

Transitional care can reduce hospital readmissions

A bundle of activities linked to transitional care principles can reduce both short- and long-term readmission risk.

By Joan M. Nelson, DNP, ANP-BC, and Amy L. Pulley, BA

AVOIDABLE hospital admissions are a key patient safety and quality concern. A significant cause of preventable readmissions is poor communication and coordination of care during transitions. Transitions between care settings are vulnerable periods for all patients, but especially older adults and those with multiple comorbidities. Transitions include admissions and discharges within and between acute-care hospitals, skilled nursing facilities, long-term care facilities, long-term acute-care hospitals, assisted living facilities, and home.

All too often, poor coordination between the acute setting and primary care provider results in poor longitudinal care planning. Fewer than 50% of patients see their primary care providers within 2 weeks of hospital discharge. Comprehensive programs to enhance care during transitions between settings can reduce not only 30-day hospital readmissions but also readmissions for the entire year after the initial hospitalization. This article reviews the rationale for administrative implementation of high-quality transitional care initiatives and provides tools to help nurses implement these initiatives.

Readmission by the numbers

One in five Medicare enrollees is readmitted to the hospital within 30 days, and up to 75% of these readmissions are preventable. The readmission rate for patients discharged to skilled nursing homes is even higher: 25% are readmitted within



30 days. Such readmissions cost the U.S. healthcare system approximately \$17 billion annually, not including readmissions to emergency departments (ED) or urgent-care settings.

The Institute of Medicine (IOM) highlighted this problem in its 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*. Yet readmission rates re-

mained stable between 2004 and 2011. The IOM identified poor patient-discharge instructions—including information about medications, red flags for worsening condition, and contact information for questions—as a care-transition problem.

Effect of the Affordable Care Act

In 2012, the Affordable Care Act (ACA) established the Medicare Hospital Readmissions Reduction Program (HRRP), giving hospitals incentives to reduce readmission rates. Financial penalties are imposed on hospitals whose adjusted 30-day readmission rates for patients with acute myocardial infarction, heart failure, and pneumonia are significantly higher than the national average. These rates are adjusted according to patient demographics and risk factors. (In 2015, the Centers for Medicare & Medicaid Service (CMS) is expanding this program to cover COPD and hip and knee arthroplasties.) Since HRRP implementation, the 30-day readmission rate for Medicare patients has decreased from 20% to 17.8% overall, with the most significant reductions in the targeted diagnostic groups.

Understanding transitional care

Transitional care refers to a collection of services aimed at ensuring optimal communication and coordination of services to provide continuity of safe, timely, high-quality care during transitions. Optimal management of care transitions includes patient and family education, coordination and arrangement of



LEARNING OBJECTIVES

1. State the problem of readmission rates.
2. Compare transitional care models.
3. Discuss strategies for effective transitional care.

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care in the post-acute care setting, and aiding communication among healthcare professionals involved in the patient's care transition.

Several transitional-care programs have gone through randomized controlled trials and been found to significantly lower readmission rates, with reductions up to 45%. These programs incorporate such services as comprehensive discharge planning, post-discharge telephone outreach, home visits, patient-centered discharge instructions, follow-up with a primary care provider, and medication reconciliation.

Specific care transition models

Transitional care programs that reduce both healthcare costs and readmissions include the care transitions intervention model (Coleman model), transitional care model (Naylor model), and Better Outcomes for Older Adults through Safe Transitions (BOOST) model.

Care transitions intervention model

Eric Coleman's care transitions intervention model is a 4-week program designed to foster patient engagement and promote a smooth transition from the hospital or skilled nursing facility to the home. It has been shown to decrease re-hospitalizations. This model rests on four pillars:

- medication self-management
- maintenance of a personal health record
- primary care physician follow-up
- alertness to red flags.

A transition coach focuses on the patient's self-identified goals and helps the patient develop self-management skills. The relationship is relatively short, spanning only the 4-week intervention period, and the coach doesn't assume home-care or case-management responsibilities. Coaching starts in the hospital, where the coach describes the transitional care program, obtains the patient's consent to participate, and

introduces the Coleman personal health record (www.caretransitions.org/documents/phr.pdf). This record guides the patient in documenting medication and other medical information and generates a list of questions for the healthcare provider. A home visit is scheduled within 72 hours of discharge.

During the home visit, the coach assists the patient with a pre-/post-hospitalization medication review and addresses any discrepancies. The patient develops his or her own list of questions for the primary care provider. The coach and patient review the discharge plan and update the personal health record. Finally, the coach discusses symptoms and drug side effects and establishes an alert-and-response system.

After the home visit, three follow-up calls take place to address the patient's remaining medication questions, discuss the outcomes of follow-up primary care provider visits, describe available support services, and assist with scheduling additional follow-up appointments as needed.

Transitional care model

Mary Naylor's transitional care model involves a 1-to-3 month period of interventions with high-risk older adults to prevent hospital readmission. An advanced practice registered nurse (APRN) performs a pre-discharge patient assessment, and then collaborates with the hospital team to develop a transitional care plan.

The APRN makes multiple home visits, uses telephone outreach throughout the transitional care period, and promotes information transfer between the acute-care and primary-care settings by accompanying the patient to the first primary care follow-up visit. Cornerstones of this model are patient engagement, goal setting, and communication with patients, families, and healthcare team members. The APRN helps the patient identify early signs and symp-

toms of a worsening condition to expedite prompt intervention and avoid future hospitalization.

Patients with specific risk factors are good candidates for this care model. (See the box below.)

Patients who can benefit from the transitional care model

Patients with cognitive impairment or any two of the following characteristics can benefit from Naylor's transitional care model:

- age 80 or older
- functional deficits
- active psychiatric condition
- four or more comorbidities
- six or more prescription medications
- two or more hospitalizations in the 6 months before the index period
- inadequate social support
- poor health literacy
- poor adherence to medical recommendations.

Project BOOST

An initiative of the Society of Hospital Medicine, Project BOOST was developed by a team of payers, regulators, and leaders in healthcare transitions and hospital medicine to improve the quality of care transitions. This model focuses on discharge processes and communication with patients and receiving providers. It uses a systemic approach to enhance the quality of transitions and gives clinicians tools to help them standardize, initiate, and improve hospital practices. Evidence-based tools are available in a toolkit available free of charge to healthcare professionals with an interest in transitional care. Project BOOST also provides technical support and education to project management teams and helps develop a community of organizations that freely share strategies and struggles with program implementation.

Project BOOST involves discharge planning, medication reconciliation, patient and family communication, and primary care provider communi-

cation before discharge. It includes post-discharge telephone follow-up (including facilitating appointment scheduling). Patient-centered discharge instructions actively involve the patient in his or her own care.

The BOOST Risk Assessment Tool, called the “8 P’s,” identifies modifiable risk factors that guide discharge planning. (See the box below.)

“8 P’s” of the BOOST Risk Assessment Tool

This assessment tool targets patient risk factors known to pose a risk for post-discharge complications. The 8 P’s are:

- Polypharmacy
- Psychological comorbidities
- Principal diagnosis of cancer, stroke, diabetes, chronic obstructive pulmonary disease, or heart failure
- Physical or functional limitations
- Poor health literacy
- Poor social support
- Prior hospitalization in the 6 months before the index period
- Palliative care needs.

Project BOOST aligns evidence-based interventions with specific problems identified by the “8 P’s” tool. It maximizes patient involvement in the plan of care through concise patient-centered discharge instructions tailored to the patient’s literacy level. The instructions include the reason for hospitalization, red flags signaling complications, follow-up appointments, post-discharge care, key contact information, and space for the patient to list questions for the primary care provider. Before discharge, nurses use the teach-back method to review this information with the patient.

INTERACT program

Interactions to Reduce Acute Care Transfers (INTERACT) is designed to improve care in long-term care (LTC) and skilled nursing facilities (SNFs), with the goal of reducing preventable hospital readmissions. It in-

cludes multiple quality-improvement strategies and tools to help health-care professionals in LTC and SNFs identify, document, and communicate early changes in the patient’s condition so interventions can begin before the condition becomes serious enough to warrant rehospitalization. INTERACT tools and strategies aid effective advance care planning; communication between LTC, SNF, and hospital providers; and management of changes in the patient’s condition.

An evaluation of 25 LTC facilities that incorporated INTERACT quality-improvement methods found readmission rates decreased an average of 17%. Facilities with a greater commitment and resources allocated to implementing the model saw greater reductions than those with a minimal commitment.

Guidelines and key strategies for transitional care

The American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society of Academic Emergency Medicine have worked together to develop consensus standards for transitional care. Practice standards have been developed based on this framework of guiding principles. Both the National Transitions of Care Coalition and the Institute for Healthcare Improvement’s State Action on Avoidable Rehospitalizations specify standards of care and provide transition guides in these consensus standards. For a summary of all key recommendations from leading transitional care organizations, see *Transitional care principles*.)

Other recommendations for improving care transitions have been developed by the National Transitions of Care Coalition (www.ntocc.org), Care Transitions Program (www.caretransitions.org), and Institute for Healthcare Im-

provement’s State Action on Avoidable Hospitalizations program (www.ihl.org/offering/Initiatives/STAAR/Pages/default.aspx.) Using standardized forms aids implementation of these recommendations. (See the box below.)

Transitional Care Toolkits

Transitional care toolkits are available from the organizations below.

National Transitions of Care Coalition
www.ntocc.org/WhoWeServe/HealthCareProfessionals.aspx

This website offers tools and information for healthcare professionals seeking to improve transitional care.

The Care Transitions Program
www.caretransitions.org/documents/checklist.pdf

This website provides patient materials to help patients track their important medical information and plan for hospital discharge.

www.caretransitions.org/provider_tools.asp
This page provides links to tools for healthcare professionals using the Care Transitions Model.

www.caretransitions.org/mdt_main.asp
This page offers access to the Medication Discrepancy Tool used in the Care Transitions Program.

Society of Hospital Medicine: Project Boost Tools
www.hospitalmedicine.org/Web/Quality_Innovation/Implementation_Toolkits/Project_BOOST/Web/Quality_Innovation/Implementation_Toolkit/Boost/BOOST_Intervention/BOOST_Tools.aspx

This website provides access to the “8P’s” Risk Assessment and other tools used in Project BOOST.

Teach-Back Method Toolkit
www.teachbacktraining.org/
This website offers the “Always Use Teach-back!” training toolkit.

INTERACT: Interventions to Reduce Acute-Care Transfers
<http://interact2.net/#>

This website provides training programs for healthcare providers and registered nurses, as well as tools to enhance recognition of a change in the condition of residents of long-term care or skilled nursing facilities.

Transitional care principles

This chart summarizes the principles and corresponding activities recommended by leading transitional care organizations.

Principle	Activities
Accountability	<ul style="list-style-type: none">• Patient receives post-acute care follow-up within 24 hours of discharge to monitor condition and reinforce and monitor transition plan.• Patient has primary-care appointment within 1 week of acute-care episode.• Sending provider is responsible for patient's care until receiving provider has communicated that he or she is assuming responsibility and acknowledges receipt and understanding of discharge information and plan of care.
Communication	<ul style="list-style-type: none">• Two-way communication between providers, patients, and care team includes opportunities for clarification and feedback.• Communication should include community provider, patient, and family in assessing post-discharge needs.• Telephone follow-up should be provided shortly after discharge
Timely feedback and flow of information	<ul style="list-style-type: none">• Use formal tools, such as Universal Discharge or Transition Checklist in patient-friendly language.• Discharge information is developed with and provided to patient and family.• Use electronic means to transfer health information expeditiously and securely, ideally, within 24 hours.• Patient information arrives to receiving provider or agency ahead of patient.
Patient and family involvement in all steps of transition	<ul style="list-style-type: none">• Use formal transitional care tools, such as Coleman personal health record, to help ensure engagement.• Inform patient in writing about "red flags" that signal worsening of condition.• Use teach-back strategies to ensure patient understands and is engaged in plan.• Discuss post-discharge care and resource needs.• Include patient goals, values, and priorities in transfer record.• Caregiver involvement is included.
Respect for care-coordination hub	<ul style="list-style-type: none">• Care coordinators facilitate communication between providers and settings.• Case management is communication hub.• Care coordination is provided by nurses.
Identify coordinating clinician or medical home	<ul style="list-style-type: none">• Clearly identify care provider or team to coordinate and manage patient's transition.• Clearly identify primary care provider.• Primary-care follow-up visit is scheduled before hospital discharge.
Contact or responsible person reachable by patient at every step of transition	<ul style="list-style-type: none">• Patient has 24/7 access to healthcare professionals, with access to patient records.• Sending provider sends contact name and number of individual who can respond to questions and concerns.
Need for national standards and related quality indicators that are widely adopted and implemented	<ul style="list-style-type: none">• Reconcile discharge plan with national guidelines.
Medication management	<ul style="list-style-type: none">• Reconcile medications, including herbal and over-the-counter products, at each stage of transition.• Provide written reconciled medication list to patient and family and review it with them.• Provide education about medications to patient and family; include teach-back.• Assess patient's polypharmacy and medication risks, allergies, drug-drug, and drug-illness interactions.• Interdisciplinary team is involved in developing and managing medication management plan.• Patient has system for managing his or her medications.

Based on the Transitions of Care Consensus policy statement: College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society of Academic Emergency Medicine. (See www.ncbi.nlm.nih.gov/pmc/articles/PMC2710485/).

In a 2014 meta-analysis of 26 randomized controlled trials involving 7,932 subjects, one research group found 30-day readmissions were reduced only by high-intensity transitional care programs that included most of the activities listed in *Transitional care principles*. They found that a home visit within 3 days of hospital discharge, care coordination by an APRN or RN, and communication between the hospital team and primary care provider within 1 week of discharge were essential to transitional care programs that reduced 30-day readmissions.

Targeted care transition: Readmission risk factors and risk assessment

Patient factors that pose a risk for readmission include comorbid medical conditions, previous acute-care hospitalizations and ED visits, older age, lack of social support, poor access to healthcare services, substance abuse, poor health literacy, and functional limitations. Patients who lack strong family support also are at risk for readmission, and family members commonly have inadequate input into transitional care planning because they're not included in discussions. Too often, only the patient receives self-management education, even though family caregivers provide the actual care. Also, weekend discharges can put patients at risk for readmission due to lack of available support services, such as pharmacies and durable medical equipment companies, during weekend hours.

Transitional care programs are resource-intensive and are most likely to be effective when they target individuals at highest readmission risk. In one study (Kansagara, et al), researchers conducted a systematic review of currently available tools used to predict a patient's risk for readmission and evaluated 13 instruments with po-

tential use in deciding which patients would benefit most from transitional care services. They found that although risk tools overall had poor predictive ability, high- and low-risk scores correlated with readmission rates in a clinically significant manner.

Another researcher (Wodchis) criticized the Kansagara study for not considering the intent of the tools in its review. Wodchis studied tools designed to select patients for transitional care interventions and assessed their comparative abilities to predict acute- and long-term care use. This study included five tools. The author found that patients identified by each tool differed significantly, because each tool was designed to identify different risk factors. Wodchis found the tools have predictive value but predicted differing outcomes. The Probability of Repeated Admission (Pra) tool and the LACE index were the best predictors of 30-day acute-care readmissions and ED visits. But because these tools use unmodifiable risk factors to assess risk, they provide little direction for targeted transitional care activities.

Pra tool and LACE index

A three-study meta-analysis involving five cohorts of subjects ($n = 8,843$) evaluated the validity of the Pra tool. The researchers found Pra to be a good predictor of hospital admission in subjects who achieved high scores on the assessment. Unfortunately, this tool has poor sensitivity, so many patients with low scores not identified as high risk for readmission may be categorized inaccurately and thus fail to receive the transitional care services they need. The Pra tool is easy and quick to administer and considers age, gender, presence of diabetes and cardiac disease, hospital and primary care use, self-rated health, and caregiver availability to assess risk for hospital admission. Scores range from 0 to 1; a score of 0.5 in-

dicates a 50% risk for two or more hospitalizations within the next 4 years or one or more admissions in the following year.

The LACE index is a valid algorithm useful in identifying patients likely to benefit from post-discharge care. LACE scores range from 0 to 19; patients scoring 10 or above are at high risk for readmission or death and are likely to benefit from post-discharge services. Like the Pra tool with its cutpoint of 10, the LACE tool accurately identifies high-risk patients but misses a significant number with low scores who will be readmitted. Administered during hospitalization, the LACE tool considers:

- Length of the hospital stay
- Acuity on admission to the hospital
- Comorbid conditions
- Emergency visits in the 6 months before hospitalization.

Patient activation

Patients with the essential skills and confidence to engage actively in their own healthcare discharge planning are far less likely to be readmitted to the hospital and less likely to overuse the ED. The term patient activation describes six key components of engagement—self-management of symptoms and health problems, engagement in health-promoting activities to optimize function, involvement in treatment decisions, collaboration with healthcare professionals, active identification of high-quality healthcare organizations and providers, and ability to navigate the healthcare system.

A developmental process, patient activation has four identifiable stages.

- *Stage 1:* Patients don't realize the importance of taking an active role in their own health.
- *Stage 2:* They lack the knowledge and confidence to participate effectively in their own health care.

- *Stage 3:* They begin to take an active role in their care but may lack confidence to assert themselves adequately in care planning.
- *Stage 4:* They generally play an active, effective role in maintaining their own health but may struggle during times of excessive stress or illness.

Patients in stages 3 and 4 have lower levels of 30-day readmission rates than those at lower activation levels.

PAM measure

The Patient Activation Measure (PAM), a 13-item survey with good validity and reliability across multiple demographic groups, can be used to determine a patient's activation level before hospital discharge. It also can be used to identify readmission risk and guide specific tailored interventions based on the patient's activation level.

In 2013, URAC (formerly called the Utilization Review Accreditation Commission) proposed using PAM to identify at-risk patients, appropriately direct interventions and resources to high-risk patients, and enhance patient activation. Unfortunately, PAM is copyrighted and its use requires purchase of a licensing agreement. Costs vary with organization size, and licenses must be purchased every 12 months. Costs vary from \$2,000 for use with up to 1,000 participants to \$7,500+ for organizations planning to use the tool with more than 2,000 patients in 12 months.

Financing transitional care

The ACA provides financial resources for providers to deliver transitional care services to reduce readmissions. Since 2013, Current Procedural Terminology codes related to transitional care allow organizations to bill CMS for this care. APRNs or physicians must oversee programs that provide:

- phone or e-mail contact with the

patient within 48 business hours of hospital discharge

- a face-to-face patient visit with the healthcare provider within 14 days of hospital discharge (7 days for high-complexity patients)
- coordination services, such as review of the discharge summary, assurance that follow-up equipment and diagnostic testing are scheduled, medication management, and additional patient education.

If all of these services are provided to patients who require moderate- or high-intensity decision-making based on their physical or mental condition, transitional care codes 99495 or 99496 may be billed.

Making progress

No single specific transitional care activity has been shown to decrease hospital admissions effectively, but a bundle of activities linked to transitional care principles can reduce short- and long-term readmission risk. High-quality transitional care programs have been shown to enhance patient safety and reduce hospital readmissions for high-risk patients. The Pra tool, LACE index, and PAM measure are useful tools for identifying patient risk.

Several well-established transitional care programs have shown consistent benefit in reducing hospital readmissions. These programs provide tools and best practices on which new programs may be modeled. The ACA offers a carrot-and-stick approach to transitional care by offering opportunities for reimbursement for transitional care programs and imposing penalties on hospitals with high readmission rates.

Your role

As a hospital nurse, you can help ensure your patients are assessed for readmission risk and referred for transitional care services as ap-

propriate. Engage patients (and families) as partners in planning and managing their care. Use effective educational strategies, including teach-back and other methods of assessing understanding, with instructions written at the patient's health literacy level. Education should include basic information about the reason for hospitalization, red flags that signal complications of the patient's condition, and instructions on what to do if symptoms worsen or red flags occur.

Conduct careful planning for post-discharge care and explore barriers to receiving needed services with the patient and family. Make sure the patient has a primary care provider; if not, work with Medicaid or community resources to match the patient with a provider and arrange for follow-up care. A discharge summary should be faxed to the patient's primary care provider at the time of discharge.

If you're a primary care nurse, reconcile your patient's medications immediately after discharge and ensure a timely follow-up visit in the primary care office. Also make sure durable medical equipment, follow-up testing, and home care have been scheduled and received. Finally, work with patients and families to mitigate preventable factors that triggered hospital admission. ★

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Joan M. Nelson is an associate professor in the College of Nursing at the University of Colorado in Aurora. Amy L. Pulley is manager of the community-based care transitions and case management program, Denver Regional Council of Government, Area Agency on Aging in Denver.

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Please mark the correct answer online.

1. Which statement related to readmissions is correct?

- Fewer than 25% of patients see their primary care providers within 1 week of hospital discharge, which inhibits care transition.
- Fewer than 50% of patients see their primary care providers within 3 weeks of hospital discharge, which inhibits care transition.
- Since hospitals have started receiving incentives to reduce readmission rates, the 30-day readmission rate for Medicare patients has decreased.
- Since hospitals have started receiving incentives to reduce readmission rates, the 30-day readmission rate for Medicare patients has increased.

2. How many Medicare patients are readmitted to the hospital within 30 days?

- One in every three
- One in every four
- One in every five
- One in every six

3. In which transitional care model does an advanced practice registered nurse provide a 1-to-3 month period of interventions with high-risk adults to prevent hospital readmissions?

- Care transitions intervention model (Coleman model)
- Transitional care model (Naylor model)
- Better Outcomes for Older Adults through Safe Transitions (BOOST) model
- Interactions to Reduce Acute Care Transfers (INTERACT)

4. Which transitional care model uses the "8 P's" to conduct risk assessment?

- Care transitions intervention model (Coleman model)
- Transitional care model (Naylor model)
- Better Outcomes for Older Adults through Safe Transitions (BOOST) model
- Interactions to Reduce Acute Care Transfers (INTERACT)

5. Which transitional care model is based on a 4-week intervention period?

- Care transitions intervention model (Coleman model)

- Transitional care model (Naylor model)
- Better Outcomes for Older Adults through Safe Transitions (BOOST) model
- Interactions to Reduce Acute Care Transfers (INTERACT)

6. A pillar of the Coleman transitional care model is:

- improving health literacy.
- focus on the discharge process.
- having a family member be responsible for medications.
- maintenance of a personal health record.

7. Which risk factor indicates your patient would benefit from the Naylor transitional care model?

- Age 55
- Two prescription medications
- Poor health literacy
- One hospitalization in the past year

8. Which of the following models would be particularly useful for long-term care nurses?

- Care transitions intervention model (Coleman model)
- Transitional care model (Naylor model)
- Better Outcomes for Older Adults through Safe Transitions (BOOST) model
- Interactions to Reduce Acute Care Transfers (INTERACT)

9. Which statement about the Pra tool and the LACE index is correct?

- Both tools have poor sensitivity, so many patients with low scores not identified as high risk for readmission may be categorized inaccurately.
- The Pra tool takes a significant amount of time to administer.
- A LACE tool score of 0.5 indicates a 50% risk for two or more hospitalizations within the next 4 years or one or more admissions in the following year.
- Both tools have excellent sensitivity, so patients are consistently identified correctly as to risk level.

10. Self-management of symptoms and health problems and engagement in health-promoting activities to optimize function are two components of:

- innovative transitional care.
- traditional transitional care.
- patient activation.
- patient readiness.

11. Which statement about financing transitional care is correct?

- Current Procedural Terminology codes allow organizations to bill CMS for this care.
- Organizations are not permitted to bill for this care.
- Physicians or APRNs don't have to oversee programs in order to bill for care.
- Physicians or APRNs must make phone or e-mail contact with the patient within 72 hours of discharge.

12. Which of the following is NOT a nursing strategy related to transitional care?

- Hospital nurses should use teach-back to assess the patient's understanding of education provided.
- Education provided in the hospital should focus only on red flags that signal complications.
- If the patient lacks a primary care provider, the nurse should work with resources to help the patient obtain one.
- Primary care nurses should reconcile the patient's medications immediately after discharge and ensure a timely follow-up visit to the office.

13. Which activity falls under the accountability principle of transitional care?

- Patients receive post-acute care follow-up within 24 hours of discharge to monitor their condition and reinforce and monitor the transition plan.
- Telephone follow-up should be provided shortly after the patient's discharge.
- Patient information arrives to receiving provider or agency ahead of patient.
- Reconcile medications, including herbal and over-the-counter products, at each stage of transition.

14. Which activity falls under the timely feedback and flow of information principle of transitional care?

- Reconcile the discharge plan with national guidelines.
- Care coordinators facilitate communication between providers and settings.
- Inform the patient in writing about "red flags" that signal worsening of condition.
- Discharge information is developed with and provided to the patient and family.