Transitions of care: Engaging patients and families

**Issue:**
All health care providers want their patients to have a smooth transition to their next care setting or provider, or to their home. But this doesn’t always happen. While many aspects of transitions of care depend on the efforts and actions of health care providers to make for a smooth and successful transition, the involvement of the patient and his or her family also is critical.

Patient/family engagement is one of the seven foundations identified by The Joint Commission to support safe, quality transitions of care from one setting to another.1 (See the sidebar for the seven foundations.)

While health care providers may be familiar with the term “patient engagement,” there are two more related but distinct terms they need to know: “patient activation,” and “patient-centered care.” The three terms are not interchangeable.

- **Patient engagement:** Also called patient and family engagement. Patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system – direct care, organizational design and governance, and policy making – to improve health and health care.2

- **Patient activation:** An individual’s knowledge, skills, ability and willingness to manage one’s own health and care.3

- **Patient-centered care:** Also called patient- and family-centered care. Conveys a vision for what health care should be: a partnership among practitioners, patients and their families (when appropriate) to ensure that decisions respect patients’ wants, needs and preferences, and that patients have the education and support they need to make decisions and participate in their own care.4

Sentinel event data compiled by The Joint Commission from January 2014 to October 2015 identified a total of 197 sentinel events – from suicide to falls to wrong site surgery – and the root causes included failures in patient communication (127 incidents), patient education (26 incidents) and patient rights (44 incidents). The majority of the patient education failures were related to not assessing the effectiveness of patient education or not providing education. The patient rights failures included absent or incomplete informed consent, and lack of the patient’s participation in their care.

From the literature, some contributing factors to failures in transitions of care specifically related to patient/family engagement include:

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Patient education breakdowns – in which patients, family members or caregivers receive conflicting recommendations or are excluded from the planning process – can lead to a lack of buy-in from the affected parties, who don’t understand the importance of the care plan.  
Practitioners may fail to provide the information that patients need to make the best decisions about their care and treatment. Even when patients receive the information, they may be overwhelmed or lack confidence in their choices.  
Patients with low levels of health literacy, who find it difficult to follow instructions on how to care for themselves or to adhere to treatment regimens, such as taking their medicines.  
Cultural differences, limited English proficiency, sex, age, education, and economic status, among other factors, may affect a patient’s level of engagement.  
Providers affected by time constraints, insufficient training, a lack of incentives, and information system shortcomings.  
Patients’ knowledge, attitudes and beliefs, such as beliefs about the patient role  
Patients’ experience with the health care system

According to a study of more than 30,000 patients, those with the lowest patient activation scores (i.e., those with the least skills and confidence to actively engage in their own health care) had costs that averaged 8 to 21 percent higher than those who scored at the highest levels of patient activation.  
Studies show that patient activation results in improvements in health outcomes; clinical indicators; adherence to treatment; improved health-related behavior; increased participation in care; and reduced symptoms, hospital readmissions, overnight hospital stays, and use of the emergency department.  
A 2013 collaboration among three hospitals and two health insurers in New York reduced readmission rates by building relationships with their patients. The Bronx Collaborative focused on 500 patients; of those who had two or more interventions, just 17.6 percent were readmitted within 60 days of discharge. As a comparison, of a group of 190 patients who received standard care, 26.3 percent were readmitted. The interventions, which combined evidence-based interventions and customized methods, included intensive pre-discharge patient education and post-discharge follow-up calls to review medications, identify concerns and verify the completion of the follow-up physician visit.

**Safety Actions to Consider:**
A number of activities have been identified as having positive effects on care transitions related to patient and family engagement, including:

- **Promoting shared decision-making with patients and their families.** Shared decision-making involves patients and health care providers working together to go over the patient’s condition, treatment options, pros and cons of the options, personal preferences, and a shared determination of how to execute the treatment plan.  
- **Developing and implementing organizational policies and practices that support patient and family engagement.** Some examples include:  
  o Organizational policies that enable families to visit 24/7  
  o Bedside rounding, i.e., conducting physician and interdisciplinary rounds at the patient’s bedside  
  o Have nurses who are coming on and going off duty give their change of shift report at the patient’s bedside  
  o Patient-centered discharge planning  
  o Electronic health records (EHRs) that patients can access and edit  
  o Involve patients as advisers and decision makers, including on quality improvement teams, patient safety committees, and patient- and family-centered care councils.  
- **Supporting two-way patient and family education, including teaching the patient and family about their roles and responsibilities in managing a health condition**

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Resources:

1. The Joint Commission. 2013. Transitions of Care: The Need for Collaboration Across Entire Care Continuum – Hot Topics in Health Care, Issue No. 2
5. The Joint Commission. 2012. Transitions of Care: The Need For a More Effective Approach to Continuing Patient Care – Hot Topics in Health Care, Issue No. 1

Other resources from The Joint Commission:

Transitions of Care (ToC) Portal
Health Equity Portal
Patient Safety Systems Chapter, Comprehensive Accreditation Manual for the Hospital program
Speak Up™: Avoid a Return Trip to the Hospital (patient education resource)

Note: This is not an all-inclusive list.