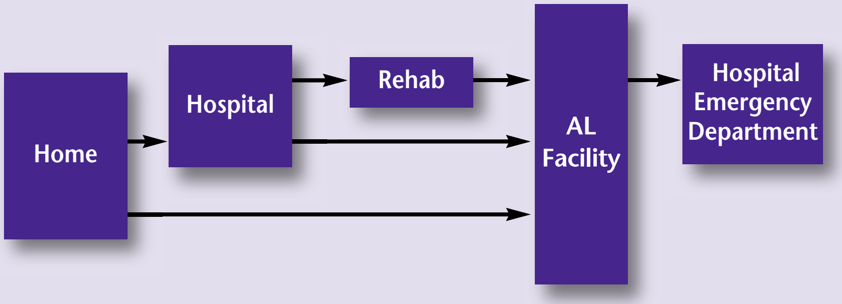
Improving the Quality of Transitional Care for Persons with Complex Care Needs

American Geriatrics Society (AGS) Position Statement

The assisted living (AL) setting is subject to multiple transitional care points. Each transition is an opportunity for a collaborative, multidisciplinary process. Of course, this can only occur with careful planning at both ends of the transition. For this process to be successful, a coordinated system involving several members of the multidisciplinary team is required. One important component of ensuring a successful process is open, regular communication with all the critical channels. By having a point person in the AL facility serve as the liaison and educator between each channel, a successful transitional care process can be achieved.



AL Facility Transitional Care Points

Definition
For the purpose of this position statement, transitional care is defined as a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. Representative locations include (but are not limited to) hospitals, subacute and postacute nursing facilities, the patient's home, primary and specialty care offices, and long-term care (LTC) facilities. Transitional care is based on a comprehensive plan of care and the availability of healthcare practitioners who are well-trained in chronic care and have current information about the patient's goals, preferences, and clinical status. It includes logistical arrangements, education of the patient and family, and coordination among the health professionals involved in the transition. Transitional care, which encompasses both the sending and receiving aspects of the transfer, is essential for persons with complex care needs.

Rationale
Persons whose conditions require complex continuous care frequently require services from different practitioners in multiple settings. Practitioners in each setting often operate independently, however, without knowledge of the problems addressed, services provided, information obtained, medications prescribed, informal support, or preferences expressed in previous settings. This potential for fragmentation of care is heightened by the growing national trend for physicians and other clinicians to restrict their practices to single settings (eg, hospitals, skilled nursing facilities, or ambulatory clinics) and to not follow complex patients as they move between settings. During transitions, these patients are at risk for medical errors, service

duplication, inappropriate care, and critical elements of the care plan “falling through the cracks.” These risks are especially threatening for frail older patients with multiple comorbid conditions. Ultimately, poorly executed care transitions lead to poor clinical outcomes, dissatisfaction among patients, and inappropriate use of hospital, emergency, postacute, and ambulatory services.

The rationale for this position statement is consistent with the release of the timely and compelling Institute of Medicine Report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, which states, “Care for the chronically ill needs to be a collaborative, multidisciplinary process. Effective methods of communication, both among caregivers and between caregivers and patients, are critical to providing high-quality care. Personal health information must accompany patients as they transition from home to clinical office setting to hospital to nursing home and back.”[1]

A Model for Transitional Care Communication

Children’s Hospital of Philadelphia developed “**IBARQ**” to provide a model for consistent communication to assist with transitions of care.

Introduction: Who is involved? (identification of yourself and the patient)

Situation: The bottom line (diagnosis and current condition)

Background: What do you know? (medical history, past tests and treatments, allergies)

Assessment: What’s happening now? (current findings; patient needs, tests, and treatments)

Recommendations: What’s next? (recommendation for plan of care, next dosing of medications)

Questions: Does either party have questions?

By using this model, AL facilities can reduce problems that commonly occur because of poor communication during transitions in care.

Position 1. Clinical Care Needs

During a care transition, older patients require:

- Preparation for what to expect at the next care site.
- The opportunity to provide input about their values and preferences into the plan of care.
- Clear advice on how to manage their conditions, recognize warning symptoms that may indicate their condition has worsened, contact a health professional who is familiar with their plan of care, and seek immediate care in the setting to which they have transitioned.
- Arrangements for the next level of care (eg, admission to a rehabilitation facility or a home health agency or an appointment and arrangements for transportation to a follow-up ambulatory visit).
- Stronger adherence to the practice standard that requires timely evaluation by the receiving clinician to identify or verify areas of concern and ensure implementation of the care plan.

During a care transition, the “sending” and “receiving” health-care professionals require:

- A uniform plan of care to facilitate communication and continuity across settings.
- An accessible record that contains a current problem list, medication regimen, allergies, advance directives, baseline physical and cognitive function, and contact information for all professional care providers as well as informal care providers (see “A Model for Transitional Care Communication”).
- Input from informal care providers who are involved in the execution of the plan of care.
- The opportunity to coordinate care with a “coordinating” health professional who oversees both the sending and receiving aspects of the transition. This professional should be skilled in identification of changes in health status, assessment and management of multiple chronic conditions, medication management, and collaboration with members of the interdisciplinary care team and informal care providers.

Position 2. Policy Needs

Policymakers need to recognize the critical role of transitional care in the quality and outcomes of care experienced by persons with complex care needs and commit to improving care by:

- Developing new performance indicators designed to measure the effectiveness of transitional care across different delivery settings.
- Launching new quality improvement efforts to address transitions between care settings. Both the sending and receiving providers of care would be accountable for the success or failure of the patient’s transition. Whenever possible, transitional care performance in both fee-for-service and capitated practice environments should be monitored by quality improvement entities such as the National Committee for Quality Assurance (NCQA), Health Plan Employer Data Information Set (HEDIS), Quality Improvement Organizations (QIOs), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or a

new quality improvement entity.

- Removing barriers and creating incentives to develop electronic communication systems that facilitate the appropriate transfer of essential clinical data between providers with heterogeneous information systems.
- Creating financial incentives for providing transitional care. Essential elements of transitional care should become Medicare benefits (eg, interinstitutional and interprofessional communication to coordinate execution of each patient's care plan).

Effective methods of communication are critical to providing high-quality care.

- Discussing the opportunity to link payment to the quality of care delivered, including transitional care, in the formulation of Medicare+Choice capitation.

Position 3. Education Needs

Professional educational institutions, specialty certification boards, licensing boards, and quality improvement programs should seek to improve, evaluate, and monitor health professionals' abilities to collaborate across settings to execute a common plan of care. Core competencies include the incorporation of patients' and informal care providers' preferences into a plan of care, active communication (telephonic, electronic, or printed paper) with healthcare professionals across settings, attention to and coordination of individual elements of the plan of care, and timely transfer to the next level of care or follow-up in the ambulatory setting.

Position 4. Research Needs

To advance the understanding and practice of high-quality transitional care, research is needed to:

- Develop and test systems of care designed to optimize transitional care. Such interventions need to be patient-centered and designed to facilitate external adoption in different delivery systems and under different payment mechanisms.
- Better understand how to empower persons with complex care needs and their informal care providers to express their preferences and manage their care needs across healthcare settings. This line of inquiry further necessitates attention to the needs of persons from various ethnic and racial groups.
- Develop and test performance indicators and quality improvement technologies that focus on the quality of transitional care.
- Determine the most effective incentive strategies for encouraging clinicians and institutions to improve transitional care.
- Improve the effectiveness of training healthcare professionals in transitional care.
- Advance and disseminate state-of-the-art information technology systems that facilitate interinstitutional and interpractitioner communication and collaboration (with appropriate safeguards in place to ensure patient confidentiality). ALC

Credits

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References

1. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington DC: National Academy Press: 2001; 9.

Improving COPD Through Energy Conservation

(continued from page 29)

Improving Quality of Life for All Residents

Although this article offers tips to help residents with COPD lead more fulfilling lives, many of these tips are appropriate for all residents. Although dyspnea and exhaustion may limit residents with COPD from tackling all the tasks they'd like to do, these simple steps can help them conserve the energy needed to enjoy the simple pleasures of life that most people take for granted. The AL multidisciplinary team can effectively help these residents manage COPD or just the wear and tear of older age by providing education in these basic energy conservation techniques and helping residents incorporate them into their daily routines. ALC

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