



# National Care Transitions Key Messages

Patients with renal disease are medically complex. Between dialysis treatments, transplant work-ups, access appointments, frequent lab draws, extended care facilities, and managing comorbid conditions—there are many opportunities to miss out on the vital communication needed to ensure seamless care transitions. When dialysis providers and community stakeholders commit to delivering high-quality, patient-centered healthcare, there is a greater opportunity to improve coordination of patient transitions between providers and to sustain positive change.

Below are key messages and taglines that promote patient and family engagement and convey the benefits of coordinated care for use with two broad groups: providers and healthcare systems and patients and families. Consistent language is used across the two sets of messages, so they align and complement each other. Tailoring to specific audiences and situations will ensure that your communications about care transitions are relevant across the continuum of stakeholders.

## Provider and Health System Messages:

- Implementing a process for care transitions empowers staff to help each other follow policies. Experience has shown that structured processes can lead to better care coordination.
- Using checklists and communication logs are best practices for transferring patients and their critical medical information in a safe, timely, and efficient manner.
- Teach-back is a proven strategy to confirm that patients and their families have a clear understanding of the medical information communicated to them. Studies have shown that 40–80% of the medical information patients are told during office visits is forgotten immediately.
- Working together across the care continuum is the best approach to support patient-centered care. It is vital that staff across all settings understand how improving the care transition process benefits the patient.

## Patient and Family Messages:

- Patients, their families, and caregivers are sources of useful and important knowledge and they will share the information if asked to do so. Engaged patients and families have improved outcomes and fewer avoidable hospital readmissions.
- Patients, caregivers, and families are encouraged to seek information about their health conditions. Patients and families feel more supported in their healthcare journey when they are well-informed, and education increases their confidence to take on self-management tasks.
- Patient involvement in discharge planning improves coordination and cooperation across all providers involved with the patient's care transitions and can reduce the chance of hospital readmissions.
- When the needs and preferences of the patient are known and communicated at the right time to the right people, they can be used to guide the delivery of safe, appropriate, and effective care.

## Taglines:

Care Transitions: Focused on patients, fostered by community  
Care Transitions: Collaborative community care  
Care Transitions: Putting patients at the center of coordinated care  
Care Coordination: Making a difference as a community  
Care Transitions: Bridges to patient-centered care  
Care Transitions: Patient-Centered | Process-Driven | Relationship-Focused  
ESRD Care: Coordinated | Connected | Committed