Transitions of Care
Defining, Measuring, and Improving

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Outline

- Define TOC
- Problem with current system
- Conceptual effort to incorporate measurement into efforts to improve
  - Structure, Process, Outcome, & Attribution
- Theory and Practice of a science-based CQI.
- Comparative Effectiveness.

Perspective

Much of the work in health reform can be put to "demand – side" improvement

- Wellness, Consumer/Patient Behavior change, Much of disease management, etc.

Transition of care can be put to "supply – side" improvement

- Provider/Doctor Behavior change, Health care IT, etc.

Both have strong measurement issues, conceptually alike, but practically different.

Problem without good TOC

- Patient get transferred; Information does not get transferred
- Duplicate tests
- Patient Safety Issues

TOC, a sub-set of Care Coordination

Clarification is essential for two key terms: *care coordination* and *transitions of care*. **Care Coordination** is the deliberate organization of patient care activities among two or more participants (including the patient and/or the family) to facilitate the appropriate delivery of health care services. Organizing care involves marshalling personnel and other resources to carry out all required patient care activities, which is often managed by the exchange of information among participants responsible for different aspects of the care.

Transitions of Care refer to the movement of patients between health care locations, providers, or different levels of care within the same location[2] as their conditions and care needs change. Specifically, they can occur:

1. Within settings; e.g., primary care to specialty care, or intensive care unit (ICU) to ward.
2. Between settings; e.g., hospital to sub-acute care, or ambulatory clinic to senior center.
3. Across health states; e.g., curative care to palliative care or hospice, or personal residence to assisted living.
4. Between providers; e.g., generalist to a specialist practitioner, or acute care provider to a palliative care specialist.

Report from the NTOCC Measurement Workgroup

The Case Management Society of America (CMSA) convenes the National Transitions of Care Coalition (NTOCC) to develop recommendations on actions that all participants in the health care delivery system can take to improve the quality of care transitions. The multi-disciplinary members of NTOCC work collaboratively to develop policies, tools, and resources as well as recommend actions and protocols to guide and support providers and patients in achieving safe and effective transitions of care. The Measures Work Group is one of four work groups convened to focus on specific areas. The objectives of the Measures Work Group are:

1. To develop a framework for measuring transitions of care.
2. To conduct an environmental scan for existing transitions of care quality measures, evaluate these measures, and assess gaps in measures.
3. To develop recommendations on how to fill gaps in measures.

“Structure”

I. Structure:

A. Accountable provider at all points of care transition:
Patients should have an accountable provider or a team of providers during all points of transition. The provider(s) would provide patient-centered care and serve as central coordinator(s) across all settings, and with other providers. This care coordination hub has to have the capacity to send and receive information when patients are transitioning between care sites. While the primary care patient-centered medical home incorporates such a hub, other practitioners can take this role as well.

B. A tool for plan of care:
The patient should have an up-to-date proactive care plan that would take into consideration the patient’s and family’s preferences and would be culturally appropriate. This care plan should be available to all providers involved in the care of the individual.

C. Use of a health information technology-integrated system that would be interoperable and available to both patients and providers.

"Process"

II. Processes:

A. Care team processes:

i. Care planning (including advance directives)
ii. Medication reconciliation (this process includes patient and family)
iii. Test tracking (laboratory, radiology, and other diagnostic procedures)
iv. Tracking of referrals to other providers or settings of care
v. Admission and discharge planning
vi. Follow-up appointment tracking
vii. End-of-life decision making

B. Information transfer/communication between providers and care settings:

i. Timeliness, completeness, and accuracy of transferred information
ii. Protocol of shared accountability in effective transfer of information

C. Patient and family education and engagement:

i. Patient and/or family preparation for transfer
ii. Patient and/or family education for self-care management (e.g., the NTOCC tools *"My Medicine List"* and *"Taking Care of My Health")*.
iii. Patient and/or family agreement with the care transition (active participation in making informed decisions)

“Outcomes”

III. Outcomes:

A. Patient’s and/or family’s experience and satisfaction with care received.

B. Provider’s experience and satisfaction with the quality of interaction and collaboration among providers involved in care transitions.

C. Health care utilization and costs (e.g., readmissions, etc.).

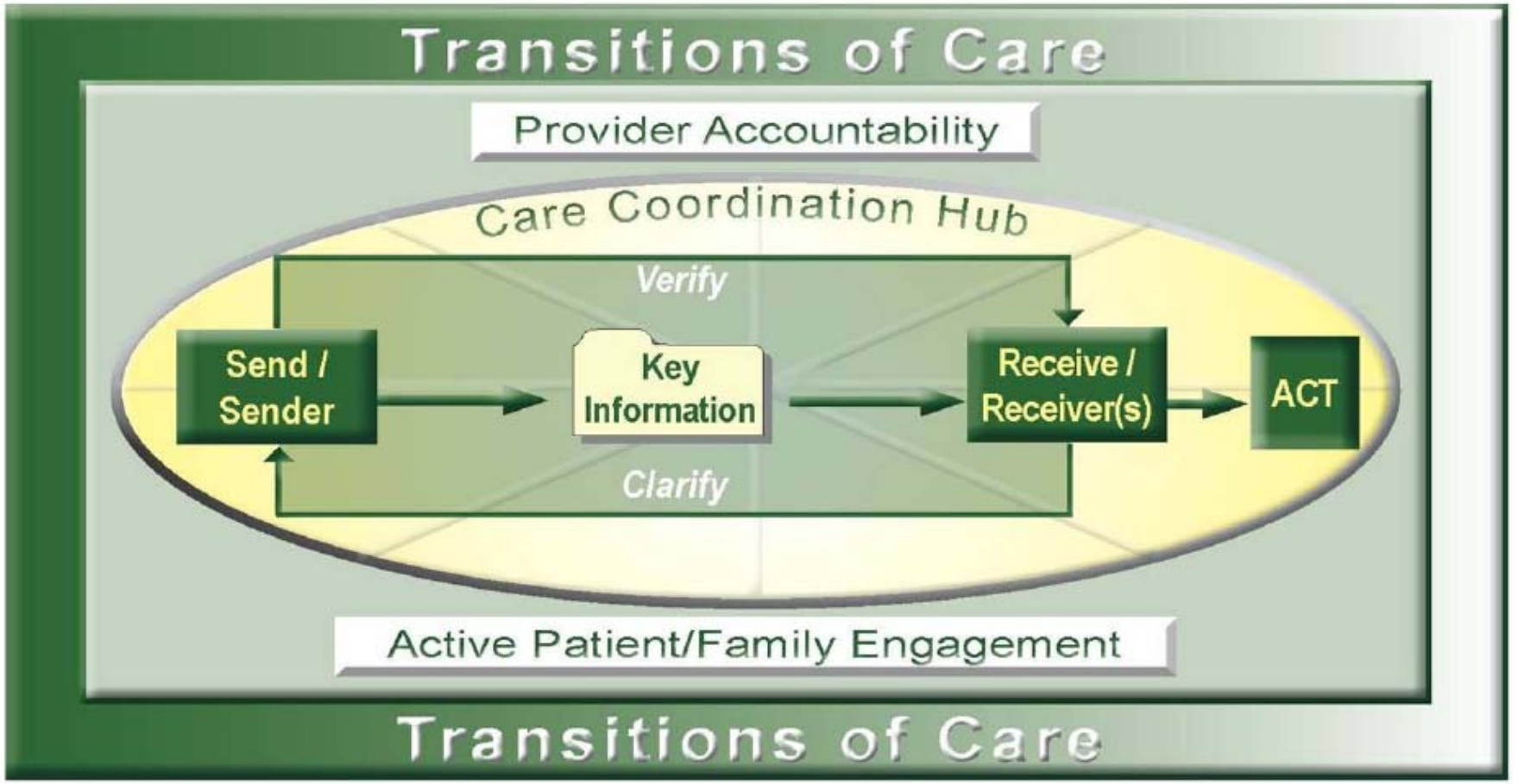
D. Health outcomes consistent with patient’s wishes (e.g., functional status, clinical status, medical errors, and continuity of care).

Conceptual Framework to Improve TOC

Attempted Transition: "Sending"

Successful Transition: "Sending" & "Receiving"

“Conceptual Model”



“Sender”

Figure 2: Clarifying the Transition of Care Interaction between the Sender and Receiver

	Who	What	To Whom	When	Verify/ Clarify	Act Upon	How is this Documented
SENDER	Accountable provider	◦ Tests ◦ Consultations ◦ Medication reconciliation ◦ Transition/ discharge summary ◦ Assessments ◦ Patient education ◦ My Medicine List	Accountable provider and patient	Send the information timely for appropriate intervention with patient	● Sender verifies information is received by intended recipients. ● Sender clarifies information for recipient.	● Sender will document transaction. ● Sender will resend information if not received by intended recipient.	Document data source: ◦ Paper medical record ◦ Electronic health record (EHR) ◦ Checklist

“Receiver”

	Who	What	To Whom	When	Verify/ Clarify	Act Upon	How is this Docu-mented
RECEIVER	Accountable provider	◦ Tests ◦ Consultations ◦ Medication reconciliation ◦ Transition/ discharge summary ◦ Assessments ◦ Patient education ◦ My Medicine List	Accountable provider and patient	Received the information timely for appropriate intervention with patient.	Receiver acknowl-edges having documents and asks any questions for clarification of informa-tion received	● Receiver uses the information and takes actions as indicated ● Receiver ensures continuity of plan of care/ services	Document data source: ◦ Paper medical record ◦ Electronic health record (EHR) ◦ Checklist

Measuring TOC Improvement

Foundation of Evidence-based improvement

- Comparative Effectiveness
  - To standard of care
  - To alternative program
    - Key principle: Equivalence of comparator

“Attribution”

IV: Attribution Options:

A) Generally accepted attribution (cause & effect) based on peer-reviewed literature and/or consensus professional opinion.

B) A methodological model that tests the extent to which the “structure” & “process” actually was responsible for the “outcome”

Metrics: Process, Outcome, and

Confounding Factors (referent)

“Attribution” Models

Metrics:

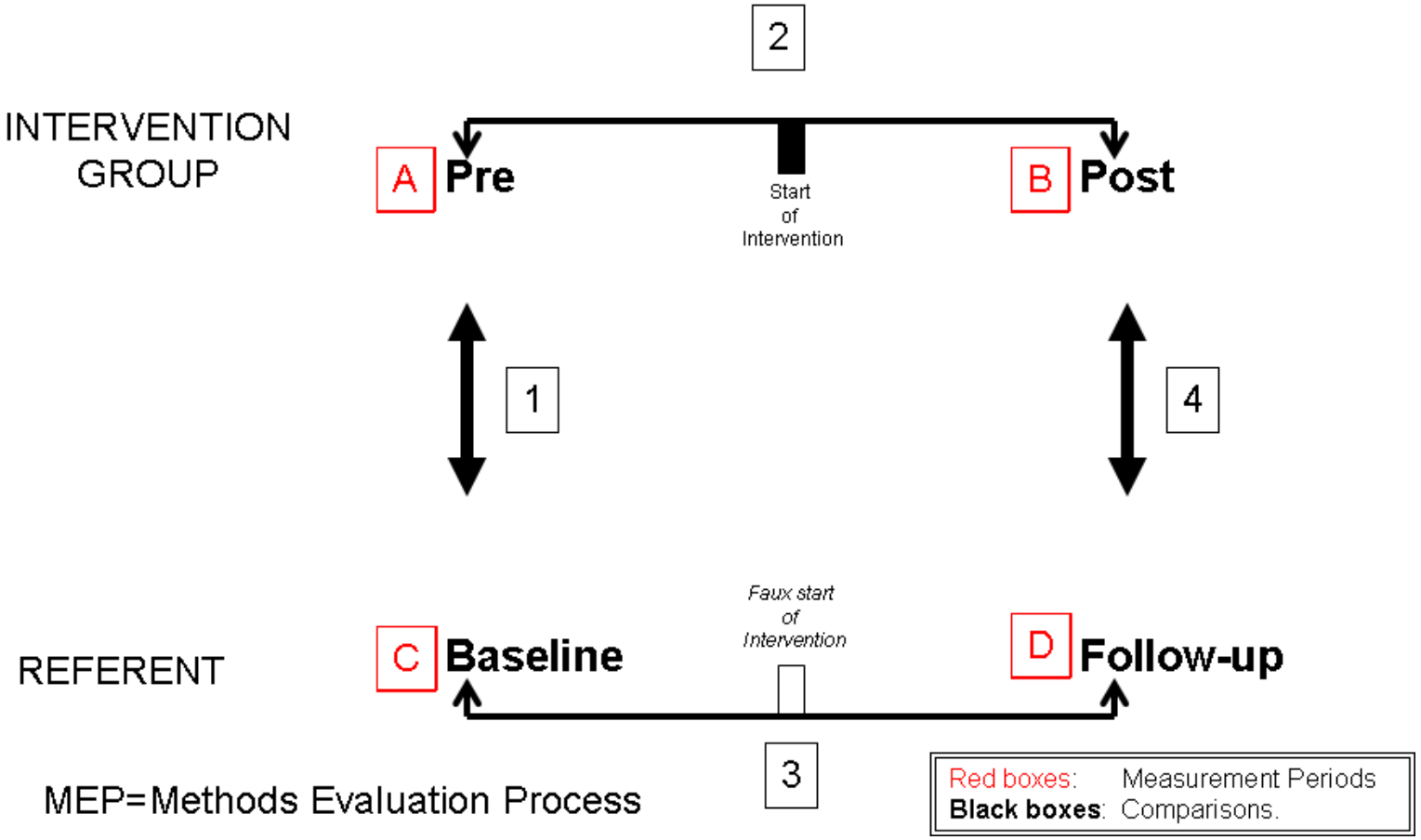
- *Intervention*
- *Process*
- *Outcome*
- *Confounding Factors*

Referent

- *To assess impact on outcomes in the absence of the TOC intervention*

A General Measurement Model

when professional opinion is not enough



Source: Population Health Impact Institute
www.phiinstitute.org

Further Informatoin

- Transitions of Care
  - http://www.ntocc.org/
- Methodology
  - www.PHIinstitute.org
    - Complimentary webinar on importance of methodological transparency, 3/11/2010