Care Transitions – Case Study

A 40 year old male with diabetes and diagnosis of HIV and CNS toxoplasmosis was referred from an outside facility on 1/17/2014 for closer medical monitoring than what he had been receiving at a “stepdown” Recuperative Care Facility (awaiting PSH). After the patient was cleared for transfer by the provider of the Recup Care Facility, the LVN was informed that the patient would be coming that afternoon. Subsequently the LVN informed the Bell Shelter Security Staff on duty to expect the patient.

At 5pm the Recuperative Care provider went out to the security desk to see if the patient had arrived and he was advised that no one by that name had arrived. The referring agency was notified that the patient had not yet arrived, but confirmed that the patient was on his way. Another hour later, the provider again went to the security desk and was told the patient had still not arrived. Finally, about thirty minutes later, the provider described the patient’s physical appearance to the security staff and they realized that the patient did arrive at the Bell Shelter facility. However, the security staff had advised the patient that there were no shelter beds available evidently because he was not aware that the patient was presenting to be admitted to Recup Care rather than the shelter.

For half an hour the provider drove around the neighborhood to look for the patient, but was unsuccessful. He subsequently notified the appropriate referring agency coordinator who indicated they would call for police assistance in locating the patient. However, the patient was not found. About one month later, on 2/6/2014, the patient was found on the street with shortness of breath and altered mental status. He was then admitted to the County hospital for altered mental status and shortness of breath.

IMPROVING CARE TRANSITIONS FOR PEOPLE EXPERIENCING HOMELESSNESS

POLICY & PRACTICE BRIEF
December 2012

Care transitions refer to the movement of patients between health care locations, providers, or different levels of care within the same location as their conditions and care needs change.[1] While health reform has created a number of new initiatives, care transition for people who are experiencing homelessness is challenging due to lack of affordable housing and transportation options, poor health literacy, and limited social support. Additionally, while a number of evidence-based care transition models offer guidelines for care transition, most target older adults enrolled in Medicare; very few models have been tested for adults under the age of 65. This paper defines care transitions, describes health reform initiatives to systemize care transitions, explores various evidence-based care transition models, and offers practice and policy recommendations for improving care transitions for people experiencing homelessness.

DEFINING CARE TRANSITION

The formal definition of "care transition" addresses the movement of patients between health care locations, providers, or different levels of care within the same location as their conditions and care needs change. This may include the transition from the hospital to a primary care provider, home, or nursing facility.[2] For people experiencing homelessness, transitions can also involve medical respite programs, supportive housing, emergency shelters, and various other community settings.

Care transition differs from care coordination. **Care coordination** involves numerous providers who are dependent upon each other to carry out disparate activities in a patient's care. In order to carry out these activities in a coordinated way, each provider needs adequate knowledge about their own and others' roles and available resources and often relies on exchange of information in order to gain this knowledge.[3] **Care transitions** are a subpart of the broader concept of care coordination. Care transition models ensure that patients and their caregivers are able to understand and use health information and those patients are able to move seamlessly from one health setting or provider to another.

Care transition initiatives aim to improve quality and continuity of care while reducing costs related to hospital readmissions. Currently, most care transition initiatives focus on high-cost Medicare beneficiaries. Research looking at hospital utilization trends of Medicare beneficiaries attributes inadequate care coordination, particularly poor care transitions, as a contributing factor to higher-than-average hospital readmission rates for this population. While other high-cost populations, like people experiencing homelessness, would benefit from improved care transitions, hospital readmissions data for this population is limited.

BARRIERS TO CARE TRANSITIONS FOR PEOPLE EXPERIENCING HOMELESSNESS

Often patients transitioning from one health setting to another are in poor health, recovering from an illness or injury, or have a new diagnosis that requires ongoing self-management. Once discharged from an acute care setting, patients usually assume primary responsibility for following through with discharge instructions, accessing transportation to attend follow-up appointments, and relaying pertinent medical information to their next provider regarding changes to their health status. As such, continuity of care largely rests on patients' ability to adequately understand and follow through with care coordination and information sharing across settings.

NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL
P. O. Box 60427 | Nashville, TN 37206 | www.nhchc.org | 615.226.2292
Health Care and Housing Are Human Rights

For people experiencing homelessness, care transitions are wrought with obstacles often leading to an interruption in care and resulting in higher health care costs from readmissions and duplications in tests and services.

- ***Lack of housing.*** After hospital discharge, most patients and their caregivers are sent home with instructions to rest, complete a course of medication, keep wounds clean, etc. However, for people who live on the streets or in shelters, following such instructions is extremely difficult. Rest is compromised as shelters are generally closed during the day and, increasingly, laws prevent people from sitting or lying down in public places for extended lengths of time. Limited access to public restrooms creates challenges for people whose condition requires a frequent need for a toilet or regular wound care. Medication is often lost, stolen, sold or compromised if refrigeration is required. Additionally, instructions to follow specific diets are difficult when individuals must rely on free and inexpensive food. Indeed, patients who do not have immediate access to their primary care provider after a hospitalization are likely to arrive in poor health if they are not readmitted to the hospital first.

- ***Lack of transportation***. In a study of care transitions from hospital to shelter for people experiencing homelessness, 59% of those surveyed reported no post-discharge transportation plan. Many of the participants were particularly concerned about their safety when discharged after dark, particularly as they made their way to a shelter for the night or attempted to locate a safe place outdoors to rest.[4] Another study looking at substance use treatment barriers for patients with frequent hospital admissions, most of whom were homeless or unstably housed, found that patients who were referred to treatment programs after an acute hospital episode faced a number of obstacles in getting to treatment facilities on their own. For example, one provider noted that between one hospital and the nearest subway station, a patient must walk past 17 liquor stores.[5]

- ***Health literacy and cognitive impairment.*** Limited health literacy and cognitive impairment are more prevalent among people who have a lower socioeconomic status, including those experiencing homelessness.[6] Poor health literacy and cognitive impairments are contributing factors to poor self-management during the transition of care leading to adverse events and increased likelihood of hospital readmission.[7] Additionally, primary care providers may be dependent on the patient for information about the acute episode and hospital treatment. Unless a system of health information exchange is established, primary care providers are likely to receive fragmented and even inaccurate information from patients who may have limited health literacy or cognitive impairment that affected comprehension of discharge instructions.

- ***Transition to housing.*** Affordable and subsidized housing can take years to acquire depending on wait lists and housing requirements that must be met. Even when housing is available, the transition from street to housing can be challenging particularly when an individual has lived on the streets for a prolonged period. Once housed, individuals may feel isolated or guilty for having a home when their peers are still living outside. As such, some people may return to the streets or invite their peers to double up with them, thus risking problems with their landlords.[8] Other issues such as physical and behavioral health problems, loss of employment and inadequate financial management can result in housing instability. As such, care transitions for people experiencing homelessness must integrate practices that bolster housing stability which are not currently emphasized in existing care transition models.

- ***Lack of insurance.*** Nearly 65% of individuals experiencing homelessness are uninsured.[9] Lacking health insurance, patients are dependent on the hospital for any needed prescriptions or medical devices. Additionally, hospitals sometimes help uninsured patients get follow-up outpatient visits, often relying on volunteer or charity providers that may lack standardized processes for care transitions. In a study of healthcare professional views on care transitions, one medical specialist noted, “Anything that’s not acutely addressed during hospitalization is subject to being foiled by lack of insurance.”[10]

HEALTH REFORM INITIATIVES TO IMPROVE CARE TRANSITIONS

The Affordable Care Act creates a number of initiatives aimed at improving care coordination, with some initiatives specifically aimed at improving and systemizing care transitions across settings. While most of these programs offer incentives for participation, others, like the Hospital Readmission Reductions Program, include penalties for some hospital readmissions.

The Community-based Care Transition Program (CCTP)

The Community-based Care Transitions Program (CCTP), created by Section 3026 of the Affordable Care Act, tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measurable savings to the Medicare program.

The CCTP, launched in 2011, as part of the Partnership for Patients initiative, will run for 5 years. As of August 2012, 47 community based organizations (CBOs) have been selected to participate in the program.[11] The CBOs will be paid an all-inclusive rate per eligible discharge based on the costs of care transition services provided at the patient level (e.g., coaching, medicine reconciliation) and of implementing systemic changes at the hospital level (e.g., Project Boost, RED). CBOs will only be paid once per eligible discharge in a 180-day period of time for any given beneficiary.

The Hospital Readmissions Reduction Program (HRRP)

In its June 2007 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) attributed high hospital readmissions by Medicare beneficiaries to inadequate care transition at discharge from the hospital and recommended transitional care interventions.[12] Based on these recommendations, Congress included the Hospital Readmissions Reduction Program (HRRP) in Section 3025 of the Affordable Care Act.

Beginning October 1, 2012 the Centers for Medicare and Medicaid Services will reduce payment rates for all acute care hospitals that experience higher-than-average readmission rates for three conditions (heart attack, heart failure, and pneumonia). In FY 2013, the maximum payment reduction is 1 percent, 2 percent in FY 2014, and capped at 3 percent for FY 2015 and beyond. In FY 2015, the scope of conditions expands to include chronic obstructive pulmonary disease, coronary artery bypass grafting, percutaneous transluminal coronary angioplasty and other vascular conditions.

Physician Quality Reporting Initiative

Section 10331 of the Affordable Care Act requires that certain performance-related information on physicians and other professionals participating in the Medicare Physician Quality Reporting Initiative be made publicly available through the Physician Compare Web Site.[13] The Web Site is intended to provide Medicare beneficiaries with timely information about provider performance so that patients can select higher performing health care providers. The Centers for Medicare and Medicaid Services can also use this information for evaluating services and suppliers.

Assessments of continuity and coordination of care and care transitions are included within the list of measures that will be made publicly available through the Physician Compare Web Site. CMS is required to make this information available to the public no later than January 1, 2013 (related to information collected during the measurement period beginning January 1, 2012). By January 1, 2015, the Secretary of Health and Human Services will provide a report to

Congress regarding the website and may expand the program to other health care professionals. By January 1, 2019, the Secretary may establish a demonstration program to steer Medicare beneficiaries toward high quality clinicians.

Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office)

Section 2602 of the Affordable Care Act created the Federal Coordinated Health Care Office (FCHCO). The Office was established to ensure that duel eligible individuals get full access to the items and services to which they are entitled under the Medicaid and Medicare programs and to improve coordination between the Federal Government and States in the delivery of benefits for such individuals. The Affordable Care Act established eight goals for the Office, one of which is to ensure safe and effective care transition services. To do this, the Office provides technical assistance and support to States, health plans, physicians, caregivers and individuals. A list of initiatives and resources available through the Office is available on the FCHCO web site.[14]

State Option to Provide Health Homes for Enrollees with Chronic Conditions

Section 2703 of the Affordable Care Act created an option for states to make an amendment to their state Medicaid plans to provide health homes for Medicaid enrollees with certain chronic conditions. Among other services, health home services must include comprehensive transitional care, including appropriate follow up, from inpatient to other settings. States receive a 90% Federal Matching Assistance Percentage (FMAP) during the first eight quarters that the state plan amendment is in effect. After, States revert to their regular FMAP for health home services.

Medicare Shared Savings Program

Section 3022 of the Affordable Care Act created the Medicare Shared Savings Program in order to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. The program facilitates the development of Accountable Care Organizations (ACO), defined as groups of doctors, hospitals, and other health care providers who coordinate high quality care to their Medicare patients. ACOs must meet quality performance standards to receive shared savings under the Medicare Shared Savings Program. While care transition measures are not yet defined for the Medicare Shared Savings Program, CMS believes that assessing care coordination, and in particular care transitions, is an important aspect of evaluating the overall quality of the care furnished by ACOs.[15]

OTHER INCENTIVES TO IMPROVE CARE TRANSITIONS

Several other initiatives aim to improve care transitions. The **Comprehensive Primary Care Initiative**, made possible by the Affordable Care Act, is a multi-payer initiative fostering collaboration between public and private health care payers to help compensate for the costs of care coordination and care transitions by providing primary care practices with monthly payments of about $20 per Medicare beneficiary for the first two years of the demonstration and $15 combined with shared savings thereafter. This initiative is a limited demonstration project involving 500 primary care practices across seven markets.[16] The **Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration**, made possible by the Affordable Care Act, is a three-year demonstration program that pays health centers $6 per Medicare beneficiary per month after meeting certain health home requirements which include processes that would improve care transitions for health center patients admitted to hospitals. There are 500 FQHCs participating in this demonstration.[17] The **Multi-payer Advanced Primary Care Practice Demonstration (MAPCP)**, authorized by Section 402 of the Social Security Amendments of 1967 (as amended), pays $10 per month per Medicare beneficiary to practices in eight states that have been formally recognized as medical homes to cover the cost of services such as care transition planning.[18] The **Bundled Payments for Care Improvement Initiative**, made possible by the Affordable Care Act, aims to link payments for multiple services Medicare beneficiaries receive during an episode of care and align incentives for providers to partner closely across all specialties and settings that a patient may encounter. For example, instead of a surgical procedure generating multiple claims from multiple providers, the entire team is compensated with a "bundled" payment that provides incentives to deliver health care services more efficiently while maintaining or improving quality of care. Providers will have flexibility to determine which episodes of care and which services would be bundled together. The Bundled Payments initiative will test both retrospective and prospective bundled payments.[19] **The Balancing Incentive Program**, made possible by the Affordable Care Act, increases the FMAP to States that make structural reforms to increase nursing home diversions and access to non-institutional long term services and supports. States participating in this program are required to capture data related to care transitions.[20]

Hence, there are a number of initiatives, demonstrations, and evaluations in process to incentivize or otherwise identify promising practices in patient care that have an emphasis on quality of care across service venues. As models are more fully developed and more outcome data becomes available, broader policy changes are likely to be introduced to a wider set of service venues and patient groups.

CARE TRANSITION MODELS

Several care transition models are considered to be evidence-based (i.e., they apply the best available research findings); however, most of these models are designed for targeted populations moving from one specific setting to another. Nonetheless, all care transition models share common elements (see Figure 1). While an evidence-based care transition model for people experiencing homelessness is not currently available, some practitioners serving this population have carefully adapted existing models.[21] Only a couple of care transition models are considered to be appropriate for adults under 65; however, homeless service providers may find that models targeting older adults, particularly those transitioning to a nursing home or other supportive environment, might benefit those clients who are transitioning to medical respite care or supportive housing.

Figure 1

Elements for safe, effective and efficient care transitions

- Patient and caregiver training to increase self-care skills and activation (i.e., motivation to follow through with health care related activities or tasks)
- Patient-centered care plans that are shared across care settings
- Standardized, accurate communication and information exchange between transferring and receiving provider.
- Medication reconciliation and safe medication practices
- Transportation for health care-related travel
- Procurement and timely delivery of durable medical equipment (if needed)
- Formal hand-off procedures that ensure full responsibility between sending/receiving provider

Source: U.S. Department of Health and Human Services. (2011). Roadmap to better care transitions and fewer readmissions. Retrieved from www.healthcare.gov/compare/partnership-for-patients/safety/transitions.html

Care Transitions Intervention (CTI)

CTI is an evidence-based model developed by Eric Coleman with a goal to improve care transitions by providing patients with tools and support that promote knowledge and self-management of their condition as they move *from hospital to home*. CTI uses a simple personal health record to facilitate cross-site information transfer, a discharge preparation checklist designed to empower patients before hospital discharge, and a "Transitions Coach" (usually a social worker or nurse) located in the hospital to help patients and their caregivers understand the personal health record and discharge preparation list. The Transitions Coach also conducts follow up visits to ensure health maintenance. The intervention is based around four pillars, or conceptual areas: medication self-management, ability to use and manage the personal health record, participation in follow-up appointments, and ability of the patient to recognize signs of worsening health and respond accordingly. CTI is widely used as it can be applied to a wide range of patient populations and free online training and tools are available and in the public domain.[22]

The Transitional Care Model

The Transitional Care Model is an evidence-based model developed by Mary Naylor and is designed to prevent health complications and rehospitalizations of chronically ill, elderly hospital patients by providing them with comprehensive discharge planning and home follow-up, coordinated by a master's-level "Transitional Care Nurse." The Transitional Care Nurse meets with the patient upon admission and conducts a comprehensive assessment of the patient's health status, health behaviors, social support, and goals; works with the patient and doctors to develop an individualized care plan; and meets with the patient daily to ensure that the patient is able to manage his/her health once discharged. Following discharge the nurse conducts periodic home visits (or scheduled phone contacts) to ensure that the patient is successfully managing his/her health. [23]

Better Outcomes for Older Adults through Safe Transitions (BOOST)

BOOST is an evidence-based model targeting high risk patients, particularly older adults. The model aims to improve the discharge process by reducing 30-day readmissions, improving patient satisfaction, improving flow of information across providers, reducing adverse events in high-risk patients through targeted interventions, and improving patient and caregiver preparation for discharge. Project BOOST, a training and technical assistance initiative designed by a national advisory board of recognized leaders in care transitions, offers communities tools and support for systemizing care transitions using the BOOST model. The model uses evidence-based interventions advocated by The Joint Commission, the National Quality Forum (NQF) and the Agency for Healthcare Research and Quality (AHRQ).[24]

Project RED (Re-Engineered Discharge)

Project RED, developed at Boston University Medical Center, is an evidence-based, patient-centered, standardized approach to discharge planning and discharge education. The intervention delineates roles and responsibilities among hospital staff, delivers patient education throughout the hospital stay, adopts a system of seamless information flow between the hospital team and primary care provider, and provides an easy to read discharge plan for the patient. Patients know at all times who is responsible for their care and how to contact them. In addition, patients receive a follow up call within three days of discharge. A Discharge Advocate (DA) coordinates the intervention, thus reducing information gaps and redundancies that can adversely affect patient care and costs. The DA position can be filled by a nurse, trained patient advocate, social worker, or other support personnel. The Joint Commission, with funding from AHRQ, assists hospitals in implementing the Project RED intervention. Currently 225 hospital organizations are deploying the RED intervention.[25]

Figure 2

Components of Re-Engineered Discharge

1. Ascertain need for and obtain language assistance.
2. Make appointments for follow up medical appointments and post discharge tests/labs.
3. Plan for the follow up of results from lab tests or studies that are pending at discharge.
4. Organize post-discharge outpatient services and medical equipment.
5. Identify the correct medicines and a plan for the patient to obtain and take them.
6. Reconcile the discharge plan with national guidelines.
7. Teach a written discharge plan the patient can understand.
8. Educate the patient about his or her diagnosis.
9. Assess the degree of the patient's understanding of the discharge plan.
10. Review with the patient what to do if a problem arises.
11. Expedite transmission of the discharge summary to clinicians accepting care of the patient.
12. Provide telephone reinforcement of the Discharge Plan.

The Bridge Program

The Bridge Program is an evidence-based approach to transitional care recognized by the U.S. Administration on Aging. Bridge combines the evidence-based practices from Rush University Medical Center's Enhanced Discharge Planning Program with best practices from the Aging Resource Center Program (developed by Aging Care Connections). This social work-based approach helps older adults safely transition back to the community through intensive care coordination that starts in the hospital and continues after discharge to the community. Master's prepared social workers, called "Bridge Care Coordinators," coordinate post-discharge older adult care and integrate Aging Resource Centers (ARC) inside hospitals. The ARCs provide a dedicated space for older adults and their caregivers to explore community resources, health information, and caregiving materials, and to develop community care plans prior to discharge. The Bridge Care Coordinators acts as both the patient advocate and the connecting link between numerous silos of care surrounding the patient.[26]

State Action on Avoidable Rehospitalizations (STAAR)

STAAR was launched by the Institute of Healthcare Improvement (IHI) with the goal to reduce rehospitalizations by working across organizational boundaries and by engaging payers; stakeholders at the state, regional and national level; patients and families; and caregivers at multiple care sites and clinical interfaces (e.g., networks, initiatives). The STAAR initiative is grounded in a two-part strategy for reducing rates of rehospitalization. First, states participating in the STAAR initiative aim to improve transitions of care by having partners across the continuum of care problem-solve and co-design an efficient care transition system. Second, the STAAR initiative brings together state-level leadership to address systemic barriers to change. Currently, four states (Massachusetts, Michigan, Ohio, and Washington) are partnering with IHI to implement STAAR. As the work progresses, IHI will make programming and information available for other states, regions, or organizations across the continuum to learn from the initiative.[27]

Geriatric Resources for Assessment and Care of Elders (GRACE)

The GRACE model targets low-income seniors in order to optimize health and functional status, decrease excess healthcare use, and prevent long-term nursing home placement. The GRACE model integrates a geriatrics team within the primary care environment; implements in-home assessment and care management provided by a social worker and nurse practitioner team; uses extensive use of specific care protocols; utilizes integrated electronic medical record and a web-based care management tracking tool; and integrates affiliated pharmacy, mental health, home health, community-based, and inpatient geriatric care services.[28, 29, 30]

Guided Care

The Guided Care model was developed by the Johns Hopkins Bloomberg School of Public Health and uses a team-based approach consisting of a specially trained registered nurse, two to five physicians, and members of a primary care office staff. This team provides clinical services to a panel of 50 to 60 of the practice's older patients at highest risk of using health care heavily during the following year. For each patient, the "Guided Care Nurse" performs a comprehensive assessment at home, creates an action plan, monitors the patient, coordinates care and transitions across sites, uses motivational interviewing to promote patient self-management, provides caregiver support, and facilitates access to community resources.[31,32]

Figure 3

Information that should be provided across care settings includes:

1. Primary diagnoses and major health problems
2. Care plan that includes patient goals and preferences, diagnosis and treatment plan, and community care/service plan (if applicable)
3. Patient's goals of care, advance directives, and power of attorney
4. Emergency plan and contact number and person
5. Reconciled medication list
6. Follow-up with the patient and/or caregiver within 48 hours after discharge from a setting
7. Identification of, and contact information for, transferring clinician/institution
8. Patient's cognitive and functional status
9. Test results/pending results and planned interventions
10. Follow-up appointment schedule with contact information
11. Formal and informal caregiver status and contact information
12. Designated community-based care provider, long-term services, and social supports as appropriate.

Source: U.S. Department of Health and Human Services. (2011). Roadmap to better care transitions and fewer readmissions. Retrieved from www.healthcare.gov/compare/partnership-for-patients/safety/transitions.html

Numerous care transition models are available, each offering different interventions to address transitional care gaps and reduce readmissions for certain populations. The Institute for Healthcare Improvement groups these models into three categories: improvements to existing processes in transitions in care, supplemental services during transitions, and effective patient and family engagement based on sound health literacy principles.[33] In order to determine the best model (or combination of models) for a targeted population, health care leaders will need to engage in conversations about existing transitional care gaps and assess the impact of the various interventions on targeted populations. Additionally, health care leaders will need to determine how best to align these robust care transition models with existing initiatives such as Patient-Centered Medical Homes which are already employing some transitional care elements.

The following recommendations offer some guidance to health care leaders who are beginning to think about opportunities to improve transitional care. While these recommendations are broadly applicable, they are especially relevant to efforts to improve care transitions for people experiencing homelessness, a population that is particularly vulnerable to interruptions in care.

RECOMMENDATIONS FOR PRACTICE

- ***Standardize the care transition process.*** Several models provide a starting point for standardizing the care transition process across settings. Outpatient providers should engage in a discussion with referring hospitals about their care transition process and opportunities to establish a standardized approach to implement across settings.

- ***Identify expectations for cross-site communication.*** Providers have different perspectives on how and when health information should be communicated as well as the kind of information that needs to be shared. Providers working across settings should engage in discussions to explicitly identify communication expectations and develop a cross-site contract specifying inpatient and outpatient responsibilities. The Department of Health and Human Services offers guidance for information that should be shared across care settings (see Figure 3); this guidance may provide a starting point for conversations.

- ***Develop strategies to align existing initiatives to improve transitional care.*** Primary care practices are engaging in a number of initiatives that integrate elements of safe, effective, and efficient transitional care. Consider how existing initiatives such as Patient-Centered Medical Homes and Meaningful Use of electronic health records can be used to optimize care transitions.

- ***Dedicate a staff person to act as a hospital liaison.*** Outpatient settings should assign one staff person to receive notification from hospitals about incoming referrals, coordinate timely information transfer, confirm that contact has been made with a mutual patient, and formally acknowledge that the organization is assuming responsibility for care. Having one staff person dedicated to coordinating care transitions will streamline communications and provides hospitals with a point of contact for cross-site communication.

- ***Increase accountability for care transitions.*** When developing a care transitions program, ensure that the hospital takes responsibility for patients until confirmation is received from the receiving health care provider or entity. Additionally, accountability should be established for care transition interventions such as medication reconciliation and patient education. Staff members involved in any aspect of a care transitions programs should receive comprehensive training on the goals of the program as well as roles and responsibilities of all who are involved.

- ***Ensure access to transportation.*** The care transition process is interrupted when patients do not arrive for follow-up appointments. Ensure that patients have transportation to and from the service point. Transportation provided by a health care entity is most effective since patients may have difficulty following directions if traveling on their own or may be tempted to use transportation vouchers for other purposes.

- ***Make sure patients know who is responsible for their care.*** Patients should know who is responsible for their care and how to contact them at any point during care transition. This information should be written down for them and also entered in the electronic medical record.

- ***Include care transition interventions that promote housing placement and stability.*** Transitional care models targeting people experiencing homelessness should include efforts to assist patients in accessing and maintaining housing so that health is not compromised by complications from living on the streets.

- ***Engage in continuous quality improvement.*** Standardized metrics should be established in order to guide continuous quality improvement and accountability. Established care transition measures are widely available and should be integrated into existing quality improvement efforts.[34, 35, 36]

- ***Explore opportunities to receive technical assistance and support for implementing a care transition program.*** Work with local and state health care coalitions and associations to facilitate conversations around systemic changes needed to facilitate effective and efficient care transitions across settings. Conversations can include opportunities to participate in care transition initiatives such as those described in this paper.

RECOMMENDATIONS FOR POLICY

- ***Expand more care transition programs to Medicaid beneficiaries.*** Most federal care transition programs target Medicare beneficiaries. Homeless and unstably housed Medicaid beneficiaries are also among the most costly health care utilizers, often due to fragmented care and lack of adequate care transition services. With many states considering Medicaid expansion to many of those earning at or below 138% of the federal poverty level, a significant number of people experiencing homelessness will become eligible for Medicaid benefits. CMS and state Medicaid agencies can create additional opportunities to engage communities in efforts to improve care transitions among this high-risk, high-cost population.

- ***Increase incentives for tracking housing status.*** Currently ICD-9 and ICD-10 codes are available for tracking and reporting homelessness; however, hospitals rarely use this code. HHS could establish incentives for hospitals to track housing status using the existing classification code. Additionally, future care coordination and care transition initiatives should require hospitals to track housing status in order to target and assess the impact of these initiatives for people experiencing homelessness.

- ***Support medical respite care programs.*** Medical respite care programs provide post-acute care and social services for homeless persons who are not sick enough to stay in the hospital but too sick to be on the streets. Medical respite programs are an ideal setting for patients to recuperate, complete a course of medication, receive patient education, and be connected to social services. Additionally, patients participating in medical respite programs are closely monitored and receive assistance in going to follow up appointments. There is a need for incentives to foster public and private partnerships to establish and sustain these critical programs.[37]

- ***Extend the Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration to Medicaid beneficiaries and increase payments.*** Medicare beneficiaries make up less than 8% of the national FQHC patient base, but only 5% for Health Care for the Homeless grantees. At $6 per

Medicare beneficiary per month, payments may be insufficient to significantly benefit practice. Extending the demonstration to Medicaid beneficiaries would create a greater incentive for FQHC participation and target another population with similar risks. Payment rates should be increased to a level that allows for dedicated staff to manage care transitions. Many FQHC patients, particularly those who are homeless, have very complex health care, psychosocial, and socioeconomic needs that complicate the delivery of health home services, making it more time intensive and costly to serve this population.

CONCLUSION

People experiencing homelessness would benefit greatly from standardized and systemized care transition programs. While existing care transition programs have primarily targeted the aging Medicare population, models such as the Care Transitions Intervention (CTI) and Project RED, may be adopted for a broader population of high-risk patient populations. Models targeting aging Medicare beneficiaries who are transitioning to a nursing home or other supported living environment should be considered by homeless health care providers, as these models could be adapted to assist individuals experiencing homelessness who are transitioning into permanent supportive housing. A significant number of resources are available to organizations seeking support for improving care transitions for their patients. With new initiatives made available through the Affordable Care Act, new funding opportunities to support such initiatives are more widely available as well.

NOTES

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Suggested Citation: National Health Care for the Homeless Council. (October 2012). *Improving Care Transitions for People Experiencing Homelessness.* (Lead author: Sabrina Edgington, Policy and Program Specialist.) Available at: www.nhchc.org/wp-content/uploads/2012/12/Policy_Brief_Care_Transitions.pdf

This publication was made possible by grant number U30CS09746 from the Health Resources and Services Administration, Bureau of Primary Health Care. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA.

JGIM

HEALTH POLICY

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

Vincenza Snow, MD[1], Dennis Beck, MD[2], Tina Budnitz, MPH[3], Doriane C. Miller, MD[4], Jane Potter, MD[5], Robert L. Wears, MD[6], Kevin B. Weiss, MD, MPH[7], and Mark V. Williams, MD[8]

[1]American College of Physicians, Philadelphia, PA, USA; [2]Beacon Medical Services, Aurora, CO, USA; [3]Society of Hospital Medicine, Philadelphia, PA, USA; [4]University of Chicago Medical Center, Chicago, IL, USA; [5]University of Nebraska, Lincoln, NE, USA; [6]University of Florida, Gainesville, FL, USA; [7]American Board of Medical Specialties, Chicago, IL, USA; [8]Northwestern University, Chicago, IL, USA.

This manuscript is being jointly published by both the *Journal of General Internal Medicine* and the *Journal of Hospital Medicine.*

The American College of Physicians (ACP), Society of Hospital Medicine (SHM), Society of General Internal Medicine (SGIM), American Geriatric Society (AGS), American College of Emergency Physicians (ACEP) and the Society for Academic Emergency Medicine (SAEM) developed consensus standards to address the quality gaps in the transitions between inpatient and outpatient settings. The following summarized principles were established: 1.) Accountability; 2) Communication; 3.) Timely interchange of information; 4.) Involvement of the patient and family member; 5.) Respect the hub of coordination of care; 6.) All patients and their family/caregivers should have a medical home or coordinating clinician; 7.) At every point of transitions the patient and/or their family/caregivers need to know who is responsible for their care at that point; 9.) National standards; and 10.) Standardized metrics related to these standards in order to lead to quality improvement and accountability. Based on these principles, standards describing necessary components for implementation were developed: coordinating clinicians, care plans/transition record, communication infrastructure, standard communication formats, transition responsibility, timeliness, community standards, and measurement.

J Gen Intern Med 24(8):971–6
DOI: 10.1007/s11606-009-0969-x

Received September 16, 2008
Revised January 21, 2009
Accepted March 17, 2009

BACKGROUND

Studies of the transition of care between inpatient and outpatient settings have shown that there are significant patient safety and quality deficiencies in our current system. The transition from the hospital to the outpatient setting has been more extensively studied than the transition from the outpatient to the inpatient setting. One prospective cohort study found that one in five patients discharged from the hospital to home experience an adverse event, defined as an injury resulting from medical management rather than from the underlying disease, within three weeks of discharge[1]. This study also concluded that 66% of these were drug-related adverse events, many of which could have been avoided or mitigated. Another prospective cross-sectional study found that approximately 40% of patients have pending test results at the time of discharge and that 10% of these require some action; yet outpatient physicians and patients are unaware of these results[2]. Medication discrepancies have also been shown to be prevalent with one prospective observational study showing that 14% of elderly patients had one or more medication discrepancies and of those patients with medication discrepancies 14% were re-hospitalized at 30 days compared to 6% of the patients who did not experience a medication discrepancy[3]. A recent review of the literature cited improving transitional care as a key area of opportunity to improve post-discharge care[4].

Lack of communication has clearly been shown to adversely affect post-discharge care transitions[5]. A recent summary of the literature by an Society of Hospital Medicine/Society of General Internal Medicine Task Force found that direct communication between hospital physicians and primary care physicians occurs infrequently (in 3%-20% of cases studied), the availability of a discharge summary at the first post-discharge visit is low (12%-34%) and did not improve greatly even after 4 weeks (51%-77%), affecting the quality of care in approximately 25% of follow-up visits[5]. This systematic review of the literature also found that discharge summaries often lack important information such as diagnostic test results, treatment or hospital course, discharge medications, test results pending at discharge, patient or family counseling, and follow-up plans.

However, the lack of studies of the communication between ambulatory physicians and hospital physicians prior to admission or during emergency department (ED) visits does not imply that this communication is not equally important and essential to high quality care. According to the Centers for Disease Control (CDC), the greatest source of hospital admissions in many institutions is through the emergency department. Over 115,000,000 visits were made to the nation's approximately 4,828 emergency departments in 2005, and about 85.2 percent of ED visits end in discharge[6]. The emergency department is also the point of re-entry into the system for individuals who may have had an adverse outcome linked to a prior hospitalization[6]. Communication between hospital physicians and primary care physicians must be established to create a loop of continuous care and diminish morbidity and mortality at this critical transition point.

While transitions can be a risky period for patient safety, observational studies suggest there are benefits to transitions. A new physician may notice something overlooked by the current caregivers[7–12]. Another factor contributing to the challenges of care transitions is the lack of a single clinician or clinical entity taking responsibility for coordination across the continuum of the patient's overall healthcare, regardless of setting[13]. Studies indicate that a relationship with a medical home is associated with better health, on both the individual and population levels, with lower overall costs of care and with reductions in disparities in health between socially disadvantaged subpopulations and more socially advantaged populations[14]. Several medical societies have addressed this issue, including the American College of Physicians (ACP), Society of General Internal Medicine (SGIM), American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP), and have proposed the concept of the "medical home" or "patient centered medical home" which calls for clinicians to assume this responsibility for coordinating their patients' care across settings and for the healthcare system to value and reimburse clinicians for this patient-centered and comprehensive method of practice[15–17].

Finally, patients and their family or caregivers have an important role to play in transitions of care. Several observational and cross-sectional studies have shown that patients and their caregivers and family express significant feelings of anxiety during care transitions. This anxiety can be caused by a lack of understanding and preparation for their self-care role in the next care setting, confusion due to conflicting advice from different practitioners, a sense of abandonment attributable to the inability to contact an appropriate healthcare practitioner for guidance, and they report an overall disregard for their preferences and input into the design of the care plan[18–20]. Clearly there is room for improvement in all these areas of the inpatient and outpatient care transition and the Transitions of Care Consensus Conference (TOCCC) attempted to address these areas by developing standards for the transition of care that also harmonize with the work of the American Board of Internal Medicine Foundation's Stepping up to the Plate (ABIMF SUTTP) Alliance ([21] in press). In addition, other important stakeholders are addressing this topic and actively working to improve communication and continuity in care including Centers for Medicare and Medicaid Services (CMS) and the National Quality Forum (NQF). In summary, it is clear that there are qualitative and quantitative deficiencies in transitions of care between the inpatient and outpatient setting that are affecting patient safety and experience with care.

METHODS

The executive committees of the ACP, SGIM, and SHM agreed to jointly develop a policy statement on transitions of care. Transitions of care specifically between the inpatient and outpatient settings was selected as an ideal topic for collaboration for the three societies as they represent the continuum of care for internal medicine within these settings. To accomplish this, a consensus conference was convened to develop consensus guidelines and standards around transitions between inpatient and outpatient settings through a multi-stakeholder process. The steering committee (see Appendix for roster) developed the agenda and invitee list for the consensus conference.

RECOMMENDATIONS ON PRINCIPLES AND STANDARDS FOR MANAGING TRANSITIONS IN CARE BETWEEN THE INPATIENT AND OUTPATIENT SETTINGS FROM THE ACP, SGIM, SHM, AGS, ACEP, AND SAEM

The TOCCC first proposed a framework that provides guiding principles for what we would like to measure and eventually report. From those principles are developed a set of preferred practices or standards; the standards are more granular and allow for more specificity in describing the desired practice or outcome and its elements. Standards then provide a roadmap for identification and development of performance measures.

The TOCCC established the following principles:

- Accountability
- Communication: clear and direct communication of treatment plans and follow-up expectations
- Timely feedback and feed forward of information
- Involvement of the patient and family member, unless inappropriate, in all steps
- Respecting the hub of coordination of care
- 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).
- 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.
- 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.
- For monitoring and improving transitions, standardized metrics related to these standards should be used in order to lead to continuous quality improvement and accountability.

The TOCCC then proposed the following standards:

- Coordinating Clinicians

Communication and information exchange between the medical home and the receiving provider should occur in an amount of time that will allow the receiving provider to effectively treat the patient. This communication and information exchange should ideally occur whenever patients are at a transition of care; e.g., at discharge from the inpatient setting. The timeliness of this communication should be consistent with the patient's clinical presentation and, in the case of a patient being discharged, the urgency of the follow-up required. Guidelines will need to be developed that address both the timeliness and means of communication between the discharging physician and the MH. Communication and information exchange between the MH and other physicians may be in the form of a call, voicemail, fax or other secure, private, and accessible means including mutual access to an EHR.

The emergency department (ED) represents a unique subset of transitions of care. The potential transition can generally be described as outpatient to outpatient or outpatient to inpatient depending on whether or not the patient is admitted to the hospital. The outpatient to outpatient transition can also encompass a number of potential variations. Patients with a medical home may be referred in to the ED by the medical home or they may self refer. A significant number of patients do not have a physician and self refer to the ED. The disposition from the ED, either outpatient to outpatient or outpatient to inpatient is similarly represented by a number of variables. Discharged patients may or may not have a medical home, may or may not need a specialist and may or may not require urgent (<24 hours) follow-up. Admitted patients may or may not have a medical home and may or may not require specialty care. This variety of variables precludes a single approach to ED transitions of care coordination.

- Care Plans/Transition Record

The TOCCC proposed a minimal set of data elements that should always be part of the transition record and be part of any initial implementation of this standard. That list includes the following:

- Principle diagnosis and problem list
- Medication list (reconciliation) including over the counter/herbals, allergies and drug interactions
- Clearly identifies the medical home/transferring coordinating physician/institution and their contact information
- Patient's cognitive status
- Test results/pending results

The TOCCC recommended the following additional elements that should be included in an "ideal transition record" in addition to the above:

- Emergency plan and contact number and person
- Treatment and diagnostic plan
- Prognosis and goals of care
- Advance directives, power of attorney, consent
- Planned interventions, durable medical equipment, wound care etc
- Assessment of caregiver status
- Patients and/or their family/caregivers must receive, understand and be encouraged to participate in the development of their transition record which should take into consideration the patient's health literacy, insurance status and be culturally sensitive.

- Communication Infrastructure

All communications between providers and between providers and patients and families/caregivers need to be secure, private, HIPAA compliant, and accessible to patients and those practitioners who care for them.

Communication needs to be two-way with opportunity for clarification, and feedback. Each sending provider needs to provide a contact name and number of an individual who can respond to questions or concerns.

The content of information transferred needs to include a core standardized dataset.

This information needs to be transferred as a "living database" whereby it is created only once and then each subsequent provider then only needs to update, validate, or modify the information.

Patient information should be available to the provider prior to patient arrival

Information transfer needs to adhere to national data standards.

Patients should be provided with a medication list that is accessible (paper or electronic), clear, and dated.

- Standard Communication Formats

Communities need to develop standard data transfer forms (templates, transmission protocols).

Access to the patient medical history needs to be on a current and ongoing basis with ability to modify information as a patient's condition changes.

Patients, family and caregivers should have access to their information ("nothing about me without me").

A section on the transfer record should be devoted to communicating a patients' preferences, priorities, goals and values (e.g., patient does not want intubation).

- Transition Responsibility

The sending provider/institution/team at the clinical organization maintains responsibility for the care of the patient until the receiving clinician/location confirms that the transfer and assumption of responsibility is complete (within a reasonable timeframe for the receiving clinician to receive the information i.e., transfers that occur in the middle of the night can be communicated during standard working hours). The sending provider should be available for clarification with issues of care within a reasonable timeframe after the transfer has been completed and this timeframe should be based on the conditions of the transfer settings. The patient should be able to identify the responsible provider. In the case of patients who do not have an ongoing ambulatory care provider or whose ambulatory care provider has not assumed responsibility, the hospital-based clinicians will not be required to assume responsibility for the care of these patients once discharged.

- Timeliness

Timeliness of feedback and feed forward of information from a sending provider to a receiving provider should be contingent on four factors:

Transition settings
Patient circumstances
Level of acuity
Clear transition responsibility

This information should be available at the time of the patient encounter.

- Community standards

Medical communities/institutions must demonstrate accountability for transitions of care by adopting national standards, and processes should be established to promote effective transitions of care

- Measurement

For monitoring and improving transitions, standardized metrics related to these standards should be used. These metrics/measures should be evidence-based, address documented gaps and have demonstrated impact on improving care (comply with performance measure standards) whenever feasible. Results from measurement using standardized metrics must lead to continuous improvement of the transition process. The validity, reliability, cost, and impact, including unintended consequences, of these measures should be assessed and re-evaluated.

All of these standards should be applied with special attention to the varying transition settings and should be appropriate to each transition setting. Measure developers will need to take this into account when developing measures based on these proposed standards.

FUTURE CHALLENGES

In addition to the work on the principles and standards development, the TOCCC uncovered six future challenges which are described below.

Electronic Health Record

There was disagreement among the group as to the extent to which electronic health records would resolve the existing issues involved in poor transfers of care. However, the group did concur that (1) established transition standards should not be contingent upon the existence of an electronic health record (2) some universally, nationally defined set of core transfer information should be the short term target of efforts to establish electronic transfers of information

Use of a Transition Record

There should be a core set of data (much smaller than a complete health record or discharge summary) that goes to the patient and the receiving provider that includes items in the “core” record described above.

Medical Home

There was a lot of discussion around the benefits and challenges of establishing a medical home and inculcating the concept into delivery and payment structures. The group was favorable to the concept; however, since the medical home is not yet a nationally defined standard, care transition standards should not be contingent upon the existence of a “medical home.” Wording of future standards should use a general term for the clinician coordinating care across sites in addition to the term “medical home.” Using both terms will acknowledge the movement toward the medical home without requiring adoption of medical home practices to refine and implement quality measures for care transitions.

Pay for Performance

The group strongly agreed that behaviors and clinical practices are influenced by payment structures. Therefore, they agreed, a new principle should be established to advocate for changes in reimbursement practices to reward safe, complete transfers of information and care. However, development of standards and measures should move forward based on the current reimbursement practices and without assumptions of future changes.

Underserved/Disadvantaged Populations

Care transition standards and measures should be the same for all economic groups with careful attention that lower socioeconomic groups are not “forgotten” or unintentionally disadvantaged, including the potential for “cherry-picking.” It should be noted that underserved populations may not always have a “medical home” due to their disadvantaged access to the health system and providers. Moreover, clinicians who care for underserved/disadvantaged populations should not be penalized by standards that assume continuous clinical care and ongoing relationships with patients who may access the health system only sporadically.

Need for Patient-Centered Approaches

The group agreed that across all principles and standards previously established by Stepping Up to the Plate coalition, greater emphasis was needed on patient centered approaches to care including, but not limited to, including patient and families in care and transition planning, greater access to medical records, and the need for education at the time of discharge regarding self-care and core transfer information.

NEXT STEPS FOR THE TOCCC

The TOCCC focuses only on the transitions between the inpatient and outpatient settings and does not address the equally important transitions between the many other different care settings such as hospital to nursing home, or rehabilitation facility. The intent of the TOCCC is to provide this document to national measure developers such as the Physician Consortium for Performance Improvement and others in order to guide measure development and ultimately lead to improvement in quality and safety in care transitions.

Conflict of Interest Statements: *Summary:*
Conflict of Interest Statement for Faculty, Authors, Members of Planning Committees and Staff
American College of Physicians – Society of Hospital Medicine – Society of General Internal Medicine
The following members of the Steering (or Planning) Committee and Staff of the Transitions of Care Consensus Conference have declared a Conflict of Interest:
Dennis Beck, MD, FACEP (ACEP Representative) President and CEO, Beacon Medical Services has declared conflict of interest of Stocks/Holdings: 100 units of stock options/holdings in Beacon Hill Medical Services
Tina Budnitz, MPH (SHM Staff) Senior Advisor for Quality Initiatives Society of Hospital Medicine has declared conflict of interest of Employment: Staff, Society of Hospital Medicine
Eric S. Holmboe, MD (ABIM Representative) Senior Vice President Quality Research and Academic Affairs American Board of Internal Medicine has declared conflict of interest of Employment: SVP Quality Research and Academic Affairs American Board of Internal Medicine

Vincenza Snow, MD, FACP (ACP Staff) Director, Clinical Programs and Quality of Care American College of Physicians has declared conflict of interest of Research grants: CDC, Atlantic Philanthropies, Novo Nordisk, Bristol Myers Squibb, Boehringer Ingelheim, Pfizer, United Healthcare Foundation, Sanofi Pasteur
Laurence D. Wellikson, MD, FACP (SHM Staff) Chief Executive Officer Society of Hospital Medicine has declared conflict of interest of Employment: CEO, Society of Hospital Medicine
Mark V. Williams, MD, FACP (Co-Chair, SHM Representative) Editor-in-Chief, Journal of Hospital Medicine Past-President, Society of Hospital Medicine has declared conflict of interest of Membership: Society of Hospital Medicine
The following members of the Steering (or Planning) Committee and Staff of the Transitions of Care Consensus Conference have declared No Conflict of Interest:
David Atkins, MD, MPH, (AHRQ Representative)
Associate Director, QUERI, Department of Veteran Affairs, Office of Research and Development, Health Services Research & Development (124)
Doriane C. Miller, MD (Co-Chair, SGIM Representative)
Associate Division Chief, General Internal Medicine, Stroger Hospital of Cook County
Jane Potter, MD (American Geriatric Society Representative)
Professor and Chief of Geriatrics, University of Nebraska Medical Center
Robert L. Wears, MD, FACEP (Society for Academic Emergency Medicine Representative)
Professor, Department of Emergency Medicine, University of Florida
Kevin B. Weiss, MD, MPH, MS, FACP (Chair, ACP Representative)
CEO, American Board of Medical Specialties

Financial Support Statement: *The TOCCC was funded under an unrestricted educational grant from Novo Nordisk, as part of the ACP Diabetes Initiative, and from the AHRQ. The funders had no input into the planning, structure, content, participants, or outcomes of the conference.*

Corresponding Author: *Vincenza Snow, MD; American College of Physicians, 190 N Independence Mall West, Philadelphia, PA 9106, USA (e-mail: vincenza@acponline.org).*

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APPENDIX

APPENDIX: CONFERENCE DESCRIPTION

In the Fall-Winter of 2006 the Executive Committees of the American College of Physicians (ACP), the Society of General Internal Medicine (SGIM), and the Society of Hospital Medicine (SHM) agreed to jointly develop a policy statement on transitions of care. Transitions of care specifically between the inpatient and outpatient settings was selected as an ideal topic for collaboration for the three societies as they represent the continuum of care for internal medicine within these settings. To accomplish this, the three organizations decided to convene a consensus conference to develop consensus guidelines and standards around transitions between inpatient and outpatient settings through a multi-stakeholder process. A steering committee was convened, chaired by Kevin B. Weiss, MD, MPH, FACP of the ACP and co-chaired by Doriane Miller, MD, representing the SGIM; and Mark Williams, MD, FACP representing the SHM. The steering committee also had representatives from the AHRQ, ABIM and AGS. The steering committee developed the agenda and invitee list for the Consensus Conference. After the conference was held the steering committee was expanded to include representation from the emergency medicine community. The American College of Emergency Physicians was represented by Dr. Dennis Beck and the Society of Academic Emergency Medicine was represented by Dr. Robert Wears.

During the planning stages of the Transitions of Care Consensus Conference (TOCCC), the steering committee became aware of the Stepping Up to the Plate (SUTTP) Alliance of the ABIM Foundation. The SUTTP Alliance has representation from medical specialties such as internal medicine and its subspecialties, family medicine, and surgery. The Alliance formed in 2006 and has been working on care coordination across multiple settings and specialties. The SUTTP developed a set of principles and standards for care transitions and agreed to provide their draft document to the TOCCC for review, input, and further development and refinement.

The TOCCC was held over two days on July 11-12, 2007 at ACP Headquarters in Philadelphia, PA. There were 51 participants representing over thirty organizations. Participating organizations included medical specialty societies from internal medicine as well as family medicine and pediatrics, governmental agencies, such as the AHRQ and CMS, performance measure developers, such as the NCQA and AMA PCPI, nurses associations, such as the VNAA and Home Care and Hospice, pharmacists groups, and patient groups such as the Institute for Family-Centered Care. The morning of the first day was dedicated to presentations covering the AHRQ Stanford Evidence-based Practice Center (EPC) Evidence Report on Care Coordination, the literature around transitions of care, the continuum of measurement from principles to standards to measures, and the SUTTP principles document. The attendees then split into breakout groups that discussed the principles and standards developed by the SUTTP and refined and/or revised them. All discussion were summarized and agreed on by consensus and presented by the breakout groups to the full conference attendees. The second day was dedicated to reviewing the work of the breakout groups and further refinement of the principles and standards through a group consensus process. Once this was completed, the attendees then prioritized the standards using a group consensus voting process. Each attendee was given one vote and each attendee attached a rating of 1 for highest priority and 3 for lowest priority to the standards. The summary scores were then calculated and the standards were then ranked from those summary scores.

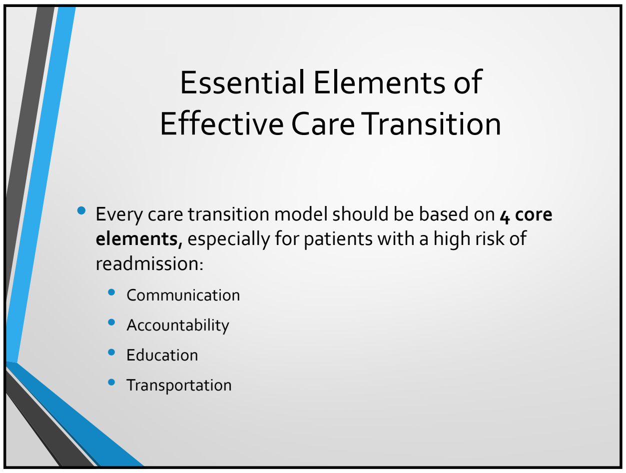
The TOCCC recognizes that full implementation of all of these standards may not be feasible and that these standards may be implemented in a stepped or incremental basis. This prioritization can assist in deciding which of these to implement. The results of the prioritization exercise are:

1. All transitions must include a transition record
2. Transition Responsibility
3. Coordinating Clinicians
4. Patient and Family involvement and ownership of the transition record
5. Communication Infrastructure
6. Timeliness
7. Community Standards

The final activity of the conference was to discuss some of the overarching themes and environmental factors that could influence the acceptance, endorsement, and implementation of the standards developed. The TOCCC adjourned with the tasks of forwarding its conclusions to the SUTTP Alliance and to develop a policy document to be reviewed by other stakeholders not well represented at the conference. Two such pivotal organizations were the American College of Emergency Physicians and the Society of Academic Emergency Medicine that were added to the Steering Committee after the conference. Subsequently the ACP, SGIM, SHM, AGS, ACEP, and SAEM approved the summary document and forwarded it to the other participating organizations for possible endorsement and to national measures and standards developers for use in performance measurement development.

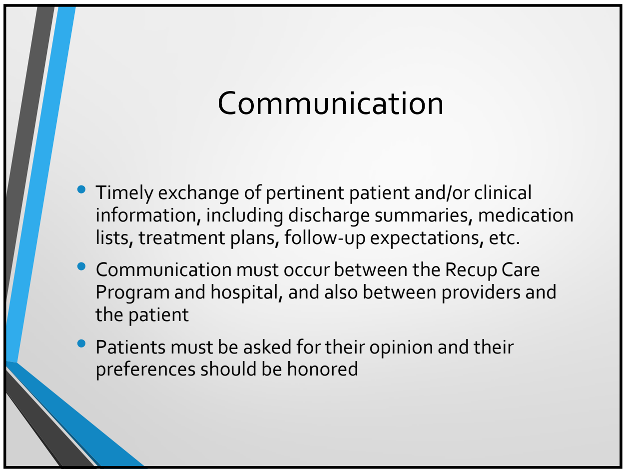
Implementing Standards: Taking the Next Step in Care Transitions

Paul Gregerson, M.D. M.B.A.
Chief Medical Officer
JWCH Institute, Inc.



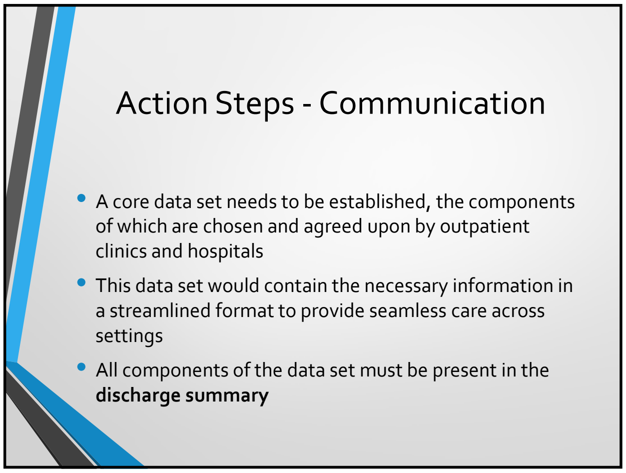
Essential Elements of Effective Care Transition

- Every care transition model should be based on **4 core elements,** especially for patients with a high risk of readmission:
  - Communication
  - Accountability
  - Education
  - Transportation



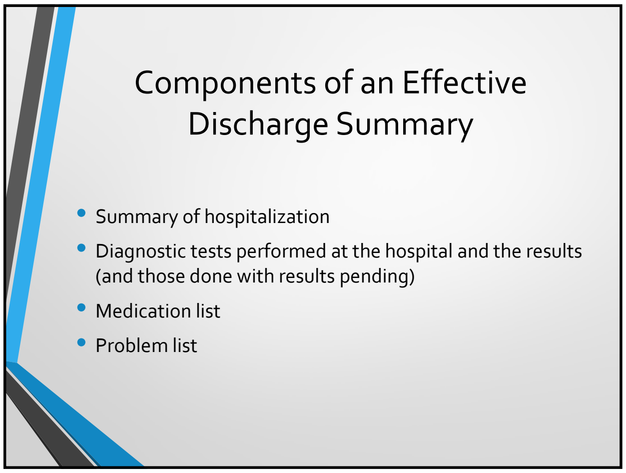
Communication

- Timely exchange of pertinent patient and/or clinical information, including discharge summaries, medication lists, treatment plans, follow-up expectations, etc.
- Communication must occur between the Recup Care Program and hospital, and also between providers and the patient
- Patients must be asked for their opinion and their preferences should be honored



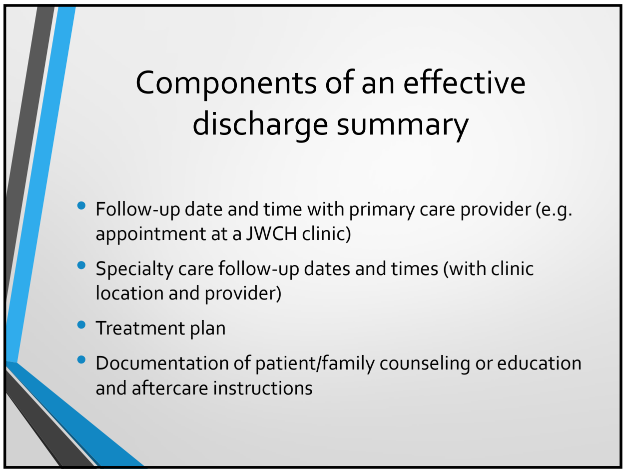
Action Steps - Communication

- A core data set needs to be established, the components of which are chosen and agreed upon by outpatient clinics and hospitals
- This data set would contain the necessary information in a streamlined format to provide seamless care across settings
- All components of the data set must be present in the **discharge summary**



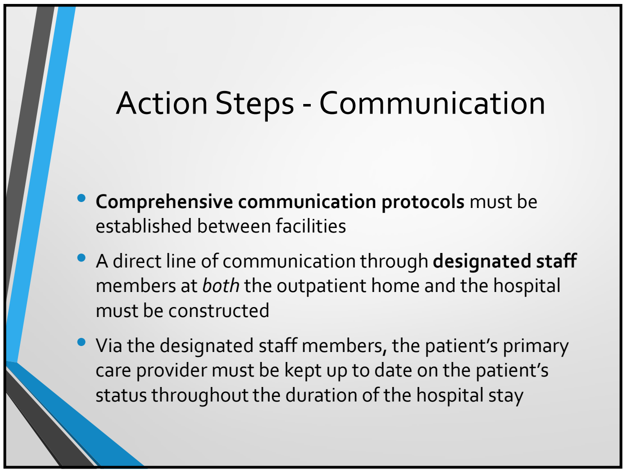
Components of an Effective Discharge Summary

- Summary of hospitalization
- Diagnostic tests performed at the hospital and the results (and those done with results pending)
- Medication list
- Problem list



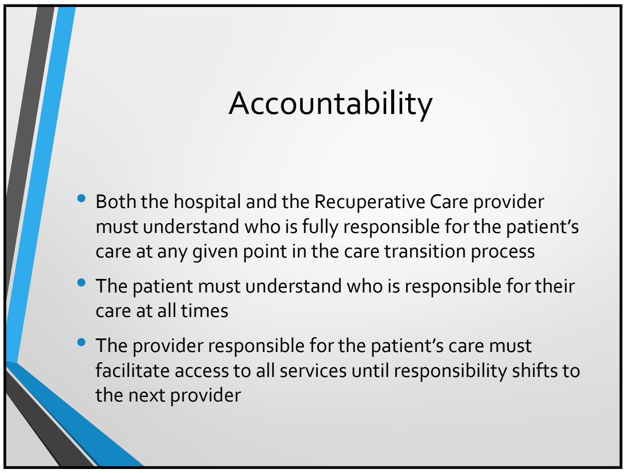
Components of an effective discharge summary

- Follow-up date and time with primary care provider (e.g. appointment at a JWCH clinic)
- Specialty care follow-up dates and times (with clinic location and provider)
- Treatment plan
- Documentation of patient/family counseling or education and aftercare instructions



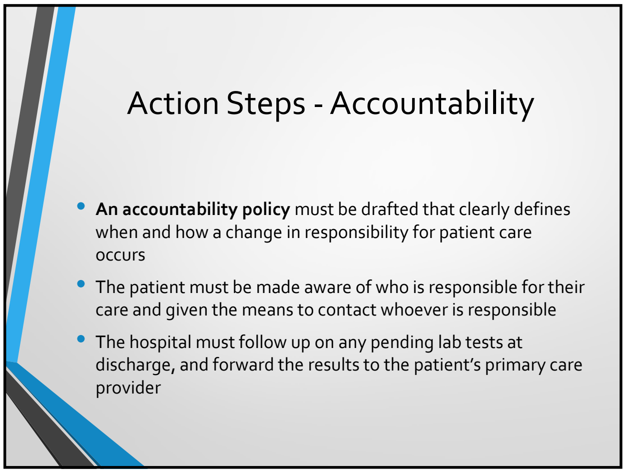
Action Steps - Communication

- **Comprehensive communication protocols** must be established between facilities
- A direct line of communication through **designated staff** members at *both* the outpatient home and the hospital must be constructed
- Via the designated staff members, the patient's primary care provider must be kept up to date on the patient's status throughout the duration of the hospital stay



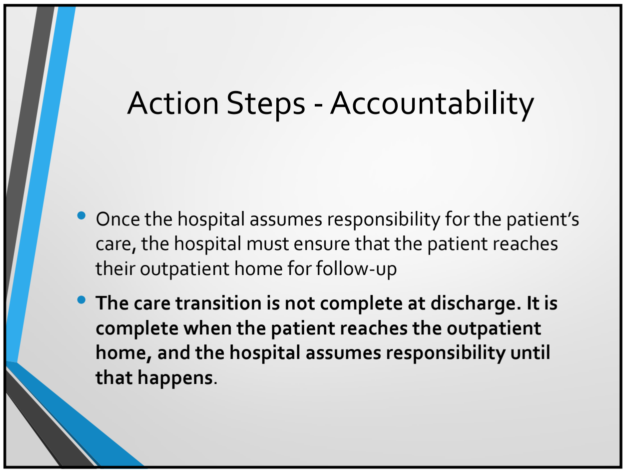
Accountability

- Both the hospital and the Recuperative Care provider must understand who is fully responsible for the patient's care at any given point in the care transition process
- The patient must understand who is responsible for their care at all times
- The provider responsible for the patient's care must facilitate access to all services until responsibility shifts to the next provider



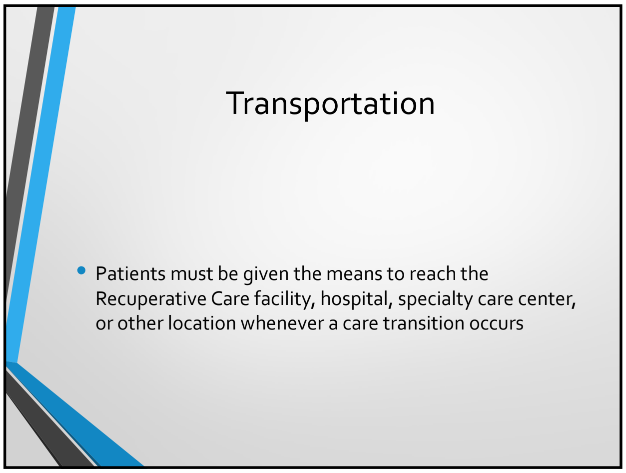
Action Steps - Accountability

- **An accountability policy** must be drafted that clearly defines when and how a change in responsibility for patient care occurs
- The patient must be made aware of who is responsible for their care and given the means to contact whoever is responsible
- The hospital must follow up on any pending lab tests at discharge, and forward the results to the patient's primary care provider



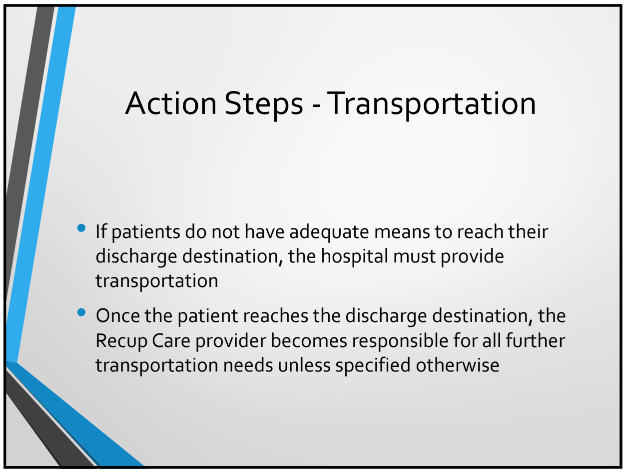
Action Steps - Accountability

- Once the hospital assumes responsibility for the patient's care, the hospital must ensure that the patient reaches their outpatient home for follow-up
- **The care transition is not complete at discharge. It is complete when the patient reaches the outpatient home, and the hospital assumes responsibility until that happens.**



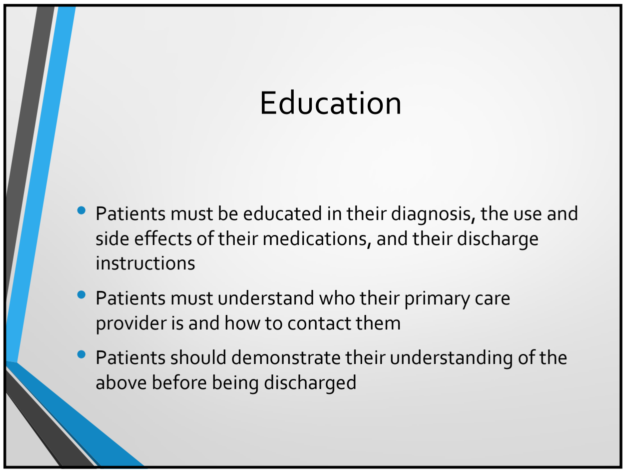
Transportation

- Patients must be given the means to reach the Recuperative Care facility, hospital, specialty care center, or other location whenever a care transition occurs



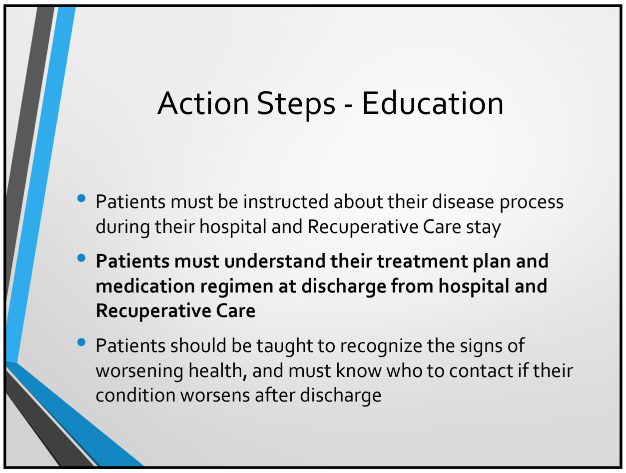
Action Steps - Transportation

- If patients do not have adequate means to reach their discharge destination, the hospital must provide transportation
- Once the patient reaches the discharge destination, the Recup Care provider becomes responsible for all further transportation needs unless specified otherwise



Education

- Patients must be educated in their diagnosis, the use and side effects of their medications, and their discharge instructions
- Patients must understand who their primary care provider is and how to contact them
- Patients should demonstrate their understanding of the above before being discharged



Action Steps - Education

- Patients must be instructed about their disease process during their hospital and Recuperative Care stay
- **Patients must understand their treatment plan and medication regimen at discharge from hospital and Recuperative Care**
- Patients should be taught to recognize the signs of worsening health, and must know who to contact if their condition worsens after discharge

EXAMPLE/TEMPLATE
BUSINESS ASSOCIATE AGREEMENT

THIS CONTRACT is entered into this 1st day of February, 2014 by Hospital A, hereinafter known as "ASSOCIATE" and Recup Program A, hereinafter known as "AGENCY X."

TERM: This contract shall be from February 1, 2014 to February 1, 2015 and shall automatically renew at the end of the term for another year. However, if either party elects to end the relationship, thirty-day notice shall be given to the other party. The party receiving the notice of termination shall respond in turn with written correspondence acknowledging the termination.

WHEREAS AGENCY X will make available and/or transfer to ASSOCIATE confidential, personally identifiable health information.

WHEREAS such information may be used or disclosed only in accordance with the privacy regulations [CFR §§ 164.502 (e); 164.504 (e)] issued pursuant to the Health Insurance Portability and accountability Act [42 USC §§ 1320-1320d-8] and the terms of this agreement:

NOW THEREFORE, the parties agree as follows:

1. *Protected Health Information* ("PHI") means individually identifiable information relating to the past, present or future physical or mental health or condition of an individual, provisions of health care to an individual, or the past, present or future payment for healthcare provided to an individual, as more fully defined in 45CFR § 164.501, and any amendments thereof, received from or on behalf of AGENCY X.

2. ASSOCIATE agrees that it shall not receive, create, use or disclose PHI except as follows:

    a. To conduct comprehensive assessments, deve1op and implement case management plans and develop and implement treatment plans for clients.

    b. If necessary for the proper management and administration of ASSOCIATE or to carry out legal responsibilities of ASSOCIATE. PHI may only be disclosed to another person/entity for such purposes if:

        i. Disclosure is required by law; or
        ii. Where ASSOCIATE obtains reasonable assurance from the entity to which disclosure is made that the PHI released will be held confidential.
        iii. Entity agrees to notify ASSOCIATE of any breaches of confidentiality.

    c. To permit ASSOCIATE to provide data aggregation services relating to the health care operations of AGENCY X.

3. ASSOCIATE and AGENCY X agree that neither will request, use or release more than the minimum amount of PHI necessary to accomplish the purpose of the use, disclosure or request.

4. ASSOCIATE will establish and maintain appropriate safeguards to prevent any unauthorized use or disclosure of PHI.

5. ASSOCIATE agrees that it shall immediately report to AGENCY X any unauthorized uses/disclosures of which it becomes aware, and shall take all reasonable steps to mitigate the potentially harmful effects of such breach. ASSOCIATE hereby indemnifies AGENCY X and agrees to hold AGENCY X harmless from and against any and all losses, expenses, damage or injury that AGENCY X may sustain as a result of, or arising out of, ASSOCIATE or its agent's or subcontractor's unauthorized use or disclosure of PHI.

6. ASSOCIATE shall ensure that all of its subcontractors and agents are bound by the same restrictions and obligations contained herein whenever PHI is made accessible to such subcontractors or agents, and shall give prior notice to AGENCY X of any subcontractors or agents who are to be given access to PHI.

7. ASSOCIATE shall make all PHI and related information in its possession available as follows:

    a. To the individual or his/her personal representative or to AGENCY X to the extent necessary to permit AGENCY X to fulfill any obligation to allow access for inspection and copying in accordance with the provision of 45CFR § 164.524.

    b. To the individual or his/her personal representative or to AGENCY X to the extent necessary to permit AGENCY X to fulfill any obligation to account for disclosures of PHI in accordance with 45CFR § 164.528.

8. ASSOCIATE shall make PHI available to AGENCY X to fulfill its obligation to amend PHI and related information in accordance with 45 CFR § 164.526, and shall, as directed by AGENCY X, incorporate any amendments or related statements into the information held by ASSOCIATE and any subcontractors or agents.

9. ASSOCIATE agrees to make its internal practices, books and record relating to the use of disclosure of information received from or on behalf of AGENCY X available to the US Secretary of Health and Human Services or the Secretary's designee for purposes of determining compliance with the privacy regulations and any amendments thereof.

10. Upon termination of the contracts ASSOCIATE agrees at the option of AGENCY X to return or destroy all PHI created or received from or on behalf of AGENCY X. ASSOCIATE agrees that it will not retain any copies of PHI except as required by law. If PHI is destroyed, ASSOCIATE agrees to provide AGENCY X with appropriate documentation or certification evidencing such destruction. If return or destruction of all PHI and all copies of PHI is not feasible, ASSOCIATE agrees to extend the protection of this Contract to such information for as long as it is maintained. Termination of this Contract shall not affect any of its provisions that, by wording or nature, are intended to remain effective and to continue in operation.

11. The PHI and any related information created or received from or on behalf of AGENCY X is and shall remain the property of AGENCY X. ASSOCIATE agrees that it acquires no title in or rights to the information, including any identified information.

12. Any non-compliance by ASSOCIATE with the terms of this Contract or the privacy

regulations shall be a breach of this Contract, if ASSOCIATE knew of the breach and failed to take immediate or reasonable steps to cure the non-compliance. ASSOCIATE agrees that AGENCY X has the right to immediately terminate this Contract and seek relief, including the right to contract for replacement service through another entity at the same cost, with ASSOCIATE responsible for paying any difference in cost, if AGENCY X determines that ASSOCIATE has violated a material term of the Contract.

13. Notwithstanding any rights or remedies under this Contract or provided by law, AGENCY X retains all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of PHI by ASSOCIATE, any of its subcontractors or agents, or any third party who has received PHI from ASSOCIATE.

14. The Contract shall be binding on the parties and their successors but neither party may assign the contract without the prior written consent of the other, which consent shall not be unreasonably withheld.

15. Any notice to the other party pursuant to this. Contract shall be deemed provided if sent by first class United States mail.

Recup Program A

Chief Executive Officer

Hospital A

Chief Executive Officer