Appendix E: Example: Structures in Organizations to Support Care Transitions

TYPE OF STRUCTURE	COMPONENTS	
Nurse case management	• Used with frail older adults in rehabilitation hospital to transition to a home setting; • Interprofessional team partnership (a nurse manager working with a geriatrician); • Access to integrated service environments for coordination and facilitation of appropriate and timely services (nurse case manager has access to hospital inpatient service, hospital-based day rehabilitation service, ad hoc medical consultation, as well as community services such as home care and respite care); and • Clients to have timely access to the nurse case manager (clients have a direct line to the manager).	Yau et al. (2005)
Home care service model	• Nurse-led case management; • Streamlined access to health-care services and resources; and • Focus on clients' functional ability and caregiver burden.	Morales-Ascenio et al. (2008)
Discharge planning conferences	• Client participation; • Focus on education of client, their family and caregivers to make informed decisions; • Timing and location of scheduled meetings to meet the client's needs; and • Conscious use of language that facilitates the discussion and does not create barriers.	Efraimsson, Sandman, Hyden, and Rasmussen, (2004)

TYPE OF STRUCTURE	COMPONENTS	
Intensive case management	• Community-based package of care for provision of long term care for severely mentally ill clients who do not need immediate admission; • Evolved from 2 models: Assertive Community Treatment and Case Management; • Involves smaller caseload and high intensity care; • Requires training for mental health workers; and • Known to increase client satisfaction with care.	Dieterich et al. (2010)
Transitional discharge model	• Peer support volunteers and inpatient staff to support the client with mental health disorders; • Act as a bridge on client transition to community care provider(s); and • Requires effective resourcing, organization readiness and change management activities for successful implementation.	Martin (2007)
Primary care outreach service by emergency department-trained nurses	• Involves outreach services by Emergency Department-trained nurses; and • For prevention of Long Term Care Home transfers to the Emergency Department.	Codde et al. (2010)
Post-hospital discharge case management	• Focus on hospitalized older adults; and • Use of knowledgeable staff to provide case management on discharge from the hospital.	Popejoy (2011); Parker et al. (2004)
PACT – Patient assessment, assertive: communication, continuum of care, teamwork with trust	• Uses handover prompt card template for shift-to-shift and person-to-person handover; and • Standardized reporting templates or scripts to communicate client issues to primary care provider or most responsible physician.	Clark, Squire, Heyme, Mickle, and Petrie (2009)

TYPE OF STRUCTURE	COMPONENTS	
Project Red – Reengineered hospital discharge program	▯ Use of nurse discharge advocate to develop and coordinate clients hospital discharge plan and ensure onsite preparation of clients; ▯ Creation of a personalized post-hospitalization discharge booklet for the client appropriate to their health literacy and language proficiency levels; ▯ Booklet outlines the essential education information, provider contacts, future scheduled appointments, outstanding test results, medication schedule; ▯ Booklet is given to the client prior to discharge and a copy faxed along with the discharge summary to the primary care provider; and ▯ Post-discharge phone follow-up in two to four days by clinical pharmacist.	Jack et al. (2009)
Improving transitions for young people from child to adolescent mental health services	▯ Suggest organizations review and identify elements of good practices that support effective transitions for young people who move from child to adolescent mental health services; ▯ Local health services should examine transition practices and adapt them to cater to the needs of young people they serve; and ▯ All models of care must identify any transition points so that they can be incorporated into care pathways and service delivery models.	Munoz-Solomando et al. (2010)
ROLES	**COMPONENTS**	
Liaison nurse role	▯ Role used on client move from ICU to ward; ▯ Use dedicated staff to support transitional processes; ▯ Team of nurses trained in critical care used to provide clinical support and advice on hospital wards; and	Baker-McClearn & Carmel (2008); Chaboyer, Foster, Foster, & Kendall (2004); Chaboyer et al. (2012)

ROLES	COMPONENTS	
Other titles for nurses in transition roles	Nurse as: ▯ Champion; ▯ Clinical nurse specialist; ▯ Discharge coordinator/facilitator; ▯ Mediator; ▯ Navigator; and ▯ Nurse discharge advocate.	Anderson, Helms & Kelly (2004); Bowles et al. (2003); Caffin, Linton, & Pellegrini (2007); Enguidanos, Gibbs, & Jamison (2012); Finn et al. (2011); Jack et al. (2009); Lee et al. (2011); Nosbusch et al. (2010); Parker et al. (2004)
OTHER TRANSITION SUPPORT STRUCTURES	**COMPONENTS**	
Integrated care pathways for orthopaedics (femur neck fracture)	▯ Pathways used to enhance interprofessional team collaboration and communication and subsequently support effective and safe transitions; and ▯ Integrating practice found considerable improvement in client management in reduction in the length of stay.	Atwal and Caldwell (2002)
Successful organization pathways	▯ Pathway is supported by the executive board to be used as an organization strategy and vision for care. Supported by executive board; ▯ Must have strong client-centred structures in place; ▯ Clear communication path for why and how pathways are to be used by staff; and ▯ Pathways facilitate within and between organization communications.	Gerven, Vanhaecht, Deneckere, Vleugels, & Sermeus (2010)

OTHER TRANSITION SUPPORT STRUCTURES	COMPONENTS	
Intervention toolkit to prevent readmissions of elderly	▯ Admission form with geriatric cues; ▯ Facsimile to primary care provider; ▯ Use of a standardized worksheet among interprofessional team members to identify barriers to discharge; ▯ Pharmacist–physician collaboration on medication reconciliation; and ▯ Pre-discharge planning appointments.	Dedhia et al. (2009)
Discharge teaching	▯ Focus on neonate intensive care unit setting; ▯ Increase in discharge teaching content for parents; and ▯ Includes peer support as part of program.	Sneath (2009)

OTHER TRANSITION SUPPORT STRUCTURES	COMPONENTS	
Policy and procedures to guide the process for: ***1. Handovers;*** ***2. Transfer of information; and*** ***3. Assessment and referrals.***	1. Handovers: ▯ Necessary to consider the type of handover process (bedside handover with client validation to ensure accuracy or standard verbal report, taped report); ▯ Consider documentation requirements; ▯ Written versus verbal handoffs between care providers; and ▯ Should address use of rough notes (Are notes kept in client health record or disposed of?).	McMurray, Chaboyer, & Wallis (2010); McSweeney, Lightdale, Vinci, & Moses (2011); Riesenberg et al. (2010); Trachtenberg and Ryvicker (2011)
	2. Transfer of Information: ▯ Consider role and responsibilities (who is responsible for cross-checking the transfer reports for diagnosis, medication reconciliation, treatment intervention accuracy) on transition.	Perren, Conte, DeBitonti, Limoni, & Merlani (2008)
	3. Assessment and Referrals: ▯ Use standardized, reliable, and valid instruments for assessments for service and service referrals across service providers and settings; and ▯ Use of standardized referral forms.	Bowles et al. (2003)

OTHER TRANSITION SUPPORT STRUCTURES	COMPONENTS	
Standardized communication and documentation systems	Use of any of the following: ▯ Framework or structure to guide client handovers or transitions; ▯ Discharge preparation summary sheet; ▯ Checklists (paper or electronic format); ▯ Handover instruments or protocol used when moving a client (from ICU to ward); ▯ Handover sheet with standardized information required for information exchanges between health-care providers and any concerns regarding client discharge); ▯ ICU discharge planning booklet focused on what clients/ families can expect on discharge to the ward (such as lower nurse-client ratios and ward routines); ▯ Discharge alert sheets to facilitate staffing levels on the ward receiving the client. ▯ Integrated electronic documentation systems within point of care systems such as electronic medical health record (EMR) and hospital information systems (HIS's) and electronic health records (EHR's) for inter-organization and external organization continuity of care; ▯ Transfer forms (paper but encourage electronic formats); ▯ Electronic discharge summaries; ▯ Use of health information and communication technology for example, electronic whiteboards for handovers in emergency departments; and ▯ Written information tailored to meet client's needs following verbal education or after any information exchange (client brochures with tips for when discharge).	Arora et al. (2009); Brown et al. (2009); Bost et al. (2010); Chaboyer et al. (2004); Chaboyer et al., (2012); Collins et al. (2011); Hadjistavropoulos et al. (2009); Helleso and Lorensen (2005); Johnson et al. (2008); Kerr (2002); McFetridge, Gillespie, Goode, & Melby (2007); Nagpal et al. (2010); Perren et al. (2008); Segall et al. (2012); Staggers and Jennings (2009); Terrell and Miller (2007); Wayne et al. (2008)

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