

Transitions of Care: Professional Expectations

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ABSTRACT

Successful cross-setting care transitions require timely, accurate and sufficient communication of clinical information between healthcare providers, so that downstream providers can immediately assume responsibility for patient care. However, despite our desire to provide the highest quality care to our patients, much variability exists in the frequency and effectiveness of communication during transitions. This article describes care transitions using case studies and a review of current policy, and then proposes professional standards. To define professional standards for care transitions, the authors draw upon their combined experience with licensure, regulation and quality improvement. They also present information about the Department of Health's Continuity of Care Form and Healthcentric Advisors' Best Practice Measures for Safe Transitions. Both tools establish core expectations for communication that can improve patients' experiences and health outcomes, as well as facilitate cross-setting collaboration, relationship building, and referral patterns.

KEYWORDS: Care transitions, communication, professional standards, patient safety, cross-setting

TRANSITIONS IN CARE

A care transition occurs when a patient moves from one healthcare provider or setting to another.^{1,2} Successful transitions require timely, accurate and sufficient communication of clinical information between healthcare providers, so that downstream providers can immediately assume responsibility for patient care.^{3,4} Well-executed transitions can improve outcomes and patient satisfaction, decrease costs and ensure that patients understand how, when and where to seek help.^{4,5,6} But how do providers know what is their responsibility regarding care transitions? And how can we build a healthcare system in Rhode Island that ensures that providers have the knowledge and means to implement such expectations? Although both the American Nurses Association (ANA) and national medical associations⁷ have endorsed a care transitions consensus policy statement that calls for clear communication, timely information transfer and professional accountability (see Table 1),⁸ a great deal of

variability exists among providers (by role and setting) in the frequency and effectiveness of communication during transitions – despite our desire to provide the highest quality care to our patients.

Case Studies

Case 1: A 39-year-old woman presents to an outpatient clinic complaining of headache, fever and neck pain. The provider conducts an exam and assessment. The nurse takes vitals, administers medications and obtains labs. The provider tells the patient to go to the nearest emergency department (ED). He offers directions to the emergency department; the patient knows how to get there and travels there by personal vehicle. In the ED after triage, registration and sitting in the waiting room for two hours, the patient has a generalized tonic-clonic seizure. The patient is evaluated by ED staff immediately and, after appropriate diagnostic evaluation, determined to have meningitis.

Case 2: An 82-year-old male had cardiac bypass surgery last year and now admitted for an aorta-femoral bypass. The surgery is complicated and unexpected complications, pneumonia, wound infection and atrial fibrillation lead to a prolonged hospital stay. Upon discharge late Friday night, he is given a list of his medications. Although mentally quite sharp, he is confused regarding the dosage of the beta blocker: the cardiologist in the hospital told him to take two tablets twice a day and the prescription says one tablet once a day. He is confused about the dose of the antibiotic as well that was written by the hospital physician. He leaves messages for the cardiologist, the hospital physician and his primary care provider seeking clarity. Not knowing what to do, he does not take any medication. Three days later, he is readmitted for shortness of breath.

State of the Science:

Evidence to Support the Need for Transitions in Care

In our increasingly fragmented healthcare system, providers often do not have the information we need to ensure seamless care delivery within or between settings. For patients discharged from the hospital, for example, this can result in medication errors,⁹ incomplete transfer of discharge information to downstream providers (including community

Table 1. Transitions of Care Consensus Policy Statement

| National Recommendation ¹ | Current Status Rhode Island | Future State |
|---|---|--|
| 1. Accountability | Based on individual organizations' policies and procedures. | Well established professional standards for relevant disciplines |
| 2. Communication: clear and direct communication of treatment plans and follow-up expectations | Communication standards (content and timing) are set forth in Healthcentric Advisors' Safe Transitions project's setting-specific care transitions best practices (available upon request). | Communication occurs in real time, is multidirectional and is interoperable with various interfaces. |
| 3. Timely feedback and feed forward of information | | |
| 4. Involvement of the patient and family member, unless inappropriate, in all steps | Based on individual organizations' policies and procedures | Patients have up to date personal health record and achieved optimal level of health literacy. |
| 5. Respecting the hub of coordination of care | Fragmentation across settings of care Pockets of successful coordination of care | Patients are routinely part of a PCMH where care is transparently coordinated. Infrastructure is supported by up to date technology. |
| 6. All patients and their family/caregivers should have and be able to identify who is their medical home or coordinating clinician (i.e., practice or practitioner). | Recent legislation requires patients to self-identify their primary care physician, although requirements to print the PCP's name on insurance card were eliminated. | PCMH is fully integrated into a health care system. |
| 7. 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 and who to contact and how. | Healthcentric Advisors' care transitions best practices incorporate the four patient activation concepts pioneered by Dr. Eric Coleman, ² including ensuring that patients understand their conditions, the "red flags" that should prompt outreach and whom they should call for help. | Patients/Caregivers optimize secure media for multidirectional relevant communication. |
| 8. National 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, medical societies, medical institutions etc., in order to improve patient outcomes and patient safety. | National standards do not yet exist, but Healthcentric Advisors' care transitions best practices establish local standards. The Office of the Health Insurance Commissioner has directed local health plans to incorporate the hospital best practices into contracting. | Well established and accepted national standards which incorporate professional expectations, appropriate reimbursement and technology |
| 9. For monitoring and improving transitions, standardized metrics related to these standards should be used in order to lead to continuous quality improvement and accountability. | Healthcentric Advisors' care transitions best practices include metrics that are driving the quality improvement activities underway by the Safe Transitions project's five community coalitions. The hospital and physician best practices are also incorporated into some providers' contracts with local health plans. | Quality metrics are used continuously and tied to health outcomes. |

1 Snow V, Beck D, Budnitz T, et al. Transitions of Care Consensus Policy Statement American College of Physicians-Society of General Internal Medicine-Society of Hospital Medicine-American Geriatrics Society-American College of Emergency Physicians-Society of Academic Emergency Medicine. Gen Intern Med 2009 August;24(8):971-976.

2 Coleman EA, Parry C, Chalmers S, et al. The care transitions intervention: results of a randomized controlled trial. Arch Intern Med 2006 Sept 25;166(17):1822-8.

physicians)^{10,11} and increased healthcare utilization,¹² all of which reduces the likelihood of optimal patient outcomes. In 2009, the Commonwealth Fund's State Scorecard on Health System Performance ranked Rhode Island 49th out of 51 for ambulatory care-sensitive hospital admission among Medicare beneficiaries¹³ and Rhode Island Department of Health data demonstrate approximately one in five hospitalized adults are readmitted to the same hospital within 30 days of discharge.¹⁴ Both measures are considered somewhat preventable with high-quality care, and are often used as proxy measures for care transition outcomes.

Numerous efforts are underway in Rhode Island to improve care transitions, including the Rhode Island Department of Health's long-standing Continuity of Care Form,¹⁵ required for facility-to-facility transitions, and Healthcentric Advisors' Medicare-funded Safe Transitions project,¹⁶ which includes multi-stakeholder collaboration to implement systems change that improves care coordination and reduces unplanned care and costs.¹⁷ Since the project began in 2008, readmissions have decreased from 31.7 to 25.1 per 1,000 Medicare beneficiaries.¹⁸ This translates to 802 fewer Medicare patients readmitted to the hospital between June and December 2011 and \$8.4 million in cost avoidance to Medicare during just that six-month period. These successes illustrate Rhode Island's leadership to date and the potential for collaboration to further improve the quality of care we provide.

To define professional standards for care transitions, the authors drew on their combined experience with licensure, regulation and quality improvement. Our methods included reviewing the care transitions literature and consensus statements, case studies from disciplinary issues, and qualitative input collected throughout the Safe Transitions project and during a November 2012 group discussion with the project's community advisory board. The board includes inpatient and outpatient physicians and representatives from commercial health plans, Medicaid, and the home health, hospice, hospital, nursing home and physician office settings. We also drew from Healthcentric Advisors' setting-specific care transitions best practices, developed via stakeholder consensus between 2009 and 2012.* The best practices (available upon request) are based on Rhode Island providers' preferences and the medical evidence, where it exists, and establish expectations and metrics for clinician-to-clinician communication and patient activation.

The appropriate transition of care of a patient is not an obscure vexing patient safety issue. Although at times complex and involving multiple entities, this patient safety issue can be solved with purposeful coordination and appropriate infrastructure. Facilities and institutions can create, maintain and refine the infrastructure needed to facilitate appropriate transitions. Ultimately, it is the professionals involved, whether nurses or practitioners who are accountable for the coordination and safe transition of the patient.

Minimum Expectations and Roles of Clinicians

Clinicians practice in different settings; e.g., acute, home health, nursing homes and urgent care settings. Further, patients come into care under a variety of circumstances planned or unplanned. Navigating the health care system for most patients has challenges and is not intuitive.¹⁹ At times, patients expect and need the provider's expertise regarding the next setting of care. Initiating a transition of care is usually a medical decision and at times, urgent or emergent (unplanned).

Successful transition toward a different setting of care is affected by several predictable variables. Practitioner consideration of the acuity and complexity of the patient, as well as nature of setting (scheduled or unplanned) are just some of the essential questions that need to be addressed. The transition should be viewed as a complex act and requires thoughtful action and direction for its success.

Common Transitions of care include:

- Outpatient to higher level of care (emergency department visit, observation stay or inpatient visit)
- Inpatient to higher level of care (ICU)
- Inpatient to residential type setting (assisted living, skilled nursing or long-term care)
- Inpatient to outpatient (return to specialist or primary care office, with or without home health services)

Although the actual transition might look different for each setting, minimum expectations are common to all transitions. This minimum expectations includes:

- The medical diagnosis
- Updated medication list
- Results of tests
- Pending tests
- Name of the treating clinician
- Phone number to call if more information is needed
- Follow up or Discharge instructions
- Professional to professional communication at time of transition

The Role of Health Professionals

These minimum expectations lend themselves to essential content that can be incorporated into the care delivery process. Who communicates the essential components to ensure a seamless transition is not as important as that the essential components take place effectively. It is imperative that practitioners, organizations and related entities integrate this practice into their normal everyday practice.

The Table below illustrates one way of looking at this issue regarding roles and settings of care. Note that in some cases, redundancy is warranted (seeking a higher level of care) and in other cases redundancy is not needed (lower level of care).

Table 2. Professional Standards to Ensure Timely and Adequate Information Transfer

| Best Practice | Provider referring a patient for unplanned care | Provider receiving a patient | Provider discharging a patient ¹ | Regular provider, ² if aware of recent unplanned care ³ | Professional Standards |
|---|---|------------------------------|---|---|--|
| Send summary clinical information when referring patients. | X | | X | | <ul style="list-style-type: none"> Should include the reason for referral, results of tests, pending tests, and the name and contact information of the referring clinician. |
| Respond to time-sensitive questions from next provider, as needed. | X | | X | | <ul style="list-style-type: none"> Should include immediate contact with staff (a clinician or clerical staff who can address the specific question) or a return call within one hour. |
| Notify primary care physician (PCP) about unplanned care, if not referred. | | X | | | <ul style="list-style-type: none"> PCP: Any clinician identified by the patient as their regular doctor. For hospital visits, should occur at the beginning of the hospitalization. For ED and urgent care visits, can occur with the summary clinical information sent at discharge. Should include contact information for a clinician (physician, nurse practitioner or physician assistant) who cared for the patient or has access to the patient's medical record. |
| Perform medication reconciliation. | | X | X | X | <ul style="list-style-type: none"> Excludes ED patients admitted to the hospital. Includes, at a minimum, identifying which medications the patient should stop, start or adjust after discharge. Should occur in every provider encounter. |
| For hospitalized patients, schedule outpatient follow-up appointment prior to discharge. | | | X | | <ul style="list-style-type: none"> Should include the date, time, location and contact information for questions or to reschedule. Should incorporate patient feedback, e.g., when the patient can obtain transportation. If the patient has no known PCP, should assign the patient to a PCP and schedule a new patient appointment. |
| Provide patient with effective education. | | | X | X | <ul style="list-style-type: none"> Excludes ED patients admitted to the hospital. Should include the diagnosis, any medication changes and reason for change, condition-specific "red flags" that should prompt outreach (including a contact name), activity and other limitations, and needed follow up. "Effective" education: Should assess the patient's understanding of the information provided (e.g., teach back) and incorporate health literacy and cultural competence. |
| Provide patient with written instructions. | | | X | | <ul style="list-style-type: none"> Excludes ED patients admitted to the hospital. Should include the information provided verbally as part of effective education (see above) as well as the name and phone number of the clinician (physician, nurse practitioner or physician assistant) who cared for the patient, if more information is needed after the visit. |
| Send summary clinical information to next provider. | X | | X | | <ul style="list-style-type: none"> Recipients should include the PCP and other home care or nursing home provider, if applicable. Should be sent within 24 hours. It should include the medical diagnosis, updated medication list, results of tests, pending tests, name of the treating clinician, phone number to call if more information is needed, discharge instructions, and recommended follow up. |
| Outreach to high-risk patients via phone. | | | | X | <ul style="list-style-type: none"> High-risk patients: aged 80 years or older; with a diagnosis of cancer, chronic obstructive pulmonary disease, or congestive heart failure; with polypharmacy (≥8 medications); or with a hospitalization in the previous six months. Includes an outpatient clinician (physician, nurse practitioner, physician's assistant or nurse) phone call with the patient, family or caregiver to assess the patient's condition and adherence to recommended care and to reinforce follow-up. |
| Conduct follow-up appointments with patients discharged from the ED or hospital to the community. | | | | X | <ul style="list-style-type: none"> For hospital visits, should be scheduled by the hospital prior to hospital discharge; if not, the physician office should outreach. Within 14 days of discharge from the ED or hospital, unless the timeframe is otherwise specified and documented in the medical record. Can be with a clinician (physician, nurse practitioner, physician's assistant or nurse) at the community physician's office or with a specialist, such as cardiologist, who cares for the patient in an outpatient setting. |

1 From any setting, including hospital, home health agency, nursing home or urgent care setting
 2 Regular provider: The primary care physician or any other clinician identified by the patient as their regular provider
 3 Unplanned care: Emergency department, hospital or urgent care center utilization

Minimum Standards of Professional Conduct vs. Aspirational Standards of Professional Conduct

Arranging for a seamless transition of care may seem like a novel concept to some, unobtainable to others and long overdue to many. This important patient safety issue is essential to the responsible practice of medicine and nursing.

Currently the Boards are taking a proactive role and educating health professionals regarding transitions of care. It is anticipated that in time, challenges will be overcome and this will become a seamless part of the health care experience.

Ideally transitions of care will surpass the minimal data set and transitions will be multidisciplinary, multi-directional, concise and customized to the patient-transition experience.

There are existing tools for patients and practitioners regarding appropriate transitions²⁰ which include medication lists, checklists and validated evidence based risk assessment tools.

Challenges & Opportunities vs. Barriers and Facilitators?

There are several challenges that face healthcare providers in facilitating best practices in transitions of care and, by virtue, are often the same challenges providers face in meeting professional standards of transitions of care. It is our argument that the resources expended in achieving and maintaining optimal transitional care for patients will ultimately save resources beyond what is expended implementing them. Here are some of the common barriers to safe and quality care transitions and some workable solutions to facilitate transitions.

All healthcare providers are challenged by time, especially in an increasingly complicated health care environment. There is little or no financial reimbursement for providers to send or receive patients in an optimal fashion. Currently, transition care is largely subsumed in current reimbursement schedules for routine evaluation and management of patient conditions or as part of the overall hospital cost. Moreover, in many settings, there is no longer a single practitioner responsible for communication and follow-up of transition and coordination of care, blurring the roles and responsibilities of the multiple healthcare providers typically involved in care. However, transitions are an essential part of patient care and healthcare providers have a legal, ethical and moral obligation to utilize every opportunity to ensure patient transitions meet, at the least, the minimal standards for quality and safe patient care. Although there are systems barriers that impede successful patient transitions, there are pragmatic solutions that an individual provider can employ to ensure they uphold professional standards of transitioning care for their patients. It is understood that communication, verbal, written and electronic, is an essential attribute of professional practice and care transitions across the continuum. These are skills are individual skills that can be enhanced. All healthcare providers are accountable for communication and ensuring that pertinent information is relayed

in a timely fashion when sending or receiving patients.

Collaboration and communication are essential attributes of transitions, but institution infrastructures often function in silos, making it problematic to delineate responsibilities between care providers and institutions. Even within affiliated institutions, vertical transitions are often not well executed.²¹ For example, hospital care providers may not be available after discharge, even when the primary care provider is employed at the same organization. This is problematic when a community provider is trying to clarify or understand a patient's post-discharge plan of care. Similarly, acute-care institutions struggle with poor medical histories and lack understanding of the patient's community plan of care. Further, the professionals involved in patient care may not have practiced in the settings from which they have received or are sending patients, and, as such, may not understand the capacity or infrastructure of these settings. A viable solution is to ensure that the patient, care givers and the receiving provider have accurate up-to-date contact and a covering provider to answer questions for periods when not available.

Patients and families an important element

Patients and their families are also important elements of transition care. While patients have rights to receive safe and quality transitional care, they also have responsibilities to assist and participate in the process. However, patients often do not understand their plan of care for many reasons. Primarily, the plan is often multi-faceted and complicated; patients may be impaired, both cognitively and/or physically, thus limiting their ability to participate at an optimal level. Family may or may not be involved and may also be limited in their understanding of the plan of care. There may be health literacy, cultural and language barriers. Healthcare providers can practice with a patient centered care model and should encourage patient and family/caregiver involvement, when appropriate, and reinforce patient responsibilities to help develop, understand and be able to communicate their plan of care and who their providers are in different settings. Care and consideration should be exercised when determining the plan of care for a patient. The plan of care should be simplified to the extent possible without decreasing quality or jeopardizing safety. Clear written and verbal communications are essential, and providers should use tools that already exist to facilitate transitions such as medication reconciliation and the continuity of care form.²² Care instructions should be simple and clear, including a distinct plan for post transfer care, resources and who to direct questions to. Healthcare providers can be leaders in their institutions and in their fields to educate, and bring to the forefront, the standard of care for their profession as it relates to transitioning their patients. Checklists and follow-up protocols can be adapted for each setting to assist clinicians to understand their roles and accountability within settings. This will assist clinicians to understand their roles

and also to share responsibility for transition care among clinicians. In addition, it would help educational programs to implement discipline specific transition principles in their curriculum and training.

CONCLUSIONS

Transitional care is an essential attribute of any patient plan of care. Although each profession is accountable for discipline specific elements of transitional care, prior to specific regulatory requirements being implemented, standards for discipline specific best practices need to be developed and implemented in the health care system. Both the RI DOH Continuity of Care Form¹⁵ and best practices guidelines¹⁶ are available to guide providers on how to best meet patient transition needs. Further, these tools assist to improve communication and patient activation by establishing core expectations based on clinicians' preferences and evidence, where it exists, and by creating measures that can be tracked over time. They also establish core expectations for communication that can improve patients' experiences and health outcomes, as well as facilitate cross-setting collaboration, relationship building and referral patterns. Implementing the best practices acknowledges the reciprocal nature of the healthcare system and the collective need for communication between healthcare providers to ensure delivery of high-quality care.

The time has come for interested stakeholders to further develop transitions of care to a more codified position. The logical next step might be a collaborative endeavor to modify and create regulatory changes that definitively address transitions of care.

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Through collaboration with the Rhode Island Department of Health and other community stakeholders, Healthcentric Advisors' Medicare-funded Safe Transitions project aims to transform the Rhode Island healthcare system into one in which discharged patients and their caregivers understand their conditions and medications, know who to contact with questions, and are supported by healthcare professionals who have access to the right information, at the right time. This is our vision statement.

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Footnote

*After testing evidence-based care transitions interventions locally and systematically gathering input on providers' preferences and needs, Healthcentric Advisors collaborated with physicians, nurses, health plans and community leaders to develop care transitions best practices for six provider settings: community physicians, emergency department, home health agencies, hospitals, nursing homes and urgent care centers.

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