead of coccyx
Use primary doctor or family doctor instead of primary
Use nursing home team or your care team instead of IDT
Use Your blood tests were all normal instead of Your blood tests were negative

Be specific and give detailed guidance.

Use before each meal and at bedtime or during each TV commercial instead of regularly
Use every Monday, Wednesday and Friday in the mornings instead of 3 times a week

Be very clear.

Instead of Apply Nitropatch daily, use:
1. Wash your hands before and after applying and removing your nitroglycerin (nitro) patch.
2. Apply a patch to your skin every morning and remove it every night.
3. Remove the patch from the packaging; then apply it to a clean, dry, non-hairy area of your chest, inner upper arm, back or shoulder.
4. Do not apply to irritated skin areas.
5. Each day, choose a different area on your body to apply the patch.
### Discharge summary

- Recapitulation of resident’s stay AND
- Final summary of resident’s status upon discharge
- Needs to reflect that appropriate transition planning, including patient education, has taken place
- Includes discharge plan of care for patient/family and next-level care providers

### In a nutshell...

<table>
<thead>
<tr>
<th><strong>ADMISSION INFORMATION</strong></th>
</tr>
</thead>
</table>

**Discharge summary**

- **Date of admission**
- **Reason(s) for the admission**
  - Primary admitting diagnosis in lay terms
  - Pertinent secondary diagnosis in lay terms
  - Why did they need post-acute care?
HOSPITALIZATION HISTORY

You reported being in the hospital as an inpatient during the past 6 months as follows:

- October 10, 2013: Congestive heart failure
- September 1, 2013

You also had 2 emergency room visits for chest pain in the past 6 months.

- Reported hospitalizations in the past 6 months
- Other related significant information

SUMMARY OF STAY

- Summary of treatment plan, goals and progress made during stay
- Significant results of tests or evaluations during stay
- Medication history; significant changes
- Self-care expectations on admission and status at discharge
- Home modifications recommended
- Outstanding issues and follow-up needed after discharge
- Discharge date and destination

SUMMARY OF TREATMENT AND PROGRESS

- Significant events
- Significant changes in treatment plan
- How did the patient progress?
- Patient/family involvement
SUMMARY OF STAY

During your stay here, you worked with physical therapy 5 times a week to get back on your feet and increase your strength and endurance. Your weight, blood pressure and heart rate (pulse) have been taken daily to monitor your CHF and high blood pressure.

**Significant test results**

- **Significant**
- **Most recent**
- **Results which were important in patient outcomes**
- **Results that may impact future medical decisions**

**SUMMARY OF STAY: SIGNIFICANT TESTS**

- Your weight, blood pressures and heart rates have been stable with no signs of new or worsening fluid accumulation.
- Last weight on November 28 was 172 pounds, blood pressure 132/86, heart rate 84. Blood pressures have averaged about 130/80 and heart rate about 76.
- Blood sugars were high earlier in your stay here, but have stabilized in the range of 90-120 fasting in the past 2 weeks.
- Your chest x-ray on November 25th showed no fluid accumulation in your lungs.
- You will continue to monitor your weight, blood pressure and heart rate at home.
- You will have mild swelling in your legs and some shortness of breath with activity. You have been prescribed continuous oxygen to help you breathe more easily and will continue on that at home. You should continue to wear your compression stockings while up to help control the swelling in your legs.
SUMMARY OF STAY: MEDICATION HX

Your medications at home were compared to the medications you are taking now. You should now follow the list of medications constructed included in this plan. If you have any questions or concerns about your medications, call your doctor immediately.

Your water pill (Lasix) was increased from 40 mg once a day to 40 mg twice a day on November 10th because of continued swelling of your legs and decrease of breath. Your low protein level was on November 24.

- New or changed medications
- Reasons for changes
- Any other important info related to medication regimen

SELF-CARE EXPECTATIONS & STATUS UPON DISCHARGE

We talked early in your stay about what and when you expected your independence level to be by the time you were discharged.

- You told us that you wanted to be independent in the areas of walking, using the restroom, preparing meals and eating.
- You felt you would need assistance with bathing, dressing and obtaining transportation. In addition, you felt an outside service or professional assistance would be helpful with housekeeping.

- Functional status upon discharge
- How needs will be met after discharge
- Add any additional info specific to patient
- Note resolution to expectation gaps

Your daughter will help you with grocery shopping and housekeeping. ABC Home Care will visit to help you shower and monitor your congestive heart failure. Although initially you thought you would be able to make your own meals, you agreed that Meals on Wheels should bring you lunch until you feel strong enough to cook.
SUMMARY OF STAY: HOME MODIFICATIONS

The following home modifications were recommended:
• Grab bars in bathroom by the toilet and in the shower
• Handicap on front step and basement steps
Your son has installed a grab bar in your shower. He has arranged for a contractor to install a handrail on your front steps and basement steps next Tuesday, December 12.

• Complete? In progress?
• Who is responsible?
• Has the patient/family declined?
• Referrals made related to home modifications?

SUMMARY OF STAY: OUTSTANDING ISSUES

You were not sure whether or not you wanted a hospital bed to raise the head to help with your breathing at night. If you decide you want a hospital bed, contact Dr. Jones for a prescription, then take it to City Medical Supply Company, and they will order it and deliver it to your home.

On November 28, 2015, you will discharge to an assisted living facility, Horizon West.

• Concerns
• Risks
• Follow-ups
... end with discharge date/destination

Discharge plan of care

• Developed with patient and family
• Addresses how continuing care needs will be met after discharge; includes referrals and follow-up needed
• Interdisciplinary
• Describes specific needs, procedures, instructions and guidance for self-management and self-monitoring
• Explains what to watch for; how and when to report
• Conveys plan of care to next-level caregivers
Avoid medical terms, abbreviations or jargon without defining them in lay terms.

**Your medications**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>When to take</th>
<th>How to take</th>
<th>Why to take</th>
<th>Other instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>500 mg</td>
<td>Daily</td>
<td>By mouth</td>
<td>For cough</td>
<td>None</td>
</tr>
<tr>
<td>Zafirlukast</td>
<td>5 mg</td>
<td>Daily</td>
<td>By mouth</td>
<td>For asthma</td>
<td>None</td>
</tr>
</tbody>
</table>

**Medications sent with you**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Strength</th>
<th>Amount sent</th>
<th>Notes</th>
<th>With</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin</td>
<td>500 mg</td>
<td>500 mg</td>
<td>Cold/fever</td>
<td>Patient</td>
</tr>
<tr>
<td>Zafirlukast</td>
<td>5 mg</td>
<td>5 mg</td>
<td>Asthma</td>
<td>Patient</td>
</tr>
</tbody>
</table>

**Your appointments**

**SCHEDULED APPOINTMENTS**

<table>
<thead>
<tr>
<th>Contact/Name</th>
<th>Phone</th>
<th>Location</th>
<th>Reason</th>
<th>Special instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Smith 1</td>
<td>123456</td>
<td>Office</td>
<td>Follow-up</td>
<td>None</td>
</tr>
<tr>
<td>Dr. Smith 2</td>
<td>654321</td>
<td>Hospital</td>
<td>Consultation</td>
<td>None</td>
</tr>
</tbody>
</table>

**APPOINTMENTS YOU SHOULD MAKE**

<table>
<thead>
<tr>
<th>Contact/Name</th>
<th>Special instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist</td>
<td>Schedule appointment</td>
</tr>
</tbody>
</table>

**TIP**

Include all contact information, reason for appointment and special instructions.
Care instructions

• Detailed care instructions
  – Written directly to patient and/or family/caregiver
  – Developed by each team member
  – Organized by discipline
• Follow tips for writing in patient-friendly language

CARE INSTRUCTIONS: NURSING

• Specific instructions for self-care, monitoring and reporting after discharge
  • Are there any instructions related to meds you should explain that might not be on the medication list?
  • Does the discharge medication list differ from the medications the patient was taking at home before? If so, emphasize those changes to patient

Signs and symptoms to watch for

WONDER DO: Are you warning of these signs and symptoms? CARE OF DOCTOR (face your patient):

• Tachycardia (tachy waves in the EKG)
• Tachy and/or tachy bradycardia
• Tachy on telemetry
• Tachy on telemetry with meds in the system

MEDICAL MENTION

• Any mention of heart failure: During discharge, these signs and symptoms are a medical emergency. CARE OF DOCTOR
  • Tachy waves on the EKG with meds in the system
  • Tachy waves on the EKG with meds in the system
  • Tachy waves on the EKG with meds in the system
  • Tachy waves on the EKG with meds in the system
  • Tachy waves on the EKG with meds in the system
  • Tachy waves on the EKG with meds in the system
  • Tachy waves on the EKG with meds in the system
  • Tachy waves on the EKG with meds in the system
  • Tachy waves on the EKG with meds in the system

CONTINUED ON NEXT PAGE
References any logs or forms sent home with patient

Reference any other instructional handouts given to the patient, such as diet, exercise or procedure handouts

- Weight yourself daily or at the same time as instructed and record on weight log. (A blank log is included in this plan.)
- Take your blood pressure and pulse daily and record on BP/Pulse log as you were instructed here. (A blank log is included in this plan.)
- Refer to tips for writing person-centered instructions
- Remember — avoid medical jargon
- Keep it simple but with enough detail
- Multi-disciplinary approach

**TREATMENT AND PROCEDURES**

- Refer to tips for writing person-centered instructions
- Remember — avoid medical jargon
- Keep it simple but with enough detail
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- Remember — avoid medical jargon
- Keep it simple but with enough detail
- Multi-disciplinary approach
Your services

- Complete contact info for all services that have been arranged for patient
- Add helpful info, such as:
  - Reason for the referral
  - Type of services the provider will provide
  - When patient might expect to be contacted for first time

Ace Home Care will provide assistance with bathing, housekeeping, and blood pressure and congestive heart failure monitoring. The nurse from ABC Home Care will come for the first time on Thursday, November 7th, at around 10 a.m., to evaluate your needs.

Other instructions

- Reference to any equipment or supplies the patient will require
- Include any specific instructions about the equipment: How to use, maintain, clean and re-order, or status of procurement
Person-centered discharge summary and plan of care

Process to practice – An exercise

- Refer to tip sheet
- Refer to Quality Check
- Is your sample really patient-centered?
- What recommendations do you have to improve?
Transition Care Management and QAPI

QAPI – Five Elements

1. Design and Scope
2. Governance and Leadership
3. Feedback, Data Systems and Monitoring
4. Performance Improvement Projects (PIPs)
5. Systematic Analysis and Systemic Action

Transition Care Management PIP

1. Identify problem – DATA
2. Study current processes; investigate root causes and contributing factors – DATA
3. Plan strategies targeting rc/cf
4. Implement interventions
5. Monitor process and outcomes for effectiveness and progress – DATA
6. Revise plan as needed – stay the course!
Study transition management processes

Examine these processes and systems:
- Patient/family engagement
- Communication
- Discharge planning and discharge plans
- Staff knowledge and competence
- Medication reconciliation
- Patient/family education
- Leadership!
- ???????

Your mission...

- Evaluate current transition planning systems and processes (self-assessment tool, etc.)
- Identify system weaknesses
- Understand the problem(s) (RCA)
- Plan and implement targeted strategies
- Monitor and evaluate progress
- Celebrate success!
“By the time I left, I was confident I could manage at home with all the services arranged for me. The staff taught me about my condition, medications and treatment plan, and every staff member regularly reminded me of important points. I practiced taking and recording my own blood pressure. I know what to watch for and report to my doctor. Everything I needed was arranged for me when I got home. If I ever need rehab again, I will definitely go back there!”

QUESTIONS?

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Enhancing your organization's transition-planning process first requires you to identify your current processes, and carefully appraise what's working well and what you could do better. Take an honest look at your current transition-planning process in relation to timeliness, efficiency, interdisciplinary teamwork, patient/family engagement and education, the written discharge plan and positive patient outcomes. Studying your current processes, and identifying strengths and challenges, will help you develop strategies and set goals for a more efficient and effective process. You won't know how to get there until you first identify where you are today.

To assist you in your self-assessment, consider the entire short-stay patient/family experience as you answer the following questions. There is no right or wrong answer — just your honest opinion!

### Rate how well, in your organization:

<table>
<thead>
<tr>
<th></th>
<th>POOR</th>
<th>FAIR</th>
<th>GOOD</th>
<th>EXCELLENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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<tr>
<td></td>
<td>Staff begins discussions with all short-stay patients/families very soon after admission about discharge potential, goals and needs.</td>
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<td>2</td>
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<tr>
<td></td>
<td>Staff engages patients/families by discussing progress, goals and discharge plans with them regularly throughout their stays.</td>
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<td>3</td>
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<tr>
<td></td>
<td>Staff involves families/caregivers in transition planning throughout the stay, and resolves any expectation gaps among patient, family and providers before discharge.</td>
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<tr>
<td>4</td>
<td></td>
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<tr>
<td></td>
<td>All disciplines caring for the patient participate in transition planning and contribute to the written discharge plan.</td>
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<tr>
<td>5</td>
<td></td>
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<tr>
<td></td>
<td>Staff teaches patients/families important information about the patient's conditions, treatment plan, medications and what to watch for in simple, lay terms they can understand.</td>
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<tr>
<td>6</td>
<td></td>
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<tr>
<td></td>
<td>Staff is able to easily and quickly access patient education materials written for the older adult learner.</td>
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<tr>
<td>7</td>
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<tr>
<td></td>
<td>Staff engages patients/families by encouraging them to practice throughout their stay the knowledge and skills they will need after discharge.</td>
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<tr>
<td>8</td>
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<tr>
<td></td>
<td>Staff knows how effective they are in teaching patients the information they need to know about their conditions, treatment plans and medications.</td>
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</tbody>
</table>
**Transition Planning Self-Assessment**  
For Organizations with Short-Stay Patients

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>POOR</th>
<th>FAIR</th>
<th>GOOD</th>
<th>EXCELLENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Staff carefully reconciles medications the patient was taking at home before admission to those ordered at discharge, so the patient/family clearly understands their post-discharge medication regimen.</td>
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<tr>
<td>10</td>
<td>Staff provides the patient/family with a discharge medication list that is legible, using no medical abbreviations, terms or acronyms. The list includes medication names that align with prescription labels, strength, dosage, how and when to take, the reason and any special instructions.</td>
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<tr>
<td>11</td>
<td>Staff works with the patient/family to identify equipment, home modification and healthcare service needs, and assists with making those arrangements before discharge.</td>
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<tr>
<td>12</td>
<td>Staff communicates any follow-up appointments made for the patient and those needed to made by the patient/family (with whom, when and why).</td>
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<td></td>
<td></td>
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<tr>
<td>13</td>
<td>Staff communicates important information about the patient’s care and conditions to post-transition healthcare providers at discharge.</td>
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<tr>
<td>14</td>
<td>At discharge, staff provides each patient with a detailed, patient-centered, written discharge plan with clear instructions in simple, lay terms on how to manage all healthcare needs after discharge.</td>
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<tr>
<td>15</td>
<td>Before transition, staff carefully reviews the post-discharge plan of care with each patient/family and ensures their understanding.</td>
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</tr>
</tbody>
</table>

Now circle the numbers of any of the above questions in which you responded **FAIR** or **POOR**.
Rate how strongly you disagree or agree with these statements:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>STRONGLY DISAGREE</th>
<th>DISAGREE</th>
<th>AGREE</th>
<th>STRONGLY AGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>The <strong>roles and responsibilities</strong> of each discipline in our transition-planning process are clearly defined, communicated, understood and regularly carried out.</td>
<td></td>
<td></td>
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<tr>
<td>17</td>
<td>Our staff <strong>readily knows where each short-stay patient</strong> is in his/her patient education and post-transition preparations at any given time.</td>
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<tr>
<td>18</td>
<td>I feel confident that our <strong>patients are well prepared</strong> to manage and monitor their care and conditions effectively after transition.</td>
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<tr>
<td>19</td>
<td>We have a <strong>method for learning whether our patients are successful</strong> at managing and monitoring their health after transition.</td>
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<tr>
<td>20</td>
<td>We <strong>have data that tells us how satisfied our patients/families are</strong> with their short-stay experiences.</td>
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</tbody>
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Now circle the numbers of any of the above questions in which you responded **DISAGREE** or **STRONGLY DISAGREE**.
BASED ON YOUR SELF-ASSESSMENT:

What part(s) of the transition-planning process does your organization do best?

What are the biggest challenges in your organization’s transition-planning process? Why?

What opportunities for improvement in your organization’s transition-planning process would you suggest?

What are your goals for improving your transition-planning process and outcomes?
# TIPS FOR PREPARING A PERSON-CENTERED DISCHARGE SUMMARY AND PLAN OF CARE

<table>
<thead>
<tr>
<th>Tip</th>
<th>Example</th>
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</table>
| Engage the patient and family by addressing the patient. Talk TO him, rather than ABOUT him. Write in second person. | Use You ... instead of He...
EXAMPLE: “While you were at ABC Rehab Center, you had physical therapy 5 days a week to work on your balance and walking skills.” |
| Use active voice. | Use Take this medication with something to eat instead of This medication should be taken with food |
| Write at a 3rd- to 5th-grade level. | Use Your skin is very dry and thin, and could tear easily instead of You have poor skin turgor that could lacerate easily |
| Use short sentences and words. | Use Get up and walk at least every 2 hours instead of It is critical that you ambulate frequently to facilitate strengthening of your muscles and joints |
| Write in conversational-style. | Use When you are at home, Jane, don’t be afraid to call us at 000-000-0000 if you have any questions or problems |
| Avoid all uppercase text. Use bold or capitalize text carefully to emphasize a key term or phrase. | Use Take ALL medications as directed instead of TAKE ALL MEDICATIONS AS DIRECTED |
| Eliminate all medical/nursing home jargon and acronyms. Use lay terms. Give explanations and definitions of terms as needed. | Use tailbone instead of coccyx
Use primary doctor or family doctor instead of primary
Use nursing home team or your care team instead of IDT
Use Your blood tests were all normal ... instead of Your blood tests were negative |
| Be specific and give specific guidance. | Use before each meal and at bedtime or during each TV commercial instead of regularly
Use every Monday, Wednesday and Friday in the mornings instead of 3 times a week |
| Be very clear: Explain procedures or tasks with a brief list of bulleted steps vs. a long narrative paragraph. | Instead of Apply Nitropatch daily, use:
1. Wash your hands before and after applying and removing your nitroglycerin (nitro) patch.
2. Apply a patch to your skin every morning and remove it every night.
3. Remove the patch from the packaging; then apply it to a clean, dry, non-hairy area of your chest, inner upper arm, back or shoulder.
4. Do not apply to irritated skin areas.
5. Each day, choose a different area on your body to apply the patch. |
QUALITY CHECK: PERSON-CENTERED DISCHARGE SUMMARY AND PLAN OF CARE

The hard work you do with your patients and their families to prepare them for successful transition after discharge should be evident in each discharge summary and plan of care your team writes. Both should be comprehensive and written in a manner that will be clear to the patient and next-level caregivers. Use this checklist to help you evaluate the quality of each discharge summary and plan of care, and make improvements as needed before reviewing with and giving to the patient.

The Discharge Summary and Plan of Care:
☐ Has been developed with patient and family
☐ Is interdisciplinary
☐ Addresses the patient; is written in second person; uses “you” instead of “he/she”
☐ Uses active voice
☐ Is written at a 3rd- to 5th-grade level
☐ Uses short sentences and words
☐ Is written conversational-style rather than clinical progress-note style
☐ Avoids all uppercase text; uses bold and caps carefully for emphasis
☐ Contains NO medical or nursing home jargon, abbreviations or acronyms; uses lay terms
☐ Provides explanations and definitions, if needed
☐ Provides a clear summary of significant events and progress throughout the stay
☐ Includes a final summary of the patient’s status upon discharge
☐ Reflects appropriate discharge planning (including patient education) has taken place
☐ Encourages patient to take an active role in health, decision-making, self-monitoring and self-managing
☐ Provides a detailed list of post-discharge needs, care recommendations, instructions and resources to ensure needs are met
☐ Lists specific, detailed instructions
☐ Uses bulleted steps rather than long narration, whenever possible
☐ Contains suggested text that has been edited to personalize for the patient
☐ Facilitates an orderly transfer or discharge from our center
☐ Clearly communicates to next-level care providers key information needed to continue timely quality care and follow-up
☐ Includes a discharge medication list that has been verified for accuracy and completeness
☐ Has been reviewed with the patient/family for clarity and completeness