Care Transitions

Emergency Department Care Transitions Assessment

Facility Name: _____ **CCN:** _____ **Assessment Date:** _____ **Completed by:** _____

Work with your department leadership team to complete the following assessment. Each item relates to care transition elements that should be in place for a program to improve care transitions within your facility. This Care Transitions Implementation Assessment is supported by published evidence and best practices including, but not limited to, the Joint Commission, National Quality Forum (NQF), Project RED (Re-Engineered Discharge from the Agency for Healthcare Research and Quality [AHRQ]), Project BOOST (Better Outcomes to Optimize Safe Transitions from the Society of Hospital Medicine), and the Care Transitions Model ([CTM®] also known as the Coleman Model). Select the level of implementation status on the right for each assessment item. Once this form is complete, please go online and enter your answers.

Assessment Items	Not implemented/ no plan	Plan to implement/no start date set	Plan to implement/ start date set	In place less than 6 months	In place 6 months or more
A. Medication Management					
1. Your emergency department (ED) conducts **audits** at least quarterly to verify the accuracy of medication histories for patients on high-risk medications (anticoagulants, opioids, and diabetic agents).[i]	☐	☐	☐	☐	☐
2. Your department has a monthly dashboard that tracks:[ii] **a.** Percentage of patients prescribed opioids per physician prescriber.	☐	☐	☐	☐	☐
b. Percentage of patients prescribed naloxone with opioid prescriptions.	☐	☐	☐	☐	☐
3. Your department has a process in place to ensure patients can both access and afford **essential** prescribed medications prior to discharge (i.e., affordability verification).[iii]	☐	☐	☐	☐	☐
B. Discharge Planning					
4. Your department uses electronic health record (EHR) best-practice alerts to:[iv] **a.** Identify patients that are taking or are newly prescribed high-risk medications (anticoagulants, antidiabetics, and opioids).	☐	☐	☐	☐	☐
b. Identify patients who are prescribed both benzodiazepines and opioids.	☐	☐	☐	☐	☐
c. Notify case management of high-risk/high-need patients (e.g., homelessness, financial need, access to care, food insecurities, transportation needs, etc.).[v]	☐	☐	☐	☐	☐

Assessment Items	Not implemented/ no plan	Plan to implement/no start date set	Plan to implement/ start date set	In place less than 6 months	In place 6 months or more
5. Your department has 24-hour intensive/complex case management coverage that provides involvement for:[vi]					
a. Super-utilizers (four admissions in one year—**or**—six ED visits within one year).	☐	☐	☐	☐	☐
b. Patients classified as high readmission risk.	☐	☐	☐	☐	☐
c. Patients who have had an admission within 30 days.	☐	☐	☐	☐	☐
d. Patients who have been discharged from the ED in the past seven days.	☐	☐	☐	☐	☐
6. Your department uses a process to screen patients' eligibility for lower level of care placement (e.g., skilled nursing facility [SNF] or home health) from the ED setting (i.e., prior three-day hospital qualifying stay).[vii]	☐	☐	☐	☐	☐
C. Care Continuum					
7. Your department has a system in place that alerts the patient's originating setting (e.g., SNF, home health, and primary care physician).[viii]	☐	☐	☐	☐	☐
8. Your department has a contact list that is routinely updated with representatives at local SNFs for care coordination communication purposes.[ix]	☐	☐	☐	☐	☐
9. Your department follows up with patients after discharge who are identified as high risk for return to the ED or hospital (e.g., phone call, telehealth, community paramedics, home health, etc.).[x]	☐	☐	☐	☐	☐
D. Facility Infrastructure					
10. Your department is involved in the facility's monthly multidisciplinary readmission prevention team.[xi]	☐	☐	☐	☐	☐
11. Your department has a process in place to validate providers are using an evidence-based patient education methodology (e.g., teach-back).[xii]	☐	☐	☐	☐	☐

Open Response:

1. **What do you believe is going well in your organization related to care transitions (please provide any tools you are using)?**

2. **Where are opportunities for improvement regarding care transitions?**

3. **What are your organizational goals for this calendar year surrounding care transitions?**

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i **Rationale:** Admission medication history errors frequently cause adverse drug events that can lead to avoidable readmissions and/or ED visits.
References: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5912995/
- https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB1254
- https://bmjopen.bmj.com/content/bmjopen/6/2/e010003.full.pdf
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4296593/
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5768299/

ii **Rationale:** Dashboards measure the extent to which providers adhere to policies and allow providers to see how their patients and their implementation of specific clinical practices compare to their colleagues. Tracking opioid prescribing rates and the co-prescribing of benzodiazepines with opioids helps identify potential risks that lead to adverse events.
Reference: https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf
- https://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/hospital-discharge-opioids.pdf
- https://www.mbc.ca.gov/Download/Publications/pain-guidelines.pdf
- https://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opioid-prescribing-guidelines.pdf

iii **Rationale:** Cost-related non-adherence among older adults has been documented as a significant problem in care coordination. Organizations should integrate an affordability analysis and insurance verification process in the discharge plan to address this barrier.
References: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3780603/
- https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html

iv **Rationale:** EHR templates and fields should be incorporated in the ED clinical workflow and auto-populated to the extent possible (e.g., triggers, best-practice alerts) to facilitate consistent use and to support standards of practice when identifying high-risk patients. Identifying patients prescribed high-risk medications and those who are co-prescribed with benzodiazepines and opioids will help reduce adverse events.
Reference: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4407637/
- https://www.healthit.gov/sites/default/files/2018-12/CDSSession.pdf
- https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf

v **Rationale:** Focusing increased transitional intervention for those identified as high risk for readmission based on associated factors reduces probability for subsequent rehospitalization. Causes of readmissions are often related to unmet social factors which impact an individual's health.
References: https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
- https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf
Resource: https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/8ps_riskassess-1.pdf

vi **Rationale:** Admission patterns can be used to predict the likelihood of a patient returning to the ED and identify barriers and gaps associated to the patient's ability to manage his or her condition. Customizing patient-centered care plans through an intensive case management approach can reduce utilization and readmission risk for this complex population.
References: https://www.chcs.org/media/FINAL_Super-Utilizer_Report.pdf
- https://www.ncbi.nlm.nih.gov/pubmed/21079705

vii **Rationale:** Appropriate placement in a lower level of care helps support overall healthcare spending and allows the patient to heal within the least restrictive care setting.
References: https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf
- https://innovation.cms.gov/Files/x/aco-carecoordination-toolkit.pdf
- http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx
- https://www.ncbi.nlm.nih.gov/pubmed/28874939
- https://partnersathome.org/about/news/direct-to-snf

Resources: http://www.ihi.org/resources/Pages/IHIWhitePapers/AGuidetoMeasuringTripleAim.aspx

viii **Rationale:** Alerting primary providers of ED utilization encourages comprehensive oversight maximizing effective disease management.
References: https://www.ahrq.gov/sites/default/files/publications/files/redtoolkit.pdf
- https://www.ncbi.nlm.nih.gov/pubmed/25755159
- https://www.healthit.gov/sites/default/files/onc-beacon-lg1-adt-alerts-for-toc-and-care-coord.pdf

ix **Rationale:** The use of an updated contact list increases the bidirectional communication and accuracy of information communicated during SNF–ED care transitions.
References: https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf
- https://www.huddleforcare.org/story/improving-bidirectional-communication-between-the-emergency-department-and-post-acute-care-facilities/

x **Rationale:** The risk for readmission to the hospital or ED increases significantly when there are failures in post-discharge communication, planning, and follow-up.
References: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3128446/
- https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf
- https://www.chcf.org/wp-content/uploads/2017/12/PDF-PostHospitalFollowUpVisit.pdf

xi **Rationale:** Assessment and management of high-risk patients is a complex, multi-process, multi-role activity that requires consistent systemic vigilance, evaluation, and communication. A multidisciplinary task force establishes shared responsibility and opens lines of communication. ED participation is integral as it is one of the primary entry points for many acute care facilities.
References: https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf
- https://www.ahrq.gov/sites/default/files/publications/files/redtoolkit.pdf
- https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/hot_topics_transitions_of_carepdf.pdf?db=web&hash=CEFB254D5EC36E4FFE30ABB20A5550E0

xii **Rationale:** Evidence-based education methodologies (such as teach-back) have a positive association with retention of discharge instructions in the ED.
References: https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
- https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf
- http://www.ihi.org/resources/Pages/Tools/AlwaysUseTeachBack!.aspx