

HOT TOPICS IN HEALTH CARE, ISSUE #2

Transitions of Care: The need for collaboration across entire care continuum

Safe, quality Collaborative Transitions Effective Successful



The need for collaboration across entire care continuum

This paper is the second in a series of reports on developments from The Joint Commission enterprise (The Joint Commission, Joint Commission Resources, and the Center for Transforming Healthcare) about work underway to address the challenges related to transitions of care. The first paper in the series, “The need for a more effective approach to continuing patient care,” is available on the [Transitions of Care Portal](#) on The Joint Commission website. This second paper focuses on the need for collaboration across the care continuum (as a patient moves from one care setting to another).

The Joint Commission enterprise is in the first year of a three-year initiative **to define methods to achieve improvement in the effectiveness of the transitions of patients between health care organizations and provide for the continuation of safe, quality care for patients in all settings.** All three components of The Joint Commission enterprise will offer various interventions and resources that are designed collectively to improve transitions of care. The interventions will apply to six accreditation programs: hospital, critical access hospital, behavioral health care, home care, nursing and rehabilitation center, and ambulatory care. As part of this work, **The Joint Commission has defined a “transition of care” as the movement of a patient from one health care provider or setting to another.**

Developing ways to assure safe transitions of care requires collaboration among providers all along the care continuum. The Joint Commission recently organized a series of learning visits and focus groups to better understand the progress providers are making and the challenges they still face.

The learning visits and focus groups helped The Joint Commission to gain feedback on transitions-related standards, survey processes, and tools under consideration, said Kathy Clark, M.S.N., R.N., associate project director specialist in The Joint Commission’s Division of Healthcare Quality Evaluation.

Participating in the learning visits were leadership and staff from four organizations – Avera Health, Everett Clinic/Providence Regional Medical Center at Everett, Marianjoy Rehabilitation Hospital and Clinics, and MD Anderson Cancer Center. Staff from The Joint Commission’s Division of Healthcare Quality Evaluation worked with the leaders of these organizations to set the agenda for the visits, which usually lasted two to three days and involved anywhere from 10 to 50 individuals from the host organization, depending on its size.

In addition, 90-minute focus group conference calls were held for front-line staffers from organizations participating in six of The Joint Commission’s accreditation programs: hospitals, critical access hospitals, behavioral health care, home care, nursing and rehabilitation center, and ambulatory care. The calls enabled these workers to provide insights into the care transitions challenges they face and to share interventions contributing to successful care transitions. Discharge nurses, doctors, care coordinators, case managers, social workers, and staff from other disciplines shared their experiences transitioning patients across settings.

Common approaches to making transitions successful

The learning visits and focus groups found that health care organizations commonly address transitions at two main points of care: at admission to the facility and then at discharge – when the patient leaves. For example, at admission, the “sender” organization contacts the next provider or “receiver” to share required information such as prior medical history, current medications, and the reasons why the patient is being discharged and transitioned to the new setting or provider.

During the learning visits, Joint Commission observers visited various health care settings associated with the four organizations, including acute care and specialty hospitals, nursing and rehabilitation centers, behavioral health care clinics, home health care agencies, and ambulatory clinics. The observers found that all of the organizations were working on sender/receiver issues with partner health care organizations; these issues pertained to referrals made to the organization and to transitioning patients after discharge.

In all of these settings, there is often a screening process in place to identify patients at higher risk for health care problems that could possibly lead to a readmission after discharge, the observers learned. The process commonly involves an interdisciplinary team, including a physician (or in some cases, a nurse practitioner), working together to determine what the patient will likely need after he or she leaves the setting.

Usually, case managers and/or discharge planners (who are often registered nurses or social workers) complete a formal assessment of these needs and work with physicians and other team members to plan and coordinate the transition to the next setting. Case managers, discharge planners, and other staff then provide discharge instructions and often make follow-up appointments for patients.

The assessment identifies factors that must be addressed to assure a good outcome and prevent a readmission. Factors that may increase the risk of readmission include:

- Diagnoses associated with high readmissions
- Co-morbidities
- The need for numerous medications
- A history of readmissions
- Psychosocial and emotional factors, such as issues relating to mental health, interpersonal relationships, or family matters
- The lack of a family member, friend or other caregiver who could provide support or assist with care
- Older age
- Financial distress
- Deficient living environment

“The literature discusses the importance of identifying patients who are at high-risk for readmission. The organizations we visited were all working on developing or improving a process to identify those high-risk patients,” said Clark.

Among the organizations participating in the learning visits, there was a consensus that these activities had very positive effects on transitions:

- Strong leadership support for new transitions processes
- Positive relationships between the sending and receiving providers
- Interdisciplinary team involvement
- Handoffs that involve interpersonal communication (instead of only written or electronic communication)
- Medication reconciliation, with the involvement of pharmacists
- Two-way patient and family education – teaching the patient and family about their role and responsibility in managing a condition while gaining an understanding of psychosocial issues affecting the patient and family
- Electronic health records (EHRs), as long as they were not relied upon as a sole method of communication. The participating organizations “all had some form of both EHRs and paper records,” Clark said.
- Assigned accountability for transitions-related tasks and outcomes

Caring for patients receiving treatments at its Houston facilities for a wide range of cancers, MD Anderson incorporated these and other activities into the development of its primary team nursing model resulting in positive transitions. A 48-bed unit is divided into four 12-bed cohorts, with each cohort assigned a team led by a clinical nurse leader. Now implemented on four demonstration units, the model’s goal is to increase patient satisfaction scores.

Among the activities implemented within the model are interdisciplinary communication, planning for proper support and accommodations after discharge, and advanced education aimed at the patient’s specific condition.

Debra Adornetto-Garcia, M.S.N., R.N., the executive director of MD Anderson’s Nursing Professional Practice Office, said the model works well because it designates responsibility and accountability for particular roles and persons. “If you don’t name that person who’s accountable, you can struggle in an organization of our size,” she said. Another important aspect of the model is that it surrounds the accountable people with resources. “The main focus of primary team nursing is having highly effective teams,” she stated.

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Common challenges

Health care organizations can do a better job in contacting the receiving provider to ask what information it needs to receive about a patient to ensure a safe transition, Clark said. “It’s important to know the organizations to which you are transitioning patients,” she emphasized. For example, Ismene Munch, Marianjoy’s director of quality, accreditation, safety and corporate compliance, said the Centers for Medicare & Medicaid Services (CMS) has strict admission and discharge requirements for rehabilitation facilities that acute care hospitals must understand. To assist in this matter, Marianjoy has clinical liaisons on-site at sending hospitals within its west suburban Chicago service area to conduct pre-admission assessments and to assure that Marianjoy has the appropriate equipment, staff and medications to care for the patient when he or she arrives.

Serving a population living within the intersection of South Dakota, Minnesota, Iowa and Nebraska, Avera Health organized focus groups to learn how to better direct information to receiving facilities, said Stacy Reitmeier, M.S.W., M.B.A., the care transitions director at Avera McKennan Hospital in Sioux Falls, S.D. Avera found that a summary focusing on the patient’s immediate care needs and staffing requirements helped receiving providers to grasp the most urgent messages quickly without becoming overwhelmed with pages of documentation.

The organizations that participated in the learning visits and focus groups are also taking steps to overcome other common challenges, such as inaccurate or incomplete referral information; contradictory or confusing order information when more than one physician is involved; primary care physicians unaware of admission or discharge; patient illiteracy or non-compliance; transport delays; using non-clinicians to coordinate transitions or to relay sender information; and a lack of nursing, pharmacy, or other necessary clinical staff after regular business hours.

Variables of successful transitions

While finding agreement on “what” comprises a positive transition, the learning visits and focus groups uncovered many variables on “how” to make a successful transition from one organization to another. These variables point to the need to have better tools and more in-depth standard processes. For example, the person or persons responsible for a successful transition – and when that responsibility ends – varies. The many tasks involved in a transition – from calling the patient after discharge to the exchange of information from one setting to another – are done differently from organization to organization. For example, who calls the patient after discharge? Who does the patient call if he or she has questions? Is information between providers communicated by mail, phone, fax, e-mail or electronic health record? Are there sender and receiver point persons for transitions, and if so, who are they?

Clark said the process of transitioning a patient from one organization to another needs to be better addressed in all health care settings. “The current Joint Commission standards and survey process address the discharge from an organization, but they do not adequately address the gap between the sending and receiving care providers,” she explained. The Joint Commission is taking an in-depth look into how health care organizations can most effectively communicate and collaborate between the time the sender begins to prepare for discharge to when the patient arrives at the receiving care facility. “We want to bridge our organizations by better aligning their processes,” she said. Dawn Tomac, R.N., CIC, Avera’s director of quality and safety initiatives, added that acute care hospitals, nursing and rehabilitation centers, home care organizations, and other providers must “form a bigger picture together of how we all meet Joint Commission standards.”

To help accomplish this goal, The Joint Commission will be looking at the tracer methodology used in its on-site survey process. Tracer methodology is an evaluation method in which surveyors select a patient, resident or client and use that individual's record as a roadmap to move through an organization to assess and evaluate the organization's compliance with selected standards and the organization's systems of providing care and services. Learning visit participants suggested taking a closer look at the screening process for discharge, education and follow-up to education (response to teaching), and discharge planning. They also suggested engaging the mid-level providers and case managers more in the tracers.

Measuring the effectiveness of transitions

The primary goal of transitions of care processes is to provide the patient a safe, successful transition from one provider to the next. However, health care organizations are also working to improve care transitions to, in turn, reduce unnecessary readmissions. For this reason, most providers evaluate their transitions processes by evaluating their impact on readmissions data. Another common way to evaluate transitions is through patient and family satisfaction scores. Some health care organizations go beyond readmissions and satisfaction data to measure specific components of the transitions process relating to pre-admission activities, follow-up telephone calls, follow-up appointments, medication orders and management, post-discharge activities, home visits, and more.

Avera Health's Care Transitions program arranges for a home health nurse to visit patients within two days of discharge. The program also emphasizes medication management, disease-specific patient education using "teach-back" methodology, multidisciplinary intervention, and continual follow-up over a 30-day period. Focused on four major diagnoses most responsible for readmissions – congestive heart failure, acute myocardial infarction, pneumonia and chronic obstructive pulmonary disease – the program, as of Nov. 1, 2012, had cared for more than 820 patients since February 2012. Preliminary data provided by Avera showed reduced readmission rates for the four major diagnoses ranging from 8.8 to 15.8 percent, across these diagnoses.

The main take-away – the need for collaboration

The need for collaboration was the most common thread through the discussions about transitions improvement. Among the many good examples of collaboration were the Everett Clinic's partnership with the Providence Regional Medical Center at Everett, both in Everett, Wash., as well as the work of Quality Improvement Organizations (QIOs), which provide a robust set of resources promoting seamless transitions between care settings (<http://www.cfm.org/integratingcare>). QIOs are part of CMS's Integrating Care for Populations and Communities (ICPC) initiative.

Physician-owned Everett Clinic in northwest Washington has developed systems to work smoothly with Providence Regional Medical Center and with area skilled nursing facilities and home care organizations. "You have to be able to reach out to the people you're working with," said Jennifer Wilson-Norton, R.Ph., M.B.A., the clinic's associate administrator of coordinated care. The clinic's goal is to improve quality and decrease costs by 25 percent, primarily by preventing unnecessary hospitalizations. "There has to be ongoing collaboration. If I'm sending you a patient, what do you need to come with that patient, and if you're sending a patient back to me, what do I need?" she asked.

Wilson-Norton said “there are tremendous opportunities to improve” cost efficiency and quality. For example, Everett started a pilot with Providence’s emergency department (ED) that offers patients who come to the ED without an urgent need the opportunity to see a physician at the Everett Clinic the next day. MD Anderson has a similar program in which discharge nurses call patients who have been discharged to help with concerns and to direct them back to the clinic if necessary, said Jacqueline Anderson, MD Anderson’s director of nursing programs. Before this program was implemented, these patients often would come to the ED with questions about follow-up care.

Funded by CMS, 53 QIOs across the country are taking progressive steps to form community coalitions consisting of hospitals, nursing homes, patient advocacy organizations, and other stakeholders. Each QIO works to reduce avoidable readmissions by improving processes relating to issues such as medication management, post-discharge follow-up, and care plans for patients who move across health care settings.

So far, QIOs have formed 222 coalitions or “communities” across the country, said Dr. Jane Brock, chief medical officer at the Colorado Foundation for Medical Care, the QIO for the state of Colorado. Each community is working to form cross-continuum care processes, and the work will be measured by improvements to 30-day readmission rates and overall hospital admission rates. The current QIO work is an expansion of a concept CMS piloted during 2008-2011, when 14 QIOs worked in 14 communities to significantly reduce readmissions per 1,000 beneficiaries (compared to 50 comparison group communities).

Dr. Brock said the communities study Medicare claims data to understand the root causes of readmission and to assemble providers and other community stakeholders that together could impact the readmissions problem within their shared population. “We use data to understand which stakeholders should be part of the coalition,” she stated. The data also point to the need for cross-continuum teams.

With the goal of doing business a better way, “it makes sense to construct more efficient and better processes across the care continuum,” she stated. “When people start to participate with their colleagues in other settings, it’s satisfying work and it makes their lives much easier. There’s a lot to be gained by hospitals understanding the capabilities of partners that share their patient population.” Dr. Brock referenced the [STAAR](#) (S**T**ate Action on Avoidable Rehospitalizations) Initiative and [INTERACT](#) (Interventions to Reduce Acute Care Transfers) as two outstanding resources.

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What makes a safe, quality transition of care?

In response to the knowledge it gains about the major facets of care transitions during its three-year initiative, The Joint Commission plans to produce a wide range of materials and products, including potential new standards and an accompanying survey process, to help Joint Commission-accredited organizations to provide safe, quality transitions of care for their patients.

Clark said scientific literature and the knowledge gained through the learning visits and focus groups makes it clear that organizations in all settings must establish seven “foundations” to assure safe transitions from one health care setting to another:

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

A great opportunity to share ideas and information

The organizations participating in the learning visits and focus groups appreciated the opportunity to provide feedback, and they were excited to give their staff the chance to show the progress they are making. “We were honored to be asked to participate,” said Adornetto-Garcia. “There were so many people here who were involved – clinicians who have worked on our initiatives for a decade had the chance to talk about their accomplishments. . . It gave us the opportunity to acknowledge our clinicians for what they’ve done to make a difference here.”

To learn more about this topic, visit [The Joint Commission's Transitions of Care Portal](#).