

HOT TOPICS IN HEALTH CARE

Transitions of Care: The need for a more effective approach to continuing patient care



 **The Joint Commission**

 **Joint Commission Center
for Transforming Healthcare**

 **Joint Commission
Resources**

The need for a more effective approach to continuing patient care

This paper is the first of many planned communications that will report on new developments from The Joint Commission enterprise about work underway to address the problems related to transitions of care. This paper defines the problem and highlights the elements of some current evidence-based transitions of care models being researched by the enterprise.

Currently, The Joint Commission enterprise (The Joint Commission, Joint Commission Resources, and the Center for Transforming Healthcare) is in the first year of a three-year initiative to define methods for **achieving improvement in the effectiveness of the transitions of patients between health care organizations, which provide for the continuation of safe, quality care for patients in all settings**. All three components of The Joint Commission will offer various interventions and resources that are designed collectively to improve transitions of care. The interventions would apply to The Joint Commission's accreditation programs for hospitals, critical access hospitals, behavioral health care, home care, long term care, and ambulatory care settings.

The Joint Commission currently has standards, National Patient Safety Goals, survey activities, and educational services that address transitions of care. However, these mechanisms have limited utility or reach. For example, the current standards and survey process address certain transitions of care concerns within a health care setting, but neither "cross settings," nor do they address what happens to patients after they leave a health care setting.

The problem: Ineffective transitions of care

The following vignettes illustrate why health care organizations need to improve transitions of patient care.

- An 80-year-old retired school teacher visited the emergency department four times in a month for exacerbations to a mild heart failure condition, twice requiring hospitalization. When provided with discharge instructions, she is able to repeat them back accurately. However, she doesn't follow through with the instructions after returning home because she has not yet been diagnosed with dementia.¹
- A 68-year-old man is readmitted for heart failure only one week after being discharged following treatment for the same condition. He brought all of his pill bottles in a bag; all of the bottles were full, not one was opened. When questioned why he had not taken his medication, he began to cry, explaining he had never learned to read and couldn't read the instructions on the bottles.¹
- After falling at home, a 78-year-old woman received three new prescriptions from her primary care physician because during the exam her blood pressure was 164/90. The doctor instructed

her to start taking the new medication for hypertension the same day, and to stop taking her current blood pressure medication the following day. The physician also arranged for a home care nurse to come to her home and check on her in a few days. When asked whether she had any questions about the new medications, she replied that she understood and didn't have any questions. Two days later, the home care nurse came to see her. The patient complained of a headache and dizziness, and the nurse noted that she had a blood pressure of 190/96. When the nurse asked what medications she was taking, the patient said she had stopped taking her "old blood pressure medicine, like the doctor told me to." When the nurse asked about her new medication for hypertension, the patient became upset, and said that she didn't have them yet. When the nurse asked her why, the woman's husband said, "because we don't have the money to get them, that's why!" The woman was on Medicare, but they did not have enough money for the co-pay amounts for the new medications.

These patients left the care setting without the ability to care for their conditions, due to inadequate risk assessment, communication or education breakdowns, or false assumptions made by care providers.

What are transitions of care?

"Transitions of care" refer to the movement of patients between health care practitioners, settings, and home as their condition and care needs change. For example, a patient might receive care from a primary care physician or specialist in an outpatient setting, then transition to a hospital physician and nursing team during an inpatient admission before moving on to yet another care team at a skilled nursing facility. Finally, the patient might return home, where he or she may receive care from a visiting nurse or support from a family member or friend.² The scope of the Joint Commission transitions of care initiative encompasses transitions of patients between health care settings. For example, from a nursing home to a home care agency.

Unfortunately, these transitions do not always go smoothly. Ineffective care transition processes lead to adverse events^{3,4} and higher hospital readmission rates and costs.⁴ One study estimated that 80 percent of serious medical errors involve miscommunication during the hand-off between medical providers.⁵ Problematic transitions occur from and to virtually every type of health care setting, but especially when patients leave the hospital to receive care in another setting or at home, according to experts on this issue. To reduce both readmission rates and adverse events, hospitals must improve the effectiveness of transitions of care in which they play a role. The federal government has taken notice: Hospitals with unacceptably high readmission rates for Medicare and Medicaid patients will soon face financial penalties under the Patient Protection and Affordable Care Act.

Root causes of ineffective transitions of care

Many factors contribute to ineffective transitions of patient care, and these root causes often differ from one health care organization to another.⁶ The root causes most often described in medical literature and by experts include:

- **Communication breakdowns.** Care providers do not effectively or completely communicate important information among themselves, to the patient, or to those taking care of the patient at home in a timely fashion.^{5,6,7,8} The communication method – whether verbal, recorded, or written – is ineffective. For example, the Center for Transforming Healthcare’s hand-off communication project⁶ found these risk factors among those relating to communication:
 - o Expectations differ between senders and receivers of patients in transition
 - o Culture does not promote successful hand-off (e.g., lack of teamwork and respect)
 - o Inadequate amount of time provided for successful hand-off
 - o Lack of standardized procedures in conducting successful hand-off, e.g. use of SBAR (situation, background, assessment, recommendation)

The full list of root causes and solutions is available on the Center [website](#).

- **Patient education breakdowns.** Patients or family/friend caregivers sometimes receive conflicting recommendations, confusing medication regimens, and unclear instructions about follow-up care. Patients and caregivers are sometimes excluded from the planning related to the transition process. Patients may lack a sufficient understanding of the medical condition or the plan or care.^{9,10} As a result, they do not buy into the importance of following the care plan, or lack the knowledge or skills to do so.
- **Accountability breakdowns.** In many cases, there is no physician or clinical entity that takes responsibility to assure that the patient’s health care is coordinated across various settings and among different providers.^{10,11} Providers – especially when multiple specialists are involved – often fail to coordinate care or communicate effectively, which creates confusion for the patient and those responsible for transitioning the care of the patient to the next setting or provider. Primary care providers are sometimes not identified by name, and there is limited discharge planning and risk assessment.¹² Steps are not taken to assure that sufficient knowledge and resources will be available – either at home or at the next setting – to the patient upon discharge.¹³

Current transitions of care models

Several evidence-based transitions of care models have been developed to improve patient outcomes. These models include the Care Transitions Intervention (CTI),¹⁴ Transitional Care Model (TCM),¹⁵ Better Outcomes for Older Adults through Safe Transitions (BOOST),¹⁶ The Bridge Model,¹⁷ Guided Care,¹⁸ Geriatric Resources for Assessment and Care of Elders (GRACE),¹⁹ and Project RED (Re-Engineered Discharge).²⁰ These models include many or all of the following elements, which are being researched as part of The Joint Commission enterprise transitions of care initiative:

- **Multidisciplinary communication, collaboration and coordination – including patient/caregiver education – from admission through transition.** A care team – including a physician, nurse, pharmacist, social worker, and others as appropriate – communicates, collaborates and coordinates effectively.^{10,15,20,21} The team begins to take steps at admission and continues them through the patient’s hospital stay to assure a successful transition.²⁰ In addition to daily roundings/meetings, these steps include actively teaching patient and family/friend caregivers to learn and practice self-care and to follow the care plan,^{9,10,12,14,15,20} including how to self-manage medications.^{14,22}
- **Clinician involvement and shared accountability during all points of transition.** Both sending and receiving clinicians are involved in and accountable for a successful transition.^{10,22,23} They are identified by name and exchange information electronically or by fax or telephone during the time of transition.²⁴ At every point during the transition, the responsible coordinating clinician (such as a primary care physician or nurse practitioner) is identified for the patient.¹⁰
- **Comprehensive planning and risk assessment throughout hospital stay.** Each patient and family/friend caregiver has a discharge risk assessment completed during the hospital stay, usually within the first 24-48 hours of admission. Discharge planning begins immediately after admission. During the hospital stay, patients are assessed for risk factors that may limit their ability to perform necessary aspects of self-care.¹² Such risk factors include low literacy, recent hospital admissions, multiple chronic conditions or medications, and poor self-health ratings.¹⁵ Also, clinicians begin to assess risks that may be present at the receiving setting. For example, the clinician should confirm that the patient will have access to medications he or she needs at the next setting, as the pharmacy formulary there may not have the medications, or the ability to compound medications as ordered.
- **Standardized transition plans, procedures and forms.** The following components are included in a written transition plan or discharge summary: active issues, diagnosis, medications, required services, warning signs of a worsening condition, and whom to contact 24/7 in case of emergency.^{2,10,20} Plans are provided in the patient’s preferred language and use pictures for patients having low literacy.¹²
- **Standardized training.**⁶ The organization begins by defining what constitutes a successful transition. Staff are taught the necessary steps to complete a successful transition and are engaged in real-time performance feedback. Successful transitions are made an organizational priority and performance expectation. Medical schools incorporate risk assessment, collaboration, care planning, and medication management relating to transitions of patient care into their curricula.²⁵ Nursing schools and educational programs for all other health care disciplines include training on what transitions are, the risk associated with transitions, and how they can contribute to a safe patient care transition.
- **Timely follow-up, support and coordination after the patient leaves a care setting.** Organizations develop a process that provides for timely post-discharge follow-up with patients. Telephone or in-person follow-up, support, and coordination by a case manager, social worker, nurse, or another health care provider 24-48 hours after discharge helps patients achieve successful recoveries.^{12,15,20} A 24/7 call center provides a recently transitioned patient or family member with information or reassurance after regular clinic hours.¹² Having a transitional care nurse accompany the patient to the first follow-up outpatient visit can improve the health outcome,¹⁵ as can scheduling home care visits for the patient.¹⁴

- ***If a patient is readmitted within 30 days, gain an understanding of why.*** Readmissions within 30 days of discharge can often be prevented by providing a safe and effective transition of care from the hospital to home or another setting. Convene a meeting of the care team, including the attending physician and other key staff, and the patient and family members. Ask the patient questions about what happened after discharge. Find out if there were financial or transportation barriers, and whether or not home caregivers were unavailable.¹² This important information can be used by organizations to improve care transitions for patients and family/friend caregivers.
- ***Evaluation of transitions of care measures.*** Monitor compliance with standardized forms, tools, and methods for transitions of care. Use surveys and data collection to find root causes of ineffective transitions and to identify patient and caregiver satisfaction with transitions and their understanding of the care plan. For example, this three-item survey queries patients about key aspects of a care transition:^{26,27}
 1. The hospital staff took my preferences and those of my family or caregiver into account in deciding *what* my health care needs would be when I left the hospital.
 2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
 3. When I left the hospital, I clearly understood the purpose for taking each of my medications.

Interventions and new resources

Most recently, the Joint Commission Center for Transforming Healthcare (a 501(c)3 not-for-profit affiliate of The Joint Commission) launched its Targeted Solutions Tool (TST)TM for Hand-off Communications – a customizable tool that measures the effectiveness of hand-offs within an organization or to another facility, and provides proven solutions. The TST provides a tested and validated measurement system that produces data that support and drive the need for improving the current hand-off communication processes. The solutions are based on the work of the original 10 participating health care organizations working with the Center’s Hand-off Communications Project. The problem-solving resources and interventions from the project were pilot tested at several other organizations and in a variety of care settings, producing measurable improvement in the ability to effectively care for patients as they transition from one care setting to another. The TST for Hand-off Communications is available at no added cost to Joint Commission accredited organizations.

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Resources

Joint Commission Resources: “*Improving Transitions of Care*,” free video