

CCIP CARE TRANSITIONS PROCESS AND GUIDELINES

Developed under guidance from the Practice Transformation Task Force (PTTF) as part of the Connecticut State Innovation Model Initiative

Program Description and Objective:

Description: The care transitions intervention process will be an elective service of the CCIP intervention for patients requiring more structured care management support when transitioning from an acute care facility to the home. In some cases, this will also govern the transition from one healthcare provider to another and between healthcare settings. This intervention can be integrated into the program developed for either the complex patient or equity gap population, but can also be implemented to support all patients who are at high-risk of readmission or preventable adverse health events.

The feedback received to date on these guidelines questions whether our objective for this standard may be better served by embedding the components of this intervention in the shared governance and patients with complex conditions standards. Commenters have noted that many elements of the guidelines are hospital-centric and embedded in other processes. As most MQISSP members may not have member hospitals, it might be more effective to address quality transitions of care through other approaches.

Objective: Develop methods to improve communication and the exchange of patient health information when transitioning between settings in order to improve patient outcomes by ensuring that patients are safely transitioned with self-management tools to implement their plan of care.

High-Level Program Design:

1. Identify patients in acute setting requiring more structured care transitions management
2. Pre-discharge consult and transition care plan in acute facility
3. Post-discharge home visit
4. Implementation of transitions care plan

Detailed Program Design:

- 1. Identification of patient in acute setting requiring structured care transitions management**
 - The network develops an assessment to conduct on all patients and administered by a transition coordinator¹ to identify patients requiring more structured care transitions and care management intervention²
- 2. Pre-discharge consult and transition care plan in acute facility**
 - The network develops protocols and processes to work with the patient and the patient's caregiver(s) on a transition care plan and goals to improve health

¹ Transition coordinator could be an existing employee with relevant clinical and patient expertise to assist the patient with transitions of care (e.g.; discharge planner).

² Metrics should take into account patient's ADLs, caregiving situation, home situation, severity of patient's condition, social determinant risks, and other factors that would qualify them for a more structured care transitions.

- A transition coordinator guides the pre-discharge consult and assists in the development of the transition care plan and goals using a person-centered³ assessment process.
- The transition coordinator consults with the following care team members on the transition care plan:
 - Attending physician
 - APRN or RN
 - Other healthcare professionals responsible for the care of the individual (e.g.; consulting physicians, behavioral health specialists, social workers)
- The network develops a standardized transitions of care plan to be shared with the patient, any caregivers, and the patient’s primary care provider that includes the following:
 - Identification of the appropriate level or “tier” of transition support based on patient need and goals⁴
 - Condition history and treatment summary
 - Medications, medication regimen with reconciliation of any existing medications, and administration instructions
 - Common anticipated healthcare concerns to identify potential complications and “red flags” indicating need to reach out to additional medical professionals with specific related clinical expertise
 - Information on all follow-up appointments, including those with any of the following: PCP, specialists, and community/social services along with contact information
 - Follow-up appointments known to the transitions coordinator and the patient will be scheduled before discharge
 - Members of transition team and other relevant care team providers with information for getting in touch when there are care questions
 - Copy of the expected transition process, including transition supports, education materials/tools that will be made available and visit schedule (in home or via telephone and frequency of touchpoints)
 - Information about patient responsibilities to ensure an optimal outcome with expectations for behavior of patient and family

³ **Person-Centered:** Person-centered means the active involvement of persons and their families in the design of care and support solutions and in decision-making about individual options for treatment. Person-centered care is respectful of and responsive to individual person preferences, needs, and values, and ensuring that person values guide all clinical decisions as well as non-clinical decisions that support independence, recovery and quality of life. Person-centered care considers an individual’s cultural traditions, personal preferences and values, family situations, social circumstances and lifestyles.

⁴ Recommended tiers are as follows: (1) Tier 1 - : complex patients requiring robust care transition management in weeks (likely aligned with CCIP defined complex patients) with follow up care in the home; (2) less complex patients requiring basic transition support, some education, and moderate telephonic or telehealth follow up; (3) patients requiring basic education and a care plan with minimum telephonic follow up

- The transitional care management plan will be developed using a person centered process with the patient/family/caregiver and relevant members of the care team⁵
- The network develops an operational plan for deploying transition coordinators to work with patients in transition. This includes:
 - Identifying who will employ the transition coordinator
 - Determining if this is a new role or if it is a role that can be fulfilled by an existing network employee
 - Determining where the transition coordinator will reside (i.e.; hospital, clinic and deployed to hospital as needed, etc.)
 - Protocol for how the transition coordinator will be notified of an eligible patient
- The network develops protocols to share care plan with all necessary members of the care team and the patient's caregivers⁶
- The network develops protocols to provide patient education tools designed to improve self-management skills⁷
- The network develops protocols for training and education for the transition coordinator and other individual(s) identified to do patient education⁸

3. Post-discharge home visit

- The network develops protocols for care team interactions with the patient post discharge.
 - Protocols will identify a timeline for initial post-discharge follow-up visit⁹
 - The post-discharge visit(s) will be conducted by a professional or set of professionals that can meet the patient's needs¹⁰
- For Tier 1 patients, the network develops a tool to assess the patients physical and social barriers to care during the initial home visit
 - The tool will assess barriers that impact: nutrition, medication management, mobility, and communications¹¹

⁵ For Tier 1 patients who will likely be transitioning to receive support from an outpatient based comprehensive care team, consider including key members in the development of the transitional care management plan

⁶ Protocols vary depending on the patient needs but should identify which healthcare professionals should have access to the care plan and the tool that should be used to share the care plan (e.g.; direct messaging, ADT, etc.)

⁷ Protocols should identify who is responsible for doing the training (usually by the transition coordinator), and any education tool should reflect best practices in the industry for specific conditions.

⁸ Training protocols for patient education should include patient "coaching" with "teach back", how to provide culturally sensitive education to patients, and identification of social and behavioral needs of a patient and how to coach the patient to address those needs

⁹ Different timelines are recommended based off the patient's tier: Tier 1: Visits should occur shortly after discharge in the home to reevaluate the patient condition and avoid readmissions as the patient is supported to acquire self-management; Tier 2/3: Should receive basic follow-up support via phone or telehealth as appropriate. Generally this follow-up should occur within 48 hours post-discharge

¹⁰ This will also likely vary by tier: Tier 1: the transition coordinator, the comprehensive care team, a CHW, or a licensed medical professional depending on who is assigned as a member of the individual's care team; Tier 2/3: the transition coordinator.

¹¹ To evaluate the barriers to health the tool could include questions on: ADLs, patient's functional deficits and physical environment (in particular to identify environmental factors that could potentially exacerbating health conditions such as mold for asthma) and social determinant risks.

- The network develops a process to finalize the care transition plan that includes:
 - Identification of individual(s) to review care-plan with patient/family/caregiver.
 - Review to verify care plan alignment with patient preferences, goals and values, cultural considerations and health literacy¹²
 - Any updates to the care plan¹³
- The network develops additional patient education resources that fit the needs of patients being served¹⁴

4. Implementation of transitions care plan

- The network defines processes and protocols for continued interaction with the patient and caregiver to monitor and execute the discharge care plan. Processes and protocols will include:
 - Determination of the frequency of touch points with the patient¹⁵
 - Forum for touch points: telephonic, telehealth, or in-home visits¹⁶
 - Creation of a standardized progress note on patient for each interaction
 - End point for transition support (i.e.; method to assess when the patient is stable and will no longer need care transition support)¹⁷
 - Inclusion of the care plan and touch points in any case conferences about patient's progress if relevant
- The network determines how to make post-discharge care plan and progress notes accessible to all relevant care team members¹⁸
- The network develops process to monitor patient follow-up appointments, including PCP and specialist appointments¹⁹
- The network develops a process to facilitate constant access to members of a care team in case of questions including:
 - Providing patients with clear instruction on how they can contact care team members if needed
 - Processes and protocols for patients to contact relevant providers should reflect the patient needs and the provider's workforce

¹² Depending on tier of patient, individual(s) who review the care-plan with the patient may vary: Tier 1: a member or multiple members of the comprehensive care team; Tier 2/3: transition coordinator over the phone.

¹³ Updates to the care plan might include: identification of additional services needed (e.g. behavioral, social, legal, developmental, etc.), identification of additional follow-up appointments needed (e.g.; specialists, pharmacist, dietician, etc.).

¹⁴ Common education provided includes: (1) Medication adherence/management; (2) management of symptoms; (3) Awareness of "red flags" (e.g.; symptoms for the patient to look for as risk factors for follow-up with someone from the medical team); (4) Communication channels and processes with relevant providers. The network should also identify who should provide the education to the patient.

¹⁵ Frequency of touch points should be dependent on patient acuity/risk for readmission. This measure of risk should consider complexity of patient from clinical, social, and behavioral perspectives to determine acuity.

¹⁶ Similarly, the forum for touch points should depend on patient acuity and stated preference.

¹⁷ The network should define stabilization, consider: when the patient's health has improved and when the patient has received the appropriate education to empower self-care management. This generally occurs 4-8 week's post-discharge.

¹⁸ The network should identify who will need access to the post-discharge care plan, develop technology to provide relevant individuals access to the care plan, and if possible, identify method to provide real-time/near real-time notifications on changes to post-discharge care plan and availability of progress notes to relevant individuals.

¹⁹ The network should identify which individual(s) on the care team should be responsible for monitoring follow-up appointments and determine where tracking of follow-up will be captured.