Transitions of Care #44-7-17

Each year, people with developmental disabilities experience many transitions of care.

Those can include significant changes, such as getting a new job, moving into a new home, or changing providers or direct support professionals. Other transitions could be unscheduled hospitalizations, newly diagnosed medical conditions, or changes in support needs or medication.

Such changes can pose significant risk to a person’s health and safety if planning and communication are not effective. It is critical for providers, county boards, and families to understand the importance of completing thorough transitions and ensure a person’s needed supports are addressed.

Keys to Successful Transitions

1. Standardize procedures for hospital discharges, medication changes, and dietary changes
2. Use a team checklist with assigned duties and timelines
3. Involve other professionals, such as pharmacists, during transition
4. Develop performance measures to encourage better transitions of care
5. Talk to staff about any change in the person following a medication change
6. Service and support administrator must ensure receiving provider has current plan in sufficient time to train new direct care staff
7. Hospitals, providers, and the person’s team must work to reduce re-admission rates and adverse events for people transitioning out of hospital care

Transferring Providers

Must manage health and safety risks by providing consolidated and appropriate information about the person to the receiving provider

Receiving Providers

Must clearly understand the person’s needs and is ready to meet those needs

Must implement services, monitor for concerns, and notify the county board, team, or other supports when there are problems with transitions

Other types of transitions

Diet change, surgery, new physician, using a feeding tube, change in mobility, death or illness of family member or caregiver