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Adapting The Joint Commission's Seven Foundations of

Safe and Effective Transitions of Care to Home

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The purpose of this article is to describe The Joint Commission's 7 foundations of safe and effective transitions of care to home: (a) leadership support; (b) multidisciplinary collaboration; (c) early identification of patients/clients at risk; (d) transitional planning; (e) medication management; (f) patient and family action/engagement; and (g) transfer of information. These foundations were identified by The Joint Commission after a review of published research; focus groups with healthcare professionals involved in transitions of care; and visits to diverse healthcare organizations. The author, who is the executive director of The Joint Commission's Home Care Accreditation Program, illustrates how healthcare organizations are adapting the 7 foundations of safe and effective transitions of care to home.

The Joint Commission (2013) identified seven foundations that assure safe and effective transitions from one healthcare setting to another. These foundations include: (a) leadership support, (b) multidisciplinary collaboration, (c) early identification of patients/clients at risk, (d) transitional planning, (e) medication management, (f) patient and family action/engagement, and (g) transfer of information. Labson (2015) demonstrated that care processes and resources emphasizing these foundations

are helping to improve quality outcomes including reduced readmissions, decreased emergency department visits, improved patient satisfaction, improved caregiver competence, and better patient compliance. The purpose of this article is to describe these seven foundations and how healthcare organizations are using them to support safe and effective care transitions.

Leadership Support

The support of executive leadership is a common theme running through successful programs. As senior leadership becomes familiar with the transitions challenge and becomes invested in finding solutions, they find the initiatives to be valuable in reducing readmissions and achieving other favorable outcomes. For example, the leadership of Virtua Home Care heartily supported the implementation of the Transitional Care Model (Naylor & Sochalski, 2010) because it was identified by the Centers for Medicare and Medicaid Services (CMS) as an evidence-based intervention—and one that could be a valuable addition to efforts to improve care transitions and reduce readmissions (Berry et al., 2011). At Pediatric Home Services (PHS), senior leadership empowers internal work groups to continually evaluate and improve patient transition processes. The groups welcome suggestions for improvement, which are then considered by team members. By involving all team members in this way, PHS leadership makes the roles of employees in creating successful transitions clear and meaningful.

There is also a good deal of leadership support coming from national policymakers and resources. For example, the CMS's effort to reduce readmissions, the CMS Innovations Center and Partnership for Patients Program, the Home Health Quality Improvement (HHQI) National Campaign, and the Visiting Nurse Associations of America (VNAA) Blueprint for Excellence all pursue the three aims of the National Quality Strategy: better care, healthy people/healthy communities, and affordable care. These standards and resources pave the way for continual process and quality improvement by healthcare organizations, which understand that current care models must evolve to the new models of care delivery emphasizing value and population health outcomes.

Effective transitions of care processes require multidisciplinary collaboration, not only at the time of transition but throughout the course of care.

More than 3,700 hospitals are taking leadership roles within 26 Hospital Engagement Networks as part of the CMS Partnership for Patients Program to reduce readmissions (CMS, 2014). In addition, the HHQI campaign has nearly 11,000 participants from about 5,000 home healthcare agencies (HHAs), according to the programs' Web sites (HHQI, 2014). The programs together have created financial incentives, provided evidence-based tools, contributed to education and training, and made measurement and evaluation resources available—all to improve care transitions to home and reduce readmissions.

Approximately 7,000 home care programs are accredited by The Joint Commission, which contributes thought leadership in this area through its participation on HHQI and VNAA committees and in other activities. The Joint Commission's Home Care Accreditation Program contributes its body of knowledge to clearinghouses such as the HHQI and VNAA and supports the spread of this knowledge to both accredited HHAs and those seeking accreditation by participating in continuing education and other quality improvement activities. An analysis of CMS outcomes data (2009–2010) shows that HHAs accredited by The Joint Commission have fewer hospital readmissions after an episode of care than do nonaccredited or competitor-accredited organizations. Also contributing toward enhanced safety and better compliance to care regimens in the home, the Food and Drug Administration (2012) and the Association for the Advancement of Medical Instrumentation (AAMI) (2013) are both leading efforts to improve the readability of instructions for the operation of home medical equipment and to incorporate human factors knowledge into the creation of home care equipment that can be used more intuitively.

Multidisciplinary Collaboration

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time of transition but throughout the course of care. Five case examples described by Labson (2015) demonstrated that it truly takes a village of skilled healthcare professionals to promote optimal outcomes for a patient. The days of treating a patient—especially one with a chronic illness or with comorbidities, outside of a connected framework, are over. Treating these patients in a multidisciplinary fashion is required to reduce risks, achieve optimal outcomes, and avoid the high costs of readmission. The concept of multidisciplinary planning also includes participation by the patient and family/friend caregivers, as well as healthcare professionals. The multidisciplinary approach now extends beyond the care conference to how care transitions are made; how care is planned and provided in the home; and how patients, caregivers, and staff are involved and educated.

For example, BrightStar Care, recognized with The Joint Commission's Enterprise Champion for Quality Award in 2014, extends the idea of multidisciplinary collaboration to include specially trained private duty caregivers overseen by registered nurses working within a corporate healthcare franchise system in which all agencies must be accredited by The Joint Commission. BrightStar made accreditation a requirement of all franchisees because it serves as a detailed operational plan for each of the company's agencies as they work within an evidence-based, quality-oriented structure to prevent illness and complications.

The accreditation program's standards and elements of performance define expectations for planning and coordinating multidisciplinary care within HHAs. These standards and elements of performance begin as a patient is brought into an inpatient environment and conclude when the patient has reached independence or the course of care. Accredited organizations' leadership is accountable for bringing effective resources to bear, and staff at all points along the care continuum are expected to communicate needed information to each other and to patients and family caregivers.

Early Identification of Patients/Clients at Risk

HHAs are acquiring a better understanding that assessing the risk of readmission is an important first step toward prevention. Patients at risk for readmission are identified by factors such as number of previous admissions, health literacy and confidence in self-care, complexity of medical condition, and discharge condition. These factors are addressed with interventions such as patient and caregiver education, multidisciplinary collaboration, follow-up visits, telehealth, and other means. Understanding a patient's state of mind, goals, and concerns while minding their health literacy status has been found to be increasingly important (Abrams et al., 2014).

Planning for Care Transitions

HHAs must place a good deal of thought into the patient's plan of care, which serves as the blueprint for ongoing patient care. To be successful, planning for care transition must be more than a set of discharge instructions. The plan of care must involve effective coordination with all of the appropriate care providers necessary to ensure that the patient is effectively transitioned home. These providers include but are not limited to home healthcare, hospice, durable medical equipment providers, private duty staff, and pharmacy staff. The care may also involve telehealth or other technology services. Rather than a one-off transaction, transitional planning is now seen as a series of ongoing transitions extending over the entire period of patient care. Planning for care transitions is more than planning a hand-off—it is planning to assure continuous patient engagement, monitoring, and evaluation.

For example, both Centura Health at Home and PHS take a robust approach to planning for care transitions. Centura Health at Home trains case managers to identify patients eligible for the telehealth program and to introduce the intervention to patients during their hospital stays. Within 48 hours of discharge, telehealth technicians train patients how to use in-home devices to foster engagement as they and their caregivers begin to follow the treatment plan.

PHS's clinical educators and technical support staff train caregivers to use equipment safely and effectively. They translate manufacturers' instructions into user-friendly language and images for caregivers. In addition, PHS developed the Stop, Take inventory, Assess, Review (STAR) Kit—free educational materials and tools designed to enhance patient safety in the home. The kit was developed after a survey assessing in-home caregiver emergency preparedness found a need for additional education and training in oxygen use and safety, emergency resuscitation bag function and use, and emergency response procedures. The kit includes informational DVDs, safety checklists and reminders, troubleshooting guides, equipment tags, and an emergency action plan.

Medication Management

Adherence to medication regimens remains vital to optimal health outcomes; as such, virtually all care transitions programs are working to promote medication adherence. Sending a medication list as part of a care transition is only a start. Tools to increase patient understanding and engagement, such as stoplighted care plans and patient-friendly medication lists, are helping to improve adherence. Learning why patients do not take medication can lead to solutions, as their decision may be based on misunderstanding and health literacy issues.

For example, the Sutter Care at Home team uses a health literacy universal precautions approach by providing a jargon-free medications list and "stoplight" action plans. Written in plain language and supported by the teach-back process, the "stoplight" plans help the patient understand and monitor signs/symptoms associated with his or her particular medical condition by organizing the symptoms by green (under control, no need for action), yellow (take action today), and red (take action now). For patients taking high-alert medications, stoplight tools help them to monitor for unintended or untoward medication effects, thereby permitting early reporting of problems in a confident manner and reducing the probability of patient harm or nonadherence.

Patient and Family Action/Engagement

The Patient Activation Measure (2004) by Hibbard et al. reflects a patient's participation in his or her care in four stages: believing one's role is important, having the confidence and knowledge to take action, taking action to maintain and improve one's health, and staying the course, even under stress. Efforts to engage patients and caregivers in understanding the nature of disease states and how to achieve optimal outcomes are now occurring along the entire care continuum. Providers also are beginning to understand that many patients simply do not understand the nature and treatment of their conditions. This limited health literacy can undermine treatments provided to the patient and decrease patient engagement in their care.

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True patient engagement requires an ongoing, multidisciplinary relationship with the patient, shared decision making, and understandable instructions. Team members in successful organizations strive to increase the number of touch points with patients and family caregivers to increase their understanding of their self-care responsibilities after discharge. Rather than just telling patients what to do, providers guide patients toward making their own decisions. Once truly engaged in their own care, patients become physically, psychologically, and socially activated for the betterment of their health. Creative uses of social media and patient activation mobile applications are

facilitating this 360-degree approach to patient engagement.

Transfer of Information

Successful transfer of information between the organizations and patients and referral sources is continuous, aided by remote monitoring and electronic health records. For example, the Cleveland Clinic's infusion therapy team uses the health system's electronic health record to share information about the patient during hospitalization, as well as after discharge when working with the Cleveland Clinic's HHA. If the patient prefers to work with another agency, the team keeps in touch with that agency via telephone and other means. The key is constant follow-up. Telehealth programs such as Centura's facilitate patient engagement and monitoring via remote technology and 24/7 access to medical advice.

As patients become more engaged in their care, information transfer will increasingly become a two-way street on which patients and providers learn from each other. The Joint Commission's Hand-Off Communications Project developed the SHARE acronym to emphasize the qualities of effective handoffs and information transfer: Standardize critical content; hardwire within the system; allow opportunity to ask questions; reinforce quality and measurement; and educate and coach.

Conclusion

This article described seven foundations that have been instrumental in building successful transition of care programs. As providers begin to master care transitions to home and reduce 30-day readmissions, healthcare will be increasingly delivered outside of traditional clinical settings. As home and community settings become preferred by patients and supported by technology, the concept of "anywhere, everywhere" healthcare will begin to be realized (AAMI, 2013). With effective communication of patient information along the entire care continuum and with increased patient activation, the location of a patient will become increasingly less important. Most important will be how well the patient is prepared and empowered to be actively engaged in self-care. This preparation and empowerment must begin in the hospital, continue through transitional stages, and be supported by effective systems extending all along the care continuum. ■

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