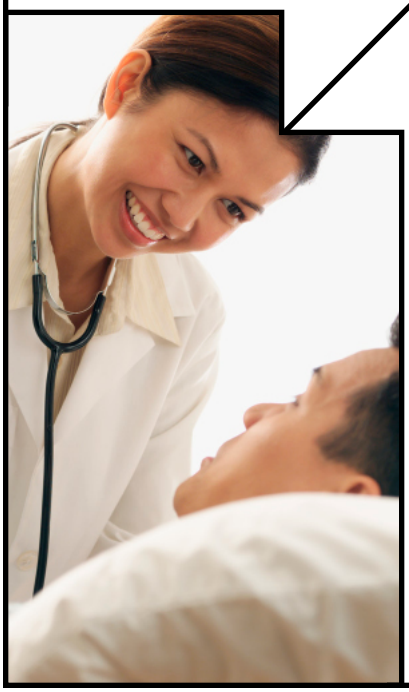
From Hospital to Home



A Guide to Transitioning Care

NYACP
New York Chapter
American College of Physicians
Advancing Internal Medicine; Improving Patient Care

744 Broadway • Albany, NY • 12207
P: 518.427.0466 • **F:** 518.427.1991
www.nyacp.org

The Transitioning Care Partnership: Hospitalists and Primay Care Physicians

A Transition of Care Framework

The intent of this brochure is to be used as a framework to assist local healthcare communities and institutions with the development of local processes to improve the quality of care and to clarify expectations for communication between physicians in the inpatient and community-based settings of the health care delivery system. This is not to be used to define guidelines or standards of care.

In 2009, the **American College of Physicians** (ACP) participated in the **Transition of Care Consensus Conference** (TOCCC) and issued a consensus Policy Statement outlining the principles and standards in the management of care transitions, and encouraged further development of community-based communication systems across the practice settings, monitoring and continuous improvement processes, practice guidelines, and metrics to improve the quality of patient care.

Building upon ACP's TOCCC policy statement, NYACP has approved a white paper, developed by the Chapter's Hospitalist Task Force and workgroup to define the role of physicians in optimizing Transition of Care by offering specific suggestions for the communication process in various TOC settings involving hospitalized patients

Collaboration Between Hospitalists and Primary Care Physicians

Our health care system increasingly relies on dedicated hospital-based physicians (hospitalists) to manage the inpatient care of patients who upon discharge resume receiving care from their primary care physicians (PCPs) in the community. This system allows physicians to devote their time and develop expertise within their preferred setting and requires specific attention to assure patient safety and optimize outcomes upon both admission to and discharge from the hospital.

Effective transition of care (TOC) is a **core responsibility of all physicians**. TOC communication is a **reciprocal responsibility** of hospital based physicians and community based physicians; it applies to **individual** clinicians as well as entire **practices**. This responsibility includes participation in the development of system changes and communication processes both as sender and receiver of information. The use of the Electronic Health Record (EHR) is an important supplement that should enhance and not replace verbal communication

Three Key Phases of TOC Optimization

- Developing community and institutional **processes**
- Implementing communication **systems** across the continuum (including intramural microsystems within institutions, practices, and call groups)
- Executing high quality TOC in clinical **practice** case by case

Special Thanks to the NYACP Hospitalist Task Force

Balazs Zsenits, MD, FACP, Chair

Hanaw Adham, MD, FACP
Anees Ahmad, MD
Alfred Burger, MD FACP
Douglas Delong, MD, FACP
Andrew Dunn, MD, FACP
Nick Fitterman, MD, FACP
Bradley Flansbaum, DO, FACP
Kausik Kar, MD, FACP
Corey Karlin-Zysman, MD, FACP
Linda Lambert, CAE
Jennifer Lee, MD, FACP
James Leyhane, MD
Radhames De Oleo Ramos, MD
Bradley Sherman, MD, FACP

What is the Objective of a Transition of Care Partnership?

The overarching objective for improving care transitions is to provide the **best possible care for patients**, as guided by medical evidence and ethical principles. These transitions are dependent upon establishing local community based communication processes. Such processes will require individualized consideration based on the existing infrastructure, risks/benefits, practice patterns, costs, and patients' expectations.

In addition to improving communication, there needs to be a "care-plan continuity" bridging the inpatient and community settings. TOC also needs to be recognized as a topic for teaching: formal medical education and quality improvement.

Phase One: Upon Admission to Hospital

Transition of Care Objectives Upon Hospital Admission

Effective transition of care begins with hospital admissions to ensure safe, patient-centered care from the start of the hospitalization by minimizing errors in medication reconciliation, preventing unnecessary admissions and errors of omission. The timely communication between outpatient and hospital based clinicians is essential and will take place prior to hospital admission whenever possible, or as soon as possible following admission.

- Define relevant information that should be retrieved and communicated during each care transition to ensure patient safety and maintain the continuum of care

- Mutually identify how to reach and reliably communicate with the PCP and the hospitalists responsible for the coordination of care of the patient

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Suggestions for Action

- Initial contact with the PCP takes place in the ED.

- The specific collaboration process should be negotiated locally between primary care groups and hospital/ED staff, and should generally include reliable identification of PCP, and user friendly and efficient systems (direct phone numbers, expedited access lines to staff/operators, designated pagers, etc.) for hospitals and the PCPs/offices to enable effective communication.

- The party that first learns about the patient's ED visit should initiate the communication (e.g. ED if unexpected visit, PCP if the patient is sent to the ED)

Physicians: Leaders of Institutional Process Development

Physicians should be leaders of institutional process development. This will assure:

- Sctructured, timely, and reliable **transmission** of information

- Being accessible to **receive and act upon** information

Phase Two: During Hospitalization

Transition of Care Objectives For Hospitalization

To establish full disclosure of plans of care, optimize continuity of care from the outpatient to the inpatient setting, and maintain collaborative relationships between hospital and community-based physicians as well as between clinicians and the patient/family. Timely, safe, effective, efficient, equitable, and patient centered communication is paramount to effective TOC during hospitalization.

- Maintain mutually open lines of communication between the PCP and hospitalist who coordinate care and to whom questions can be directed

- Similarly, maintain open lines of communication between clinicians and the patient/family

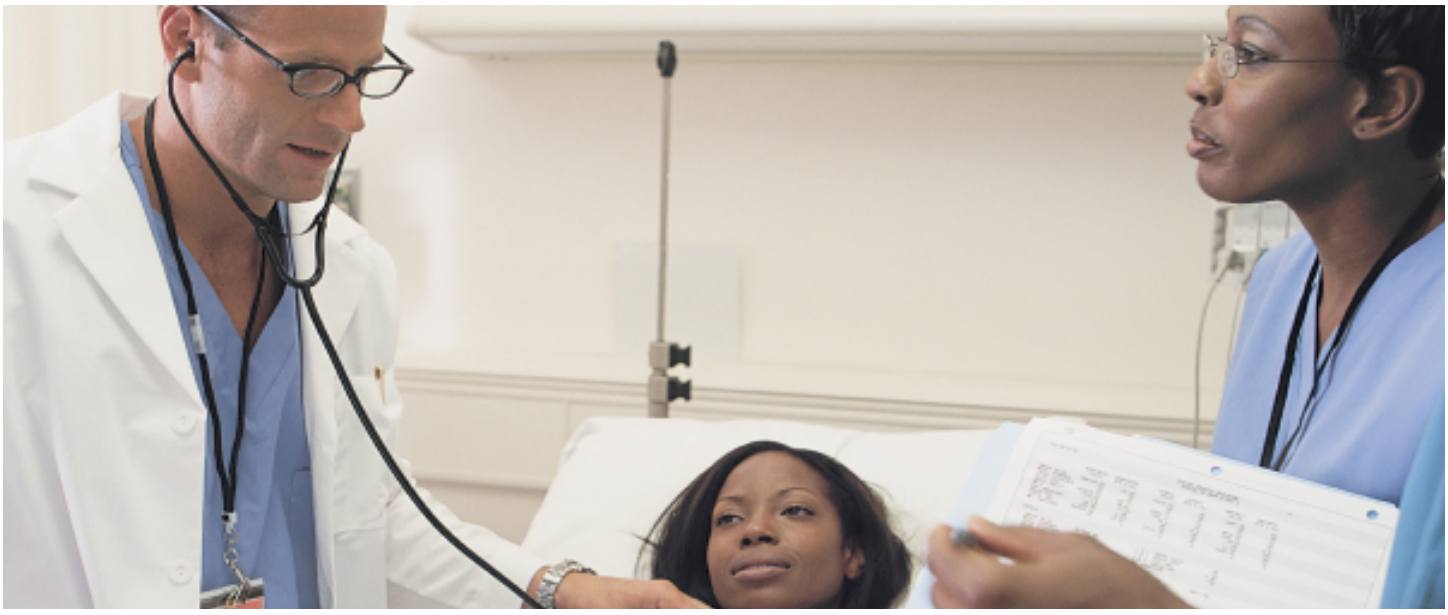
- Helping to achieve high value care by eliminating redundancy of procedures and workup already completed in the outpatient setting

Suggestions for Action

- Contact during the course of the hospitalization shall be initiated by the hospitalist to the PCP if an acute change in the patient's condition or goals of care occur.

- Clear communications be made with the patient/family by all clinicians regarding
    - The role of the hospitalist during the admission as the attending of record
    - The collaborative relationship between the hospitalist and the PCP with regards to the patient's hospital course and goals of care

- During the period of hospitalization, decisions regarding care, consultation, admission, transfer and discharge will be the responsibility of the hospitalist in consultation with the patient/surrogate and, as appropriate, in consultation with the PCP.



Phase Three: At Hospital Discharge

Transition of Care Objectives for Hospital Discharge

The timely relay of information regarding the hospital course, medication adjustments, outstanding test results and arrangements for social support is essential for keeping patients safe. This is needed in order to eliminate gaps in care during transitions from the inpatient to the outpatient environment and to resolve any apparent conflict between the patient's discharge instructions and his/her pre-hospitalization plan of care.

Suggestions for Action

- The hospitalist or designee communicates the hospital course and treatment plan, including changes to medications and other follow-up recommendations when appropriate, to the patient's PCP or designee upon discharge.

- **Handoff communication** will preferably take place within 24 hours before anticipated discharge but no later than the time of discharge. A complete discharge summary should preferably be available on the day of discharge; no later than the next business day.

Handoff Communications Include

- Major diagnoses
- Reason and highlights of hospital stay
- Relevant test results (pertaining to follow-up care)
- Procedures
- Diagnostic and care management changes (goals of care, etc.)
- Anticipated follow-up needs (clearly distinguish between already scheduled tests/appointments from those that the PCP would arrange if in agreement)
- Discharge medications and anticipated course (with unique warnings that may be specific to the patient's care)
- Information on pending and outstanding labs and test results and how to obtain them

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Communicate Efficiently

Hospitalists and PCPs should consider communicating directly, rather than through other providers from the inpatient and ambulatory settings (i.e. nurse practitioners and house staff) especially in high-risk situations (e.g. complex hospital course, new high risk medications that require regular monitoring/adjustment, major change in care-plan, complex psychosocial issues, pending critical tests or follow-up needs).

Phase Three continued on next page -->

Phase Three Continued

When is Transition of Care Complete?

Care would be considered fully transferred when there has been a clear understanding between Hospitalist and PCP as evidenced by either direct physician-to-physician communication, or a hand-off relying on a predefined and systematic process. A systematic handoff includes transmittal of clinical information as defined above, and also feedback options (enabling and requiring the receiver to reject the follow up role if that falls outside of the professional responsibilities of the physician). Until TOC is fully completed as noted above, the hospitalist and the PCP should both be informed about issues and remain accessible for clarification.

Final Suggestions

- Closing the communication loop by the PCP confirming acceptance of the TOC plan should be encouraged. A phone call or message to the discharging hospitalist at the first post discharge visit may further hospitalist-community physician collaboration.

- The method of sharing TOC data (i.e. handoff plan, follow up issues) should be tailored to the available information infrastructure, according to community practice that should be developed with the involvement of hospitalists, PCPs, other specialists, and the inpatient and outpatient communication and care systems (EMR, fax, phone call, care management system, HIPAA compliant texting, etc.).

- The follow-up plan from the hospitalist should be considered as recommendations. Follow-up on the pending and prescheduled tests is the responsibility of the PCP unless the PCP has made explicit that they are not to be responsible (e.g. not caring for the specific condition). The hospitalist team should make every effort to arrange timely follow up for patients upon discharge, though this may vary based on patient situation and community resources.

- Patients that have no PCP upon admission create unique situations. Hospitalist team should work with their health care community to assure timely continuity of care for these patients.

- If the patient is being discharged to a setting other than that from which he or she was admitted (e.g. to skilled nursing facility), the above information will also be sent to the receiving facility-based provider in addition to the PCP.

- It is advisable to address administrative documentation issues up front. For example, an issue that frequently arises is the need for a physician to sign orders for visiting nurses or other home health services that begin immediately after discharge. There should be an understanding between the hospitalist and PCP as to whose responsibility this will be.

- The hospitalist may serve as a safety net during this vulnerable post discharge period. The hospitalist's contact information should be included in the discharge instructions and/or discharge summary. The patient could be informed to contact the hospitalist if he/she has an urgent question and cannot reach their PCP.

- Both hospitalist and community based physician should "Lead, coordinate or participate in initiatives to develop and implement new protocols to improve or optimize transitions of care." (SHM core competencies 2006) A process should be in place to monitor the compliance and value of the locally developed TOC processes.