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BUILDING IMPROVED HEALTHCARE

Introduction to the Care Transitions Toolkit

About the Care Transitions Toolkit

The Care Transitions Toolkit aims to help health care organizations effectively coordinate care for patients as they move from one care setting or provider to another. In addition, this toolkit can help you empower patients to care for themselves and stay as healthy as possible during and following a transition.

The Importance of Effective Care Transitions

Transitions from one care setting or provider to another are challenging and can leave many patients vulnerable to potential adverse events and unnecessary hospital readmissions after discharge. Adverse drug events are the most common complication post-discharge, with hospital-acquired infections and procedural complications also causing significant morbidity.[1,2] Receiving proper instructions and education about diagnoses and treatment at the time of discharge is essential. However, many patients may not understand or remember the information they were given; this can result in confusion and potential mismanagement of the treatment regimen.[3]

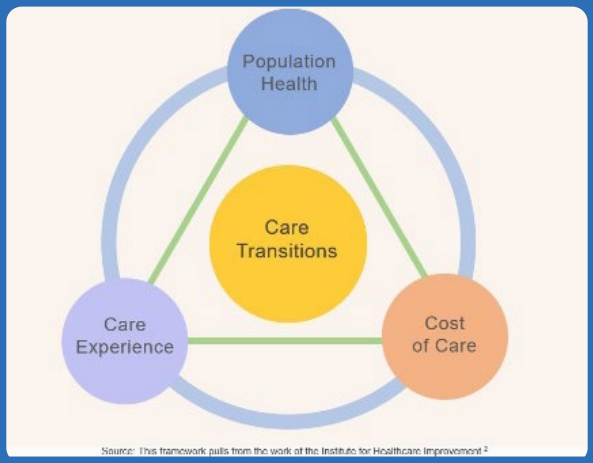
Discontinuity of care and delayed or faulty communication between providers can also contribute to adverse events, add to patient and family distress, and result in poorer health outcomes.[4] One study found that almost 20 percent of patients experienced an adverse event following discharge from the hospital, most of which could have been prevented or ameliorated, meaning the severity of the event could have been decreased by earlier corrective actions. Of these, 59% of events that were preventable or ameliorable resulted from poor communication between hospital caregivers and either the patient or primary care physician.[5]

Care Transitions and the Triple Aim

Organizations committed to delivering health care value are increasingly focusing on enhancing care transitions as a way to improve outcomes. The Institute for Healthcare Improvement (IHI) has developed the Triple Aim model that discusses health care value as being achievable by pursuing three goals simultaneously: improving the care experience, improving population health, and reducing per capita costs.[6]

These goals can be used to drive and guide efforts to improve care transitions.[7]

The Triple Aim and Care Transitions



Source: This framework pulls from the work of the Institute for Healthcare Improvement.[2]

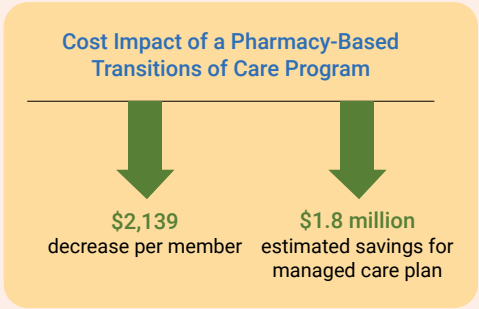
Note: In 2014, the Triple Aim was expanded to the Quadruple Aim with the addition of the goal to improve the *work life of health care providers.* In 2022, the Quintuple Aim proposed adding a fifth goal to advance *health equity.* While it has been acknowledged that addressing workforce well-being and health equity may be necessary to achieve the Triple Aim, these expansions have not been officially adopted by IHI.[8,9,10]

Improving Patient Experience. This goal encompasses both the patient's perception of the quality of care provided and their expressed level of satisfaction with that care.[6] The Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[i] surveys are a family of surveys developed by the Agency for Healthcare Research and Quality.[11] There are CAHPS® questionnaires for health plans, health care facilities, and providers.[12] These surveys are commonly used to assess the overall experience of care of a large sample of patients. The surveys include questions such as, "Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?"[11,12] The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey is used to assess care received in the hospital setting. It is administered to a random sample of adult patients admitted for any condition 48 hours to 6 weeks after discharge.[13]

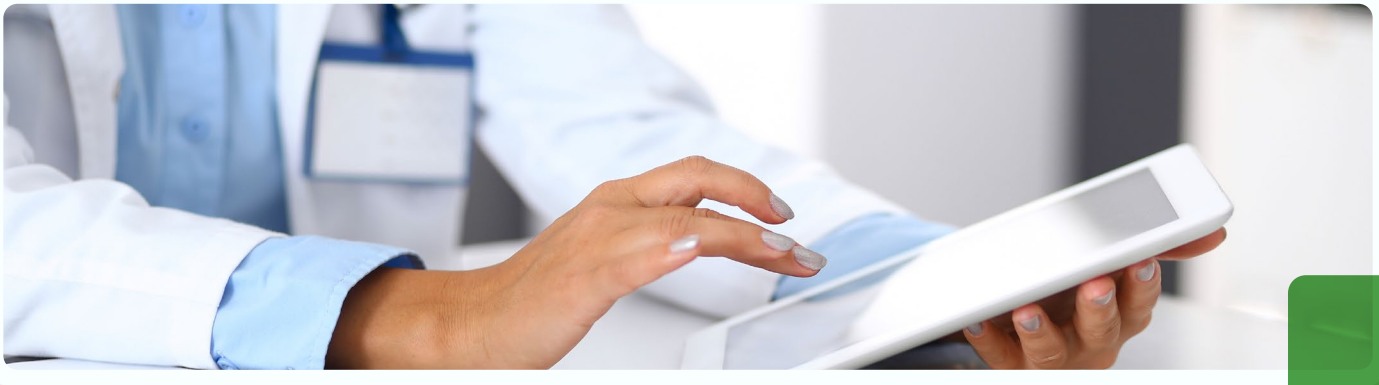
[i] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

Improving care transitions has been shown to positively affect patient experience scores, and better patient experience has been tied to quicker recovery from illness, better treatment adherence, and higher engagement with care.[13] A study by Figueroa and colleagues examined how increased use of care coordination and care transition strategies impacted patient experience as measured by the HCAHPS survey.[13] Hospitals using a higher number of care transition strategies consistently outperformed hospitals using fewer strategies. After adjusting for hospital characteristics, high-strategy hospitals had significantly higher scores on key HCAHPS measures (overall rating, recommendation of hospital, satisfaction with discharge process, and satisfaction with communication about medications). Findings also indicate that specific strategies such as using discharge coordinators, sharing discharge summaries with patients, and calling patients post-discharge are associated with better overall hospital experience.[13]

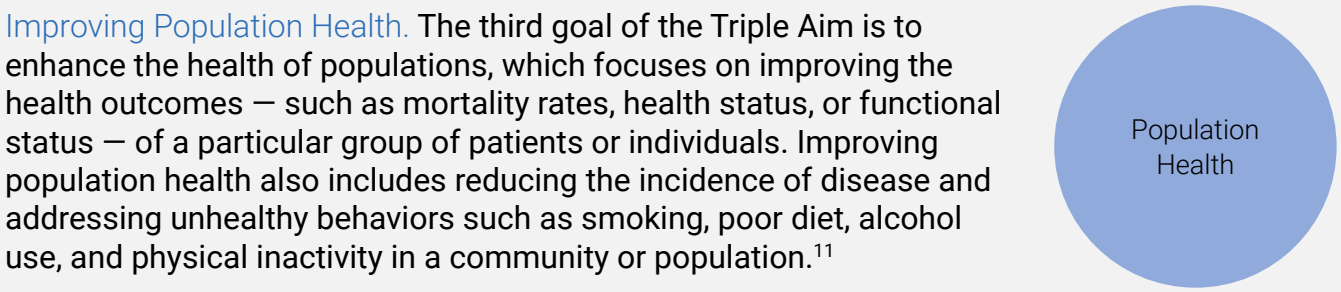
Reducing Per Capita Costs. Another Triple Aim goal is to reduce per capita costs of care.[6] It has been reported that after being discharged from the hospital, nearly 20 percent of Medicare patients return within 30 days at an estimated cost of $26 billion a year, $17 billion of which is spent on preventable expenses.[2,14] This, in part, has led to efforts to reduce unnecessary readmissions by taking steps to improve care transitions.[14]



For example, among members of a Medicaid managed care plan enrolled in an outpatient pharmacy-based care transitions program, total health care costs were an average of $2,139 lower at 180 days after discharge when compared to those receiving usual post-discharge care. This resulted in almost $1.8 million in estimated savings for the health plan.[15] Additionally, Hitch and colleagues found that implementation of a team-based transition-of-care model that included contact with a nurse care manager, medication reconciliation, and follow-up with a physician, was associated with a significant reduction in 30-day readmission rates. The 30-day readmission rate decreased from 14.2% in the pre-intervention usual care group to 5.3% in the intervention group.[14]



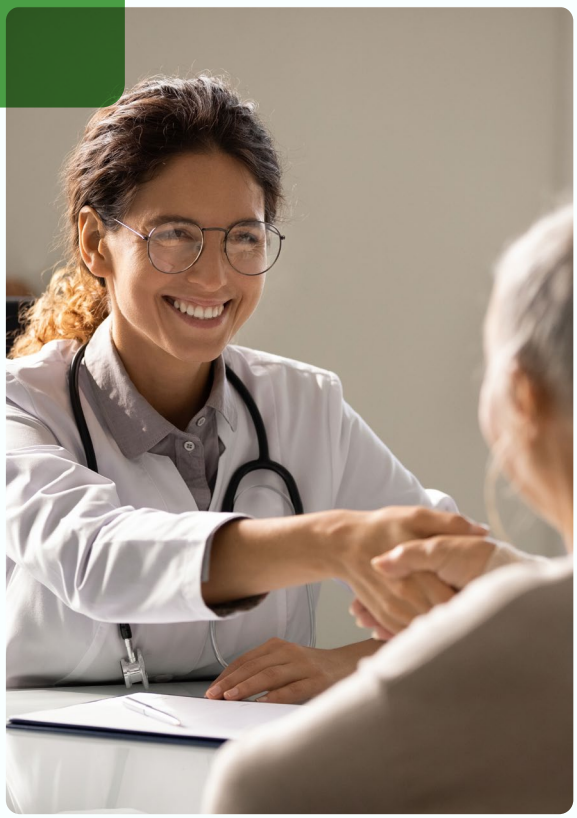
Improving Population Health. The third goal of the Triple Aim is to enhance the health of populations, which focuses on improving the health outcomes — such as mortality rates, health status, or functional status — of a particular group of patients or individuals. Improving population health also includes reducing the incidence of disease and addressing unhealthy behaviors such as smoking, poor diet, alcohol use, and physical inactivity in a community or population.[11]



The discharge planning period offers opportunities to help patients improve their health. For instance, care managers can provide patients with chronic conditions education about their disease, encourage healthy habits, and check understanding of how to monitor key biometric markers, such blood glucose and blood pressure, so they can better control the condition.[11,16] It can also be a time to educate patients about medications, and any necessary dietary modifications that can help the medications work more, or less, effectively. For example, this is the time to review foods that can affect anticoagulation therapy, glucose control, and response to congestive heart failure treatment — all of which may increase the patient's risk of readmission.[17,18]

Measuring Improvement in Care Transitions

Given the link between care transitions and health care value, payers, regulators, and other non-provider stakeholders are exploring various strategies to improve care transitions. For example, NCQA includes Transition of Care (TRC) metrics as part of its HEDIS®[ii] measures, which are widely used to assess health plan performance. The TRC measures require health plans to track and document whether Medicare beneficiaries 18 years of age and older were engaged and received follow-up care (eg, office visits, home visits, or telehealth) within 30 days of a hospital discharge, and whether medication reconciliation was performed at discharge through 30 days post-discharge. The HEDIS® measures also assess whether outpatient providers receive notification when patients are admitted to and discharged from the hospital as documented in the outpatient medical record.[19]



The Centers for Medicare & Medicaid Services (or CMS) now allows certain outpatient providers to bill Medicare for transitional care management (or TCM) visits with at-risk Medicare patients after they are discharged from an acute or post-acute facility.[20] In a study by Bindham and Cox, the absolute mortality rate was 0.6 percent lower among Medicare beneficiaries who received TCM services than among those who did not. Readmissions were also significantly lower.[21] Another example of a CMS strategy to improve care transitions is the Hospital Readmissions Reduction Program (HRRP) which encourages hospitals to reduce unplanned readmissions by improving communication and care coordination and by better engaging patients and caregivers in discharge planning. As part of the program, hospitals may receive reduced Medicare reimbursement when readmission rates for certain conditions, including heart failure and pneumonia, exceed a predictive ratio.[22]

Other value-based arrangements, such as bundled payment programs, can help to enhance care coordination. For instance, Herald and colleagues found that hospitals participating in bundled payment programs and accountable care organizations (or ACOs) had adopted more care coordination activities than those that did not participate.[23]

[ii] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

Evidence-Based Models and Frameworks

There are a number of evidence-based models and frameworks that can inform efforts to improve care transitions. This section highlights some of the most commonly used models.

The Re-Engineered Discharge (RED) Toolkit focuses exclusively on the discharge process. RED consists of 12 reinforcing actions the hospital takes during and after the hospital stay to ensure a safe and effective transition at discharge. In summary these include:[18]

- Ascertaining need for and providing language assistance
- Scheduling appointments for follow-up care
- Planning for follow-up of tests/labs results pending at discharge
- Organizing post-discharge outpatient services and medical equipment
- Identifying the correct medications and plan for the patient to obtain them
- Reconciling the discharge plan
- Teaching the patient their written discharge plan in a way that's easy to understand
- Educating the patient about their diagnosis and medications
- Reviewing with the patient what to do if a problem occurs
- Assessing the patient's understanding of the discharge plan
- Expediting transmission of the discharge plan to outpatient clinicians
- Providing reinforcement of the discharge plan via telephone

Hospitals that have adopted this model have seen increases in patient satisfaction and decreases in readmissions and post-discharge emergency department visits.[18]

Another useful care transitions model is IDEAL, which can be used alongside the RED or any other care transition model. The goal of IDEAL is to engage patients, as well as their families, as they transition from hospital to home as part of efforts to reduce adverse events and prevent readmissions. Empowering patients through educational activities throughout the stay, attending to discharge planning from the first day of the stay, and coordinating care after discharge, are best practices used by hospitals with low readmission rates related to pneumonia, heart failure, and heart attack.[24]

The IDEAL model provides details on the key elements of engaging the patient and family in discharge planning, which includes discussing 5 key areas to prevent problems at home: [24]

- Describing what their home life will be like after discharge
- Reviewing medications
- Highlighting warning signs and problems
- Explaining test results
- Making follow-up appointments

Some frameworks are not specific to any one type of transition but are intended to promote continuity of care throughout the patient's experience while also ensuring safe, seamless transitions. This is the aim of the American Case Management Association's (ACMA) Transitions of Care Standards. These standards focus on creating a dynamic care management plan that encompasses every care setting in which a patient is seen and stresses the need for all health care professionals involved in a patient's care to be able to access key information about a patient's care transition. This involves the development of a longitudinal care management plan that follows the patient's entire journey, from illness through recovery, in contrast to an episodic care plan that only focuses on one transition within the patient's journey, such as from hospital to home.[25]

All the various care transition models and frameworks incorporate a number of critical strategies to successfully help patients move across care settings. These range from identifying patients at high risk of poor outcomes, ensuring effective discharge planning processes, connecting patients to their primary care and other outpatient providers, conducting medication reconciliation, and empowering patients and families through self-care education and coaching.[24,25,26]

Using the Toolkit

More details about these different strategies, along with case examples, can be found in the "Best Practice Brief: Strategies for Successful Care Transitions" included in this Care Transitions Toolkit on ArchiTools.

Also within the Care Transitions Toolkit, you will find patient education tools that can help you empower patients to care for themselves at home after a transition. You can download and share each of the brochures listed below:

- Preparing Your Home for Your Recovery
- Getting the Care You Need at Home
- Help for Caregivers

In addition, you can find many other useful tools and resources to help patients before, during, and after care transitions on ArchiTools.

References

1. Bajorek SA, McElroy V. Discharge planning and transitions of care. Agency for Healthcare Research and Quality. Published March 25, 2020. Accessed March 17, 2023. https://psnet.ahrq.gov/primer/discharge-planning-and-transitions-care
2. Agency for Healthcare Research and Quality. Readmissions and adverse events after discharge. Updated September 7, 2019. Accessed March 15, 2023. https://psnet.ahrq.gov/primer/readmissions-and-adverse-events-after-discharge
3. Becker C, Zumbrunn S, Beck K, et al. Interventions to improve communication at hospital discharge and rates of readmission. *JAMA Network Open.* 2021;4(8):e2119346. doi:10.1001/jamanetworkopen.2021.19346
4. Parry C, Johnston-Fleece M, Johnson MC, Shifreen A, Clauser SB. Patient-centered approaches to transitional care research and implementation, overview and insights from Patient-Centered Outcomes Research Institute's Transitional Care Portfolio. *Med Care.* 2021;59: S330-S335.
5. Forster AJ, Murff HJ, Peterson JF, Gandhi TK, Bates DW. The incidence and severity of adverse events affecting patients after discharge from the hospital. *Ann Intern Med.* 2003;138:161-167.
6. Institute for Healthcare Improvement. The IHI triple aim. Accessed March 17, 2023. http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx
7. Campagna V, Nelson SA, Krsnak J. Improving care transitions to drive patient outcomes: the triple aim meets the four pillars. *Prof Case Manag.* 2019;24(6):297-305.
8. Bodenheimer T, Sinsky C. From the triple to quadruple aims: care of the patient requires care of the provider. *Ann Fam Med.* 2014;12:573-576. doi:10.1370/afm.1713
9. Nundy S, Cooper LA, Mate KS. The quintuple aim for health care improvement, a new imperative to advance health equity. *JAMA.* 2022;327(6):521-522.
10. Bodenheimer T, Sinsky C. From triple aim to quadruple aim: care of the patient requires care of the provider. *Ann Fam Med.* 2014;12(6):573-576. doi:10.1370/afm.1713
11. Stiefel M, Nolan K. A guide to measuring the triple aim: population health, experience of care, and per capita cost. Institute for Healthcare Improvement. Published 2012. Accessed May 24, 2023. http://www.ihi.org/resources/Pages/IHIWhitePapers/AGuidetoMeasuringTripleAim.aspx
12. Agency for Healthcare Research and Quality. CAHPS® health plan survey: overview of the questionnaires. Reviewed January 2023. Accessed May 25, 2023. https://www.ahrq.gov/cahps/surveys-guidance/hp/index.html
13. Figueroa JF, Feyman Y, Zhou X, Joynt Maddox K. Hospital-level care coordination strategies associated with better patient experience. *BMJ Qual & Safety.* 2018;27(10):844-851.
14. Hitch B, Parlier AB, Reed L, Galvin SL, Fagan EB, Wilson CG. Evaluation of a team-based, transition-of-care management service on 30-day readmission. *NC Med J.* 2016;77(2):87-92.
15. Ni W, Colayco D, Hashimoto J, et al. Reduction of healthcare costs through a transitions-of-care program. *Am J Health Syst Pharm.* 2018;75(10):613-621.
16. Kodner C, Anderson L, Pohlgeers K. Glucose management in hospitalized patients. *Am Fam Physician.* 2017;96(10):648-654.
17. Physician's Committee for Responsible Medicine. Basic diet orders: teaching patients good health practices. Accessed April 5, 2023. https://nutritionguide.pcrm.org/nutritionguide/view/Nutrition_Guide_for_Clinicians/1342084/all/Basic_Diet_Orders:_Teaching_Patients_Good_Health_Practices
18. Agency for Healthcare Research and Quality. Re-engineered discharge (RED) toolkit. Published March 2013. Accessed March 20, 2023. https://www.ahrq.gov/sites/default/files/publications/files/redtoolkit.pdf
19. National Committee for Quality Assurance. Transition of care (TRC). Accessed April 18, 2023. https://www.ncqa.org/hedis/measures/transitions-of-care/
20. American Academy of Family Physicians. Transitional care management. Accessed March 20, 2023. https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/transitional-care-management.html
21. Bindman AB, Cox DF. Changes in health care costs and mortality associated with transitional care management services after a discharge among Medicare beneficiaries. *JAMA Intern Med.* 2018;178(9):1165-1171.
22. Centers for Medicare and Medicaid Services. Hospital readmissions reduction program (HRRP). Revised August 8, 2022. Accessed March 20, 2023. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/Hospital-Readmission-Reduction-Program
23. Hearld LR, Carroll N, Hall A. The adoption and spread of hospital care coordination activities under value-based programs. *Am J Manag Care.* 2019;25(8):397-404.
24. Agency for Healthcare Research and Quality. Care transitions for hospital to home: IDEAL discharge planning implementation handbook. Accessed March 20, 2023. https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Implement_Hndbook_508_v2.pdf
25. American Case Management Association. Transitions of care standards framework. Accessed July 27, 2023. https://transitionsofcare.org/standards/
26. Agency for Healthcare Research and Quality. Medications at transitions and clinical handoffs (MATCH) toolkit for medication reconciliation. Revised August 2012. Accessed March 20, 2023. https://www.ahrq.gov/sites/default/files/publications/files/match.pdf

