Indiana Hospital Association

Care Transitions Toolkit 2023

Patient Safety Awareness

Your guide to raising awareness among staff, patients, and families

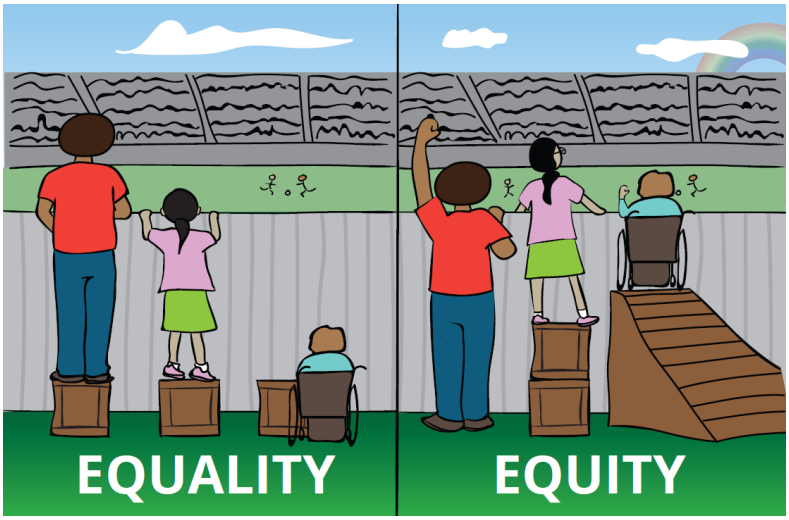
Patient Safety is Personal

Transitions of care refer to the movement of patients between health care practitioners, settings, and home as their condition and care needs change. Care transitions between social service agencies, extended care facilities, hospitals, physician offices, and home health agencies require careful coordination. When communication and coordination break down between providers, transitions can become a vulnerable time for patients and can lead to poor health outcomes and readmissions. Nationally, 17% of Medicare beneficiaries experience a readmission to the hospital within 30 days. Patients discharged to home self-care are more likely to be readmitted within 30 days than those in skilled nursing facilities or in-home health care. Care transitions are most difficult for those with multiple chronic conditions. Coordination of physical/occupational therapy, medication adjustments, social supports, at home care plans, and caregiver needs are essential steps in managing care transitions. Care transitions are improved when patients contact their primary care doctor to reiterate discharge instructions and discuss new plans of care to avoid a readmission.

Care Transitions – Use these images, messages, and links in your public and internal staff education.

Clinical Messages

Message 1: As focus on health equity increases, clinical staff should assess, and document patients' needs for food, housing, and social isolation that may affect care transitions. Social determinants of health are conditions in the places where people live, learn, work, and play that affect health risks and outcomes. Every person has specific needs. Learn more at: About Social Determinants of Health (SDOH) and CDC Health Equity Resources



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Community Messages

Message 2: To manage care at home after a hospitalization, patients, their families, and caregivers need to know and understand the next steps of care, including medications, social support needs, therapies, primary care, and other follow-up appointments. Offer this helpful education to patients and caregivers. Taking Care of Myself When Leaving the Hospital #SaferHoosiers #PatientSafetyAwareness

Message 3: When transitioning from hospital to home, patients and care partners should expect instructions for discharge, clarification of medication needs and changes, activity and/or therapy orders, dietary instructions, and plans for medical follow-up and appointments. Use Your Discharge Planning Checklist #SaferHoosiers #PatientSafetyAwareness

Message 4: It is important for patients to follow-up with their primary care physician after a hospitalization and for family caregivers to partner and engage in the patient's care. Check Taking Care of Myself When Leaving the Hospital and Be More Engaged in your Healthcare Tips for Patients #SaferHoosiers #PatientSafetyAwareness

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Message 5: Adverse drug events related to opioid drug use increased 35.6% from August 2019 to July 2020. Check Facts and Recommendations for Individuals and Families for Substance Misuse #SaferHoosiers #PatientSafetyAwareness

Resources

A variety of resources are available to support your Care Transitions campaign. Check out the websites below for information and tools and use the video links in your education and social media.

AHRQ Strategy 4: Engaging Families in Care Transitions from Hospital to Home: IDEAL Discharge Planning.
AHRQ Patient Family Engagement Guide Strategy
AHRQ Transitions of Care Resources
Primary Care-Based Efforts to Reduce Potentially Preventable Readmissions
Engaging Patients and Families in Their Health Care—Resources Across the Continuum
Toolkit to Engage High-Risk Patients in Safe Transitions Across Ambulatory Settings
Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families
Zone Tools for Patient Discharge Education