

Transitions of Care

An Overview of the Transitions of Care Consensus Policy Statement

Learning Objectives

- Recognize the dangers inherent in patient hand-offs and transitions
 - Become familiar with current recommendations for improving safety and communication in times of transition from inpatient to outpatient settings
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Case

You admit a 67 year-old man with history of osteoarthritis, CHF and hypertension with new onset upper gastrointestinal bleeding. His chronic NSAIDs and beta blockers are held given his bleeding and initial hemodynamic instability on arrival. During the course of his stay he requires a total of 4 units PRBCs for low hematocrit, and has upper endoscopy performed, during which biopsies are taken. By hospital day#4, he is stabilized, tolerating a regular diet, and is ready for discharge. You notice that his hematocrit, which was 29 after his last transfusion 2 days ago, is 25 on the day of discharge, and that his biopsy results are not yet reported. In addition to the medication changes above, you have started him on a PPI versus his outpatient H2-blocker.

The patient states he has a family doctor in the community that is not affiliated with your hospital, but does not have an upcoming appointment .

What are the risks of discharging this patient? What steps can you take to minimize them?

Background

- Multiple studies have shown that the transition from inpatient to outpatient care is a particularly dangerous time for patients:

- In one study of 400 patients, 20% of patients discharged from hospital to home experienced some adverse event (described as an injury resulting from medical management rather than the underlying disease) within 3 weeks of discharge. 66% of these events were medication related (1)
- Another study looking at post-hospitalization medication discrepancies (described as differences in pre- and post-hospitalization medication lists and what was actually being taking) in patients aged 65 and older found that 14% had at least one discrepancy, and that 14% of that group were re-hospitalized within 30 days compared with 6% of patients without medication errors. (2)
- Yet another study examining 2644 patient discharges found ~40% of patients had test results pending at the time of discharge, 10% of which required some action/ follow up, however the patients and their outpatient providers were unaware of these results (3)
- The overall 30 day readmission rate of Medicare beneficiaries is 18% (4)

- Communication between inpatient and outpatient providers (for those patients that have them) is a key, yet often missing, step in care transitions. A large review of this issue by the Society of Hospital Medicine (SHM) revealed that:

- Direct communication between inpatient and primary care occurs only 3-20% of the time
- Discharge summaries of recent inpatient stays are available by time at first post-hospital visit only 12-34% of the time, and by 4 weeks post-discharge only 51-77% of the time (5)

- Communication between inpatient providers and patients prior to discharge is just as important- patient/ caregiver anxiety regarding discharge and transitioning to self-care can make difficulties with understanding discharge instructions, which is often made further difficult in today's world of multiple teams of providers being involved with patient care- from the primary team to consult services- with sometimes differing advice/ instructions for patients on discharge.

Transitions of Care Consensus Conference (TOCCC)

- A gathering of over 30 organizations (ACP, SHM, SGIM, ACEP, SAEM) with the goal of "addressing the quality gaps in the transitions between inpatient and outpatient settings and to develop consensus standards for these transitions."

- Held a consensus prioritization of the created "standards for care transitions," with the following as the top 7 standards chosen as the most important to begin implementing for safe and smooth care transitions. The following definitions are taken directly from the consensus statement:

1. All transitions must include a transition record.

- This includes a *minimal* set of data elements that should always be a part of the transition record:
 - Principle diagnosis and problem list
 - Medication list, with reconciliation, including-over-the-counter medications, herbals, allergies, and drug interactions
 - Clear identification of the medical home, transferring coordinating physician/institution, and the contact information
 - Patient's cognitive status
 - test results/pending studies
- Also included in the "ideal" transition record would be:
 - Emergency plan and contact number and person
 - Treatment and diagnostic plan
 - Prognosis and goals of care
 - Advance Directives, power of attorney, and consent
 - Planned interventions, durable medical equipment, wound care, and so forth
 - Assessment of caregiver status

2. Transition Responsibility.

- The sending provider/institution/ team at the clinical organization maintains responsibility for the patient until the receiving clinician/ location confirms that the transfer and assumption of responsibility is complete.
- The sending provider should be available for clarification with issues of care within a reasonable timeframe after the transfer has been completed
- Hospitalists will not be required to assume ongoing responsibility for those patients who do not have an ambulatory care provider

3. Coordinating Clinicians.

- At any point of care transition, communication and information exchange should occur between the medical home and receiving provider (in the form of a call, voice mail, fax, or EMR transfer). This exchange should occur in a timely fashion, so that the receiving provider can effectively treat the patient.

4. Patient and family involvement and ownership of the transition record.

- Patients and their families/caregivers must receive, understand and be encouraged to participate in the development of the transition record, which should be culturally appropriate and take into account patients' health literacy and insurance status.

5. Communication Infrastructure.

- Communication between providers and between providers and patients needs to be HIPPA compliant but accessible
- Communication needs to be 2-way, with opportunity for feedback and clarification, with data available to the accepting provider prior to the patient's arrival
- Sending providers should include a contact name and number for an individual that can respond to questions or concerns
- The content of transferred data should be standardized (see #1)
- Patients should be provided with a medication list that is accessible, clear and dated

6. Timeliness.

- Timeliness of feedback/feed-forward of information between providers is contingent on 4 factors:
 - Transition settings
 - Patient circumstances
 - Level of acuity
 - Clear transition responsibility
- Regardless of above, information should be available at time of patient encounter

7. Community Standards.

- Call for national standards so that medical institutions and communities may more easily demonstrate accountability for transitions of care.

Other considerations

- It should be noted that this consensus did not come to conclusions regarding transition responsibilities for patients not currently affiliated with a medical home/ primary care provider who are discharged from an inpatient team or from

Emergency Department care. This issue will require further consideration and planning strategies.

Test Your Knowledge

1. Name 4 vital parts of any transition record

2. True or False: Once you have discharged a patient from the hospital, you are no longer responsible for any aspect of their care.

References:

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