



## Core Competencies, Chapter 15

### Care Coordination- Coordinating Transitions of Care

Contributor: Michelle Park, MD, Edited by Marc Avery, Stacey Devenney

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#### Definition and Why Coordinating Transitions of Care is Important to Integrated Complex Care

Transitions of care are defined as “the movement of patients between health care practitioners, settings, and home as their condition and care needs change.” (Hot Topics in Health Care: Transitions of Care, Joint Commission 2012) Effective transitions of care are essential for patient safety, to improve health outcomes and to reduce unnecessary costs or adverse effects.

#### Example

An 80-year-old retired schoolteacher 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. At her most recent hospitalization, the team assesses the need for short-term nursing care given her multiple readmissions, and coordinates care with a nursing facility and the patient’s family to ensure continuity of care from the hospital to the skilled nursing facility. (Adapted from Hot Topics in Health Care: Transitions of Care)

Care manager works with discharge planner at the hospital and family to ensure that the patient/client arrives at the skilled nursing facility. Care manager speaks with the family to help them understand discharge plans and medication regime. Care manager does an outreach to establish that the patient/client has arrived at the nursing facility and is receiving care and is comfortable. Care manager speaks with the patient/client and schedules visits for 2x/month to coordinate care.

#### Narrative Description

Coordinating care transitions for patients effectively between health care settings has become a focus for hospitals in recent years as the federal government has set goals of saving an estimated \$26 billion dollars by reducing preventable readmission to hospitals and financially penalizing hospitals with unacceptably high readmission rates. Per the Department of Health and Human Services, approximately one in five Medicare patients who are discharged from the hospital will be readmitted within 30 days. Risk factors for readmission include psychosocial and emotional factors, older age, need for multiple medications, co-morbidities and diagnoses associated with high readmissions – all potential risk factors shared by the BHICCI population.

Beyond the care transitions involving hospitals, which are the most problematic according to experts, patients also face challenges moving between outpatient health care settings or even between providers due to the fragmented nature of our health care infrastructure. A study estimated that 80% of serious medical errors involve miscommunication during the hand-off between medical providers. (Solet et al, Academic Medicine 2005) The root causes of ineffective transitions of care include breakdowns in communication between care providers or between the patient/patient’s family and the healthcare team, ineffective patient education, and lack of accountability for coordination of care.

The common factors identified by the Joint Commission in approaches to successful care transitions dovetail with the goals and structure of BHICCI- implementing a screening process to identify patients at higher risk for healthcare problems that could possibly lead to readmission after discharge, involving a multidisciplinary team, and utilizing case managers and/or discharge planners to assess needs and coordinate transitions. There are also certain activities that have contributed positively to effective care transitions such as: strong leadership support for new transitions

processes, interpersonal communication, medication reconciliation, two-way patient and family education, electronic health records, and assigned accountability for transition-related tasks and outcomes.

**Available Resources**

1. The Joint Commission Transitions of Care Portal- <https://www.jointcommission.org/toc.aspx>
2. Community-based Care Transition Program via CMS- <https://innovation.cms.gov/initiatives/CCTP/>

**BHICCI Plan for Learning / Teaching / Coaching**

- Agency reads the materials presented in Core Competency 14 - Care Coordination – Coordinating Transitions of Care (Transitions of Care), and discuss with the practice coach.
  - Audience: leadership, clinical leadership
- Web Training or In-Person Presentation: Review of basics of Transitions of Care.
  - Develop a Plan by Jen Clancy Consulting team/Agency for next steps of implementation at end of Web-Training or training to implement Transitions of Care using Plan-Do-Study-Act.
    - Audience: primary care provider, Clinic staff
- Participation of HCO executive leaders and managers in the Cross System Leadership and Care Transitions program facilitated by the Kiely Group including in-person and web-based education and a multi-agency care transitions pilot.

**How will Competence in this area be Measured?**

Identification of the evidence-based transitions of care model that best suits the organization, standardizing protocols and accountability throughout the system

Following completion/verification of the above learning/teaching/coaching plan, each team will have the opportunity to practice his/her new skills under supervision. Following this, the supervisor will rate the clinician’s competency in each of the following by:

1. Case discussion of 3 or more complex care patients, or
2. Chart review of 5 or more patients, or
3. Direct observation of clinician interaction and conversation with patients/clients and other facilities.

COMPETENCY AREA	EVIDENCED BY	SUPERVISOR’S RATING*
Effective communication with patients and their support systems during care transitions	<ul style="list-style-type: none"> <li>• Acknowledges the perspectives of the patient/client and support system during discussions, deciding on intervention strategies, and the development of the transition plan</li> <li>• Motivational interviewing strategies are used to help patient/client identify what has worked in the past.</li> </ul>	1   2   3   4   5
Effective communication within treatment teams regarding transitions	<ul style="list-style-type: none"> <li>• Seeks to understand other disciplines on the team.</li> <li>• Have regular meetings with team members to build rapport.</li> <li>• Effectively communicates patient/client and natural supports wishes to treatment team.</li> </ul>	1   2   3   4   5
Accountability for coordination of care	<ul style="list-style-type: none"> <li>• Documents transition plan developed with patient/client and support systems in the medical record.</li> <li>• Demonstrates appropriate follow up to ensure that patient/client connects with transition agency/provider.</li> </ul>	1   2   3   4   5
Medication reconciliations	<ul style="list-style-type: none"> <li>• Be able to demonstrate how to complete a medication reconciliation record based on best practices</li> <li>• Be able to verbalize how to resolve discrepancies, duplications, or drug interactions during the interaction process.</li> </ul>	1   2   3   4   5

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\*1= Excellent results with no need for prompting or support.  
3 = good results and/or required some prompting or support.  
5 = required much support and/or was unable to complete necessary skills