# Transitions of Care Clinical Practice Guideline

## OBJECTIVE

To provide guidelines on coordination of care during transitions (including discharge planning) for members who are transferring from an inpatient setting to the community or home setting.

## INTRODUCTION

Transitions of care (TOC) involves the movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another. WellCare is committed to identifying and serving the diverse needs of its members. Attention to important details will prevent communication breakdowns. Patient education allows all pertinent information to be shared with the patient as well as any caregivers involved. Accountability ensures that the multiple providers involved in a member's care work together to coordinate care effectively.[1] The Joint Commission identified key foundations that organizations should adopt to assure safe transitions from one health care setting to another:[2]

- Leadership support
- Multidisciplinary collaboration
- Early identification of patients/clients at risk
- Transitional planning
- Medication management
- Patient and family action/engagement
- Transfer of information

Research continues to support the suggestion that older adults coping with multiple chronic conditions and complex therapies are particularly vulnerable to breakdowns in care. Insufficient communication among providers and across health care settings, inadequate patient and caregiver education, poor continuity of care, and limited access to services are among the major factors contributing to negative quality and cost outcomes, resulting in a critical need to bridge the chasm between evidence-based practices and current approaches to care.[3]

## RECOMMENDATIONS[1]

The American College of Physicians (ACP), Society of Hospital Medicine (SHM), Society of General Internal Medicine (SGIM), American Geriatric Society (AGS), American College of Emergency Physicians (ACEP) and the Society for Academic Emergency Medicine (SAEM) developed consensus standards to address the quality gaps in the transitions between inpatient and outpatient settings. The following are principles and standards for managing transitions in care between the inpatient and outpatient settings were established. The Transitions of Care Consensus Conference (TOCCC) proposed a framework to provide guiding principles for items to measure and report. From those principles a set of preferred practices or standards were developed; the standards are more granular and allow for more specificity in describing the desired practice or outcome and its elements. Standards then provide a roadmap for identification and development of performance measures. The TOCCC established the following principles:[3]

- Accountability
- Communication
- Timely feedback and feed forward of information
- Involvement of the patient and family member (unless inappropriate)

- Respecting the hub of coordination of care
- All patients and their family/caregivers should have and be able to identify who is their medical home or coordinating clinician (e.g., practice or practitioner)
- At every point along the transition the patient and/or their family/caregivers need to know who is responsible for their care at that point (including who to contact and how)
- National standards
- For monitoring and improving transitions, standardized metrics related to these standards should be used in order to lead to continuous quality improvement and accountability.

The TOCCC then proposed the following standards:

- **Coordinating Clinicians.** This includes clear and direct communication of treatment plans and follow-up expectations. Communication and information exchange between the medical home and the receiving provider should occur in an amount of time that will allow the receiving provider to effectively treat the patient. This communication and information exchange should ideally occur whenever patients are at a transition of care; e.g., at discharge from the inpatient setting. The timeliness of this communication should be consistent with the patient's clinical presentation and, in the case of a patient being discharged, the urgency of the follow-up required. Communication and information exchange between the MH and other physicians may be in the form of a call, voicemail, fax or other secure, private, and accessible means including mutual access to an EHR.

  The emergency department (ED) represents a unique subset of transitions of care. The potential transition can generally be described as outpatient to outpatient or outpatient to inpatient depending on whether or not the patient is admitted to the hospital. The outpatient to outpatient transition can also encompass a number of potential variations. Patients with a medical home may be referred in to the ED by the medical home or they may self-refer. A significant number of patients do not have a physician and self refer to the ED. The disposition from the ED, either outpatient to outpatient or outpatient to inpatient is similarly represented by a number of variables. Discharged patients may or may not have a medical home, may or may not need a specialist and may or may not require urgent (<24 hours) follow-up. Admitted patients may or may not have a medical home and may or may not require specialty care. This variety of variables precludes a single approach to ED transitions of care coordination.

- **Care Plans/Transition Record.** The TOCCC proposed a minimal set of data elements that should always be part of the transition record and any initial implementation of this standard. The list includes:

  o Principle diagnosis and problem list
  o Medication list (reconciliation) including over the counter/ herbals, allergies and drug interactions
  o Clearly identifies the medical home/transferring coordinating physician/institution contact information
  o Patient's cognitive status
  o Test results/pending results

  The TOCCC recommended the following additional elements that should be included in an "ideal transition record" in addition to the above:

  o Emergency plan and contact number and person
  o Treatment and diagnostic plan
  o Prognosis and goals of care
  o Advance directives, power of attorney, consent
  o Planned interventions, durable medical equipment, wound care etc.
  o Assessment of caregiver status

- o Patients and/or their family/caregivers must receive, understand and be encouraged to participate in the development of their transition record which should take into consideration the patient's health literacy, insurance status and be culturally sensitive.

- **Communication Infrastructure.** All communications between providers and between providers and patients and families/caregivers need to be secure, private, HIPAA compliant, and accessible to patients and those practitioners who care for them. In addition:

  - o Communication should be two-way with opportunity for clarification and feedback.
  - o Content of information transferred should include a core standardized dataset. This information needs to be transferred as a "living database" whereby it is created only once and then each subsequent provider then only needs to update, validate, or modify the information.
  - o Patient information should be available to the provider prior to patient arrival.
  - o Information transfer needs to adhere to national data standards.
  - o Provide patients with a medication list that is accessible (paper, electronic), clear, and dated.

- **Standard Communication Formats.** Access to the patient medical history needs to be on a current and ongoing basis with ability to modify information as a patient's condition changes. Patients, family and caregivers should have access to their information ("nothing about me without me"). A section on the transfer record should be devoted to communicating a patient's preferences, priorities, goals and values (e.g., patient does not want intubation).

- **Transition Responsibility.** The sending provider/institution/team at the clinical organization maintains responsibility for the care of the patient until the receiving clinician/location confirms that the transfer and assumption of responsibility is complete (within a reasonable timeframe for the receiving clinician to receive the information i.e., transfers that occur in the middle of the night can be communicated during standard working hours). The sending provider should be available for clarification with issues of care within a reasonable timeframe after the transfer has been completed and this timeframe should be based on the conditions of the transfer settings. The patient should be able to identify the responsible provider. In the case of patients who do not have an ongoing ambulatory care provider or whose ambulatory care provider has not assumed responsibility, the hospital-based clinicians will not be required to assume responsibility for the care of these patients once discharged.

- **Timeliness.** Timeliness of feedback and feed forward of information from a sending provider to a receiving provider should be contingent on four factors:

  1. Transition settings
  2. Patient circumstances
  3. Level of acuity
  4. Clear transition responsibility

  This information should be available at the time of the patient encounter.

- **Community standards.** Medical communities and institutions must demonstrate accountability for transitions of care by adopting national standards, and processes should be established to promote effective transitions of care. Such standards should be established for transitions in care and should be adopted and implemented at the national and community level through public health institutions, national accreditation bodies, societies, etc., in order to improve patient outcomes and patient safety.

- **Measurement.** For monitoring and improving transitions, standardized metrics/measures should be evidence-based, address documented gaps and have demonstrated impact on improving care (comply with performance measure standards) whenever feasible. Results from measurement using standardized metrics must lead to continuous improvement of the transition process. The validity, reliability, cost, and

impact, including unintended consequences, of these measures should be assessed and re-evaluated. All standards should be applied with special attention to the varying transition settings and should be appropriate to each transition setting.

## CURRENT MODELS OF CARE AT TRANSITION)

There are two nationally known models applicable to transitions of care found in current literature. While both models were developed with a strong emphasis on transitions of care in aging populations, the recommendations included in both models can have practical implications for all populations and demographics.

The Transitional Care Model (TCM), designed by Dr. Mary Naylor and a multidisciplinary team of colleagues at the University of Pennsylvania, addresses the negative effects associated with common breakdowns in care when older adults with complex needs transition from an acute care setting to their home or other care setting, and prepares patients and family caregivers to more effectively manage changes in health associated with multiple chronic illness.[4]

The TCM is a model of care coordination with an interdisciplinary approach, delivered to elderly patients at high risk for poor post-discharge outcomes. The care is overseen by master's degree-prepared advanced practice nurses (APNs), identified as transition nurse managers (TNMs), who work in conjunction with physicians. Transition support lasts approximately eight weeks and includes comprehensive discharge planning and home follow-up to high-risk, high-cost, high-volume patient groups to improve post-discharge outcomes among this vulnerable population.[5]

Findings from multiple clinical trials have consistently demonstrated the positive impact of the TCM on older adults' outcomes while reducing total costs of healthcare.[4]

- Avoidance of hospital readmissions for primary and complicating conditions. TCM has resulted in fewer hospital readmissions for patients. Additionally, among those patients who are rehospitalized, the time between their discharge and readmission is longer and the number of days spent in the hospital is generally shorter than expected.
- Improvements in health outcomes after hospital discharge. Patients who received TCM have reported improvements in physical health, functional status and quality of life.
- Enhancement in patient and family caregiver experience with care. Overall patient satisfaction is increased among patients receiving TCM. In ongoing studies, TCM also aims to lessen the burden among family members by reducing the demands of caregiving and improving family functioning.

Elderly, chronically ill people experience frequent changes in health status that require transitions among health care providers and settings. When put into mainstream practice, the Transitional Care Model (TCM) can be successful by incorporating both in-person contact and a nurse-led, interdisciplinary team approach, can effectively interrupt patterns of frequent re-hospitalizations, reduce costs, and improve patient health status.[6]

Naylor's *Essential Components of the Transitional Care Model* specifies the following as part of a patient's transition from different care settings:[6]

- The transitional care nurse (TCN) as the primary coordinator of care, to ensure consistency of provider across the entire episode of care
- Comprehensive in-hospital patient assessment
- Preparation and development of an evidenced-based plan of care
- Regular home visits by the TCN with available, ongoing telephone support (seven days per week) through an average of two months post-discharge
- Continuity of medical care between hospital and primary care physician facilitated by the TCN, who also accompanies each patient to his or her first follow-up visit

- Comprehensive, holistic focus on each patient's needs, including the reason for the primary hospitalization as well as other complicating or coexisting events
- Active engagement of patients and their family and informal caregivers, including education and support
- Emphasis on early identification and response to health care risks and symptoms to achieve longer-term positive outcomes and avoid adverse and untoward events that lead to readmissions
- Multidisciplinary approach that includes the patient, family, informal, and formal caregivers
- Physician–nurse collaboration
- Communication among the patient, family, informal caregivers, and health care team

The Care Transitions in Intervention (CTI) model is a patient-centered model based on the work of Eric Coleman. His research examined the uncoordinated and fragmented care centering during the time a patient is hospitalized. Older patients with seriously and/or multiple chronic illnesses were found especially vulnerable. Lack of coordination on the part of health care providers and inadequate preparation of patients increases the risk for medication errors and health complications. This leads to avoidable readmissions to the hospital, leading to greater health care costs. National 30-day readmission rates among older Medicare beneficiaries range from 15 to 25 percent.[7]

Starting when a patient is scheduled to be discharged from the hospital, the Care Transitions Model helps patients at high risk for complications or re-hospitalization. The Transition Coach, a specially trained nurse, visits with the patient and their caregivers over four weeks—both in the hospital and at home—and helps patients learn to manage multiple prescriptions, follow post-hospital recommendations, and present their other health care providers with the information they need to be effective. Over 100 hospitals and health care systems had adopted the model by 2007.[6] During the four-week Care Transitions program, patients with complex care needs and family caregivers work with a "Transition Coach" and learn self-management skills that will ease their transition from hospital to home. The coach is an advanced practice nurse or a registered nurse who has received training in the Care Transitions Intervention program. This intervention is centered on four pillars:[6,7]

1. **Medication Self-Management.** *Focus:* Reinforcing the importance of knowing each medication – when, why, and how to take what is prescribed, and developing an effective medication management system.

2. **Patient-Centered Health Record (HR).** *Focus:* Providing a health care management guide for patients; the PHR is introduced during the hospital visit and used throughout the program.

3. **Primary Care Provider / Specialist Follow-Up.** *Focus:* Enlisting patient's involvement in scheduling appointment(s) with the primary care provider or specialist as soon as possible after discharge.

4. **Knowledge of Red Flags.** *Focus:* Ensuring patient's knowledge about indicators that suggest that his or her condition is worsening and how to respond.

## FUTURE CONSIDERATIONS

In addition to principles and standards development, the TOCCC uncovered six future challenges:[3]

1. **Electronic Health Record.** The TOCCC concurred that (1) established transition standards should not be contingent upon the existence of an electronic health record (2) some universally, nationally defined set of core transfer information should be the short term target to establish electronic transfers of information.

2. **Use of a Transition Record.** The development of a core set of data (e.g., smaller than a complete health record or discharge summary) that goes to the patient and the receiving provider that includes items in the "core" record described.

3. **Medical Home.** There was a lot of discussion around the benefits and challenges of establishing a medical home and inculcating the concept into delivery and payment structures. The group was favorable to the concept; however, since the medical home is not yet a nationally defined standard, care transition

standards should not be contingent upon the existence of a "medical home." Wording of future standards should use a general term for the clinician coordinating care across sites in addition to the term "medical home." Using both terms will acknowledge the movement toward the medical home without requiring adoption of medical home practices to refine and implement quality measures for care transitions.

4. **Pay for Performance.** The group strongly agreed that behaviors and clinical practices are influenced by payment structures. Therefore, they agreed, a new principle should be established to advocate for changes in reimbursement practices to reward safe, complete transfers of information and care. However, development of standards and measures should move forward based on the current reimbursement practices and without assumptions of future changes.

5. **Underserved/Disadvantaged Populations.** Care transition standards and measures should be the same for all economic groups with careful attention that lower socioeconomic groups are not "forgotten" or unintentionally disadvantaged, including the potential for "cherry-picking." It should be noted that underserved populations may not always have a "medical home" due to their disadvantaged access to the health system and providers. Moreover, clinicians who care for underserved/disadvantaged populations should not be penalized by standards that assume continuous clinical care and ongoing relationships with patients who may access the health system only sporadically.

6. **Need for Patient-Centered Approaches.** The group agreed that across all principles and standards previously established by Stepping Up to the Plate coalition, greater emphasis was needed on patient centered approaches to care including, but not limited to, including patient and families in care and transition planning, greater access to medical records, and the need for education at the time of discharge regarding self-care and core transfer information.

Persons with continuous complex care needs frequently require care in multiple settings. During transitions between settings, this population is particularly vulnerable to experiencing poor care quality and problems of care fragmentation. Despite how common these transitions have become, the challenges of improving care transitions have received little attention from policy makers, clinicians, and quality improvement entities.[6] Many transitions are unplanned, result from unanticipated medical problems, occur in "real time" during nights and on weekends, involve clinicians who may not have an ongoing relationship with the patient, and happen so quickly that formal and informal support mechanisms cannot respond in a timely manner.[7] Finally, communication and coordination with primary care physicians (PCPs) is recommended to ensure safe care transitions for hospitalized older patients. Understanding patient experiences of problems after discharge can help clinical teams design more patient-centered care transitions. Systematic interventions to improve communication with PCPs during patient hospitalization are needed.[10]

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