



# Beyond the Discharge: Principles of Effective Care Transitions Between Settings

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## A Position Paper of the American College of Physicians

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A list of Council Subspecialty Society member organizations that contributed to this paper can be found in the Appendix. The paper was approved by the Board of Regents of the American College of Physicians on February 28, 2023.

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## Abstract

Over the past several years, ACP's Council of Subspecialty Societies ("The Council") has focused on a variety of perspectives on transitions of care, including transitions from pediatric to adulthood care in the ACP Pediatric to Adult Care Transitions Toolkit,<sup>1</sup> and transitions between primary and specialty care physicians in *Beyond the Referral: Principles of Effective, Ongoing Primary and Specialty Care Collaboration* and *The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices*.<sup>3</sup> The Council identified that the next step in this series of work was to develop recommendations for effective care transitions between health care settings. The objectives of this paper are to 1) identify evidence-based principles fundamental to successful transitions across health care settings, 2) establish four driving principles for improving care transitions, and 3) discuss challenges and opportunities unique to specific care transitions. Furthermore, this paper provides recommendations that support successful care transitions between settings with the goal of improved patient safety, health care outcomes, and patient/caregiver satisfaction.

## Executive Summary

### Introduction

Care transitions occur when patients move from one health care setting to another or when patients move from the care of one health care professional to another<sup>4</sup>. Transitions in care settings occur between home, ambulatory, long-term care, and hospital settings; transitions between health care professionals (physicians, advanced practitioners, and specialties) may accompany transitions in health care settings but may also occur within a given health care setting, dependent on the level of care of a patient and the involvement of generalists and various specialists. Care transitions occur at critical times for patients; suboptimal care transitions have significant health implications and financial costs<sup>5,6</sup>. Improving communication and care coordination during care transitions is essential in achieving consistent, effective, and safe care for patients. Research highlights several best practices for optimal care transitions (e.g., ensuring coordination and continuity of care during care transitions) for patients in general<sup>7</sup>, and in particular for patients with heart failure<sup>8</sup>, end-stage renal disease<sup>9</sup>, substance use disorders,<sup>10</sup> and multiple chronic conditions among people of all ages<sup>11, 12, 13</sup>. Comprehensive transitional care is associated with improved health outcomes<sup>14</sup> and reduced financial costs for both patients and health care systems<sup>15</sup>.

The American College of Physicians (ACP) has long been committed to expanding the U.S. health care system's communication capabilities as a key tool in improving patient outcomes. Both *Beyond the Referral: Principles of Effective, Ongoing Primary and Specialty Care Collaboration* and *The Patient-Centered Medical Home Neighbor: The Interface of the Patient-Centered Medical Home with Specialty/Subspecialty Practices*<sup>2</sup> presented recommendations on best practices for coordination and collaboration between primary care and specialty care teams. Since then, ACP has continued to study and emphasize

the importance of effective care transitions. Our nation's health care system is increasingly disjointed as the number of people without a primary care physician increases and the utilization of emergency departments (EDs) and urgent care clinics for basic health care escalates. Facing this reality, finding data-driven best practices and tools to help achieve consistent, effective, safe care transitions for patients across all care settings was established as the priority of this paper. The objectives of this paper are to 1) identify evidence-based principles fundamental to successful transitions across health care settings, 2) establish four driving principles for improving care transitions, and 3) discuss challenges and opportunities unique to specific care transitions. Furthermore, this paper provides recommendations that support successful care transitions between settings with the goal of improved patient safety, health care outcomes, and patient/caregiver satisfaction. Please refer to the Appendix for a detailed rationale for each principle outlined below.

## Methods

The Council, charged with identifying issues germane to internal medicine and its subspecialties that, through its actions, will improve the health and quality of medical care and enhance the practice of medicine, drafted this position paper. The Council consists of members of societies representing 24 subspecialties of internal medicine. A full list of the societies represented on the Council are listed in the Appendix. A subgroup of the Council reviewed existing consensus guidelines, measures, and models to improve care transitions (see the Appendix). Principles were developed based on the reviewed literature and input from ACP's Board of Governors and Board of Regents. This policy paper and principles were approved by ACP's Board of Regents on February 28, 2023.

## Principles

- 1. ACP recommends health care professionals engage in conversations with patients and families around factors that influence patient goals during care transitions.**
  - a. Factors important during care transitions include protective factors (patient and caregiver values [e.g., cultural, religious, and spiritual support systems], level of frailty, functional impairment, cognitive impairment (including dementia and delirium), medical comorbidity and complex needs (e.g., end-stage organ failure), mental health, and prognosis and life expectancy.
  - b. ACP encourages the collection of more robust data on costs and on care transition outcomes of interventions, including outcomes on the health care professional and patient, and caregiver satisfaction with the transition.
  - c. Care transitions often represent changes in a patient's clinical, cognitive, or functional status and provide opportunities to evaluate goals of care, code status, and other long-term goals.
- 2. ACP recommends that successful care transition interventions (e.g., model, framework, or standard) address social drivers of health (SDOH) with the goal of decreasing health inequities.**

- a. ACP urges the Centers for Medicare & Medicaid Services and the National Center for Health Statistics to establish adequate ICD-10-CM nomenclature and payment for SDOH codes.
  - b. ACP supports incorporating SDOH into payment model design, including risk adjustment methodology.
  - c. ACP supports extensive research to determine transitional care measures that consider SDOH.
- 3. ACP recommends expanding the scope of transitional care activities to include the total care trajectory during an episode of illness (e.g., the journey the patient experiences from the start of medical care to the end of the episode).**
- a. ACP believes that the entirety of the total care team (e.g., physician, care coordination support staff, home health providers, pharmacists, social workers, rehabilitation therapists, and case managers, etc.) must collaborate to achieve these goals.
  - b. ACP recommends that the total care team identify follow-up appointments (including specialty care) and any prior authorizations (for testing or therapies) that started elsewhere in the total care trajectory.
- 4. ACP recommends clear communication among all members of the clinical care team as critical for optimal care transitions. Communication must highlight the most critical information, summarize the most important points, and avoid information overload.**
- a. ACP believes that one member of the total care team should be designated the "point person" to oversee care coordination.
  - b. ACP supports avoiding information overload and providing written documentation of any information communicated, which ensures that patients/caregivers are equipped and prepared to execute discharge instructions.
  - c. ACP believes physicians should encourage the preparation of a centralized source of information (e.g., transition folder and online portal) in the patient's preferred language and communicate with the patient and necessary parties what to expect before, during, and after a transition in both verbal and written form. An electronic central repository can be an additional asset to patient care coordination, and in certain cases, the patient/caregiver can be the central repository.

## Challenges and Opportunities Unique to Specific Care Transitions

Depending on the origin and destination of a patient's care trajectory, key challenges and opportunities exist across settings in addition to barriers between specific care locations. Regardless of location, potential barriers to all care transitions include elements of access, including but not limited to socioeconomic disparities, systemic racism, lack of a support system, delayed access to the transition site, food insecurity, and lack of electronic system interoperability. System-level barriers to improved transitions include inadequate ICD-10-CM nomenclature for SDOH, inadequate model metrics, and the lack of SDOH data integration into risk adjustments. An increasing number of Americans do not have a primary care physician. Access to primary care services and a primary care

physician remains a widespread barrier, particularly for historically and presently underserved populations.

Without patient/caregiver understanding of diagnosis, prognosis, and next steps, prepared materials may be inaccurate. Often, the materials shared with patients are medically accurate but unrealistic and/or difficult to follow for patients/caregivers if they are not involved in the discussion. Access to reliable and safe housing and transportation, health and digital literacy, risk perception, and access to a caregiver may all impact the ability or inability of the patient to prepare a folder with relevant and necessary medical information.

The total care team should be a physician-led, patient-focused care coordination system with responsibility for improved health outcomes shared among team members (physician, care coordination support staff, home health providers, pharmacists, social workers, rehabilitation therapists, case managers, etc.) and the patient/caregiver. There are practical barriers to achieving the goal of collaborative communication, which many payment models do not adequately incentivize. For example, while health care interoperability has made significant strides, much remains to be done. While efforts such as the 21st Century Cures Act have shown promise, safety and privacy considerations remain. Federal funding and implementation of updated and utilizable state-level Health Information Exchanges have the potential to improve safe care transitions, particularly between various health systems as patients will often have primary care and specialists and imaging at various health systems and practices. Other contributing factors, such as role ambiguity within a total care team, can have adverse consequences, including ineffective collaborative communication. Often referred to as the “bystander effect,” without clear delineation of responsibilities within a care team, team members will erroneously assume someone else will address the problem at hand. Additionally, many individual clinical information systems (electronic health records [EHRs], imaging platforms, etc.) do not communicate with each other. Neither the individual data elements nor the data formatting with systems is uniform throughout the health care industry. In all cases, the physician initiating the transition of care has an ethical and legal obligation to ensure the transition goes as smoothly as possible.<sup>16</sup>

There are several unique transitions that require particular attention. The recommendations below address the specific needs of the total care team, the patient/caregiver, and their community.

#### *Transition to Home, Community, or Hospice*

When the care transition destination is the patient’s home, community, or hospice, the patient’s needs are specific and vary significantly due to disease state, living situation, and other unique local conditions. General considerations include the identification of the final discharge destination, determination of modifications needed for adjustment into the home/ community (handrails, lifts, etc.), arrangement of home health care services (e.g., nursing, rehabilitation therapy, social work), and in-clinic follow-up when necessary. To establish collaborative communication between the patient, caregivers, and total care teams, the discharge professional or hospital pharmacist should coordinate all medications with the patient’s pharmacy and the patient’s primary care physician or physician’s office. Additionally, a member of the total care team should partner with community-based organizations or community health workers in the destination area.

### *Transition to Skilled Nursing Facility (SNF)/Long-Term Care (LTC)*

Upon entering an SNF/LTC, rehabilitation goals should be established promptly and communicated to the patient/caregiver. Follow-up information should be sent directly to the destination facility and given to the patient/caregiver (i.e., not relying solely on an interim provider, such as paramedics). To assure that communication remains clear across locations, the care coordinator should be included in discharge communications.

The discharge professional or hospital pharmacist should coordinate all medications with the patient's pharmacy and primary care physician or physician's office. A member of the total care team should partner with community-based organizations or community health workers in the destination area to determine their desire and ability to assist with the patient's recovery.

One must consider the impact of public health emergencies (e.g., pandemics, natural disasters) on transitions to SNF/LTC. During COVID-19, many LTC facilities required a 14-day quarantine for new patients or stopped allowing visitors altogether, potentially disrupting patient routines, interrupting information transfer, and adding to stress levels<sup>17, 18, 19</sup>.

Additionally, there may be discrepancies in the amount of information facilities receive from hospitals or from the patient/caregiver. SNF/LTC facilities cannot provide the best care to patients without a medications list, summary of recent procedures and results, contact information for the primary care physician and/or specialists, etc. As soon as possible, a care coordinator should be identified and included in all communications.

### *Transition to ED*

Due to the nature of variability and severity of ED visits, it may not be possible to communicate vital information to ED staff. However, emergency clinicians need a medications list, emergency contact information, contact information for total care team members, and a reason for the visit. If the patient is received from a physician's office or outpatient clinic, essential information such as this should be included on discharge papers and provided to the ED clinicians. This highlights the importance of creating a central repository with such critical information. As highlighted in Principle 4c of this document, the patient can be the central repository, and an electronic central repository (e.g., EHR or patient portal) can be an additional asset to patient care coordination.

The primary physician-patient relationship may be unintentionally overlooked in the ED. ED staff generally have limited contact/communication with patients/caregivers at home, and they do not typically have a longitudinal relationship with the patient. Due to these limitations, it is important to ensure complete health information is transferred from ED to primary care staff.

### *Telehealth Considerations in Care Transitions*

Because health insurance plans and Medicare coverage vary by jurisdiction, crossing state lines may increase physician burden and increase the chances of health information being lost, potentially impacting the patient's care. Rural and urban areas have variations in technologies and systems, which may significantly impact health data continuity and access.

Telehealth may provide a mechanism to enhance patient-physician collaborations, improve health outcomes, increase access to care from physicians and members of a patient's total care team, reduce medical costs when used as a component of a patient's total care trajectory, and consequentially improve care transitions. Telehealth can be most efficient and beneficial when appropriately utilized in the context of an existing and ongoing patient-physician relationship and can serve as a reasonable alternative for patients who lack in-person access due to circumstantial factors, such as transportation limitations or lack of relevant medical expertise in their geographic area.

## Summary

While studies have addressed approaches to improving care transitions between settings, ACP desired to establish principles of best practice. This paper established four driving principles for improving care transitions and discussed challenges and opportunities unique to specific care transitions. Furthermore, this paper provides recommendations that support successful care transitions between settings with the goal of improved patient safety, health care outcomes, and patient/caregiver satisfaction. Core elements of successful care transitions involve patients in the discussion; account for coordination among multiple care teams across various health care settings<sup>20, 21</sup>; ensure effective communication throughout care teams (physician-led and including patient or surrogate involvement when possible)<sup>22</sup>; define care team roles clearly<sup>23</sup>; and promote availability of accurate clinical data to patients/caregivers and care teams;<sup>24</sup> appropriate patient/caregiver education on important aspects of care;<sup>25</sup> and health information technology system interoperability<sup>26, 27</sup>.

These recommendations represent a call to action for stakeholders to improve transitional care; physicians to engage in conversations with patients and families on care goals; policymakers to address the SDOH affecting transitions; researchers to inform comprehensive transitional care metrics and payment model development; attention to the social, economic, and cultural forces that impact the individual and intergenerational health of marginalized populations during care transitions; and efforts to support clinical care teams to be informed of the patient's total care trajectory and prioritize clear and concise communication across sites of care.

## Appendix

### **Background: Fundamental Principles for Successful Transitions Across Health Care Settings**

In this paper, we refer to care transitions as shifting patients from one type of care to another (e.g., hospital to home), consistent with themes from definitions from the Centers for Medicare & Medicaid Services and the National Transitions of Care Coalition<sup>28, 29, 21</sup>. The concept of patient movement is fundamental, whether it is physical movement between care settings or a change in the level of patient care required within the same care setting.

In examining national care transition patterns between inpatient and outpatient care settings, researchers have found that approximately half of all older adults' transitions involve a transition to or from a hospital, with the other

half of older adults' transitions including other settings with patterns that were not easily predictable<sup>30</sup>. Up to one fifth of patients experience an adverse event within 2 weeks of hospital discharge<sup>31, 32</sup>. When examining Medicare patients' hospital-to-SNF transitions, over 23% of patients were readmitted within 30 days<sup>33</sup>. Similarly, lack of clarity in clinical records and miscommunication between care teams can lead to errors related to necessary postdischarge follow-up, medications, durable medical equipment, and other orders during patients' care transitions<sup>34</sup>.

Care transitions remain a challenge for health care professionals, patients, and families. Addressing each patient's needs with attention, personalization, and awareness of their total care trajectory is a foundational element of successful care transitions. Collaborative communication between the patients, caregivers, and total care teams must be established to improve care transitions, regardless of the location of the origin or destination of the patient's care journey. The physician is not expected to achieve the desired goals of these recommendations alone. One way to mitigate burden and improve the effectiveness of these recommendations is to utilize a care team and available technology to support communication and coordination.

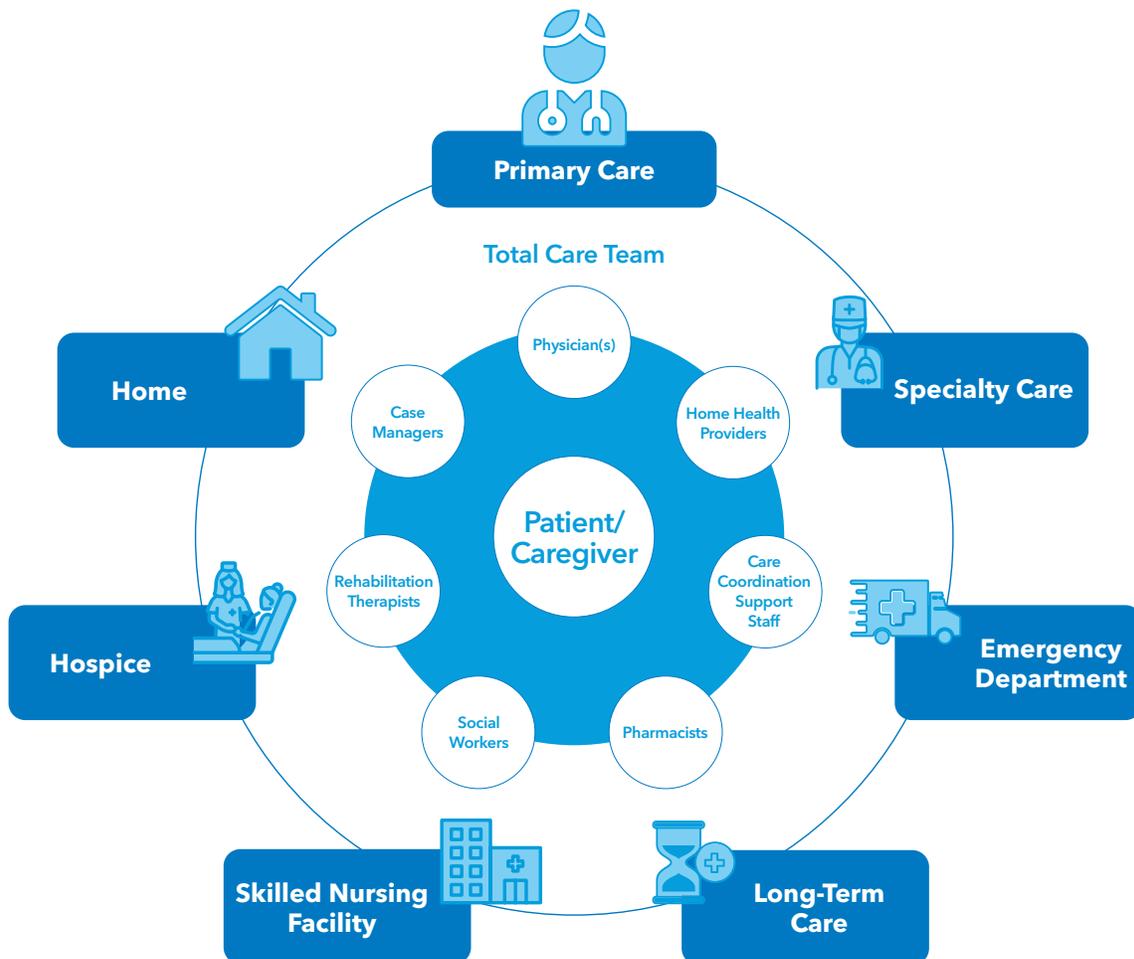
The potential impacts of improved care coordination go beyond improved health outcomes for the patient and decreased burden upon clinicians. In *Envisioning a Better Health Care System for All*, ACP emphasizes that care coordination, patient-reported experience, and outcome measures must be effectively incorporated into performance measurement and value-based payment. The College further recommended that a positive first step would be to develop a single set of standards to evaluate the validity and trustworthiness of all performance measures by a neutral third party.

We acknowledge that the barriers to practical implementation of these recommendations are numerous and complex. Inadequate reimbursement to cover the cost of the total care team remains a significant barrier to implementation. Utilization of codes, such as transitional care management, can help bridge this gap.

Regardless of location, from the moment a patient first seeks health care, that individual should be treated as a whole person with specific needs, circumstances, and desires. Regardless of their gender, sexuality, ethnicity, living condition, cognitive/social atypicality, or economic position, that individual should receive the best care available to them. Only through recognition of and action against the biases that remain for people of color, people with disabilities, LGBTQIA+ individuals, and other underserved populations can more equitable health care be achieved during care transitions. These considerations are foundational when determining optimal care coordination. Additionally, having access to and understanding the individual's total care trajectory ensures the most comprehensive and accurate assessment of the many factors that may potentially impact their care. The greater the communication between patients and their health care professionals, the greater the opportunity for personalized, patient-centered, whole-person care.

The final principle of optimal care transitions is the creation and utilization of a total care team. Though there are many variations of how to implement such a team, the paper provides the recommendation to identify a point person for the patient to review all necessary information with the patient/caregiver and

provide a paper and/or digital copy of instructions to all parties. Communication is foundational to the recommendations outlined throughout this paper.



### *Importance of Care Transition Measures of Quality*

Having clear metrics for care transitions is important to measure and evaluate patient and caregiver outcomes. Current measures of care transition quality are incomplete and do not provide real-time feedback for health systems. Approaches to assessing the quality of care transitions vary due to the different transitions a patient can experience, with each measure having limitations. Descriptions of various measures, and some of their limitations, are included below. Note that measures currently in use are associated with a time lag (often collected days to weeks after a care transition) limiting the ability to act before a patient may experience harm. Furthermore, existing measures may incompletely capture components of care transitions<sup>35</sup>. While these measures do not directly address SDOH as these measures predated the prevalence of research on SDOH in literature, it is imperative that SDOH are integrated with the explicit and intentional goals of social equity and justice and elimination of social determinants of health.

<b>Table 1: Care Transition Measure Descriptions</b>		
	<b>Description</b>	<b>Limitations</b>
<b>Care Transition Measure (CTM)</b>	<ul style="list-style-type: none"> <li>Used for assessing the quality of a patient’s transition from an inpatient facility to home in the first 30 days following discharge<sup>36,37</sup></li> <li>Includes a full and a reduced version with fifteen or three measures, respectively (often referenced as CTM-15 or CTM-3)</li> <li>A hospital-level measure of performance that reports the average patient-reported quality of preparation for self-care response among adult patients discharged from general acute care hospitals within the past 30 days<sup>38</sup></li> </ul>	<ul style="list-style-type: none"> <li>Psychometric challenges may limit the value of the CTM<sup>39</sup></li> </ul>
<b>Patient Assessment of Integrated Elderly Care (PAIEC)</b>	<ul style="list-style-type: none"> <li>An adjusted version of the Patient Assessment of Chronic Illness Care (PACIC) that is specifically designed for older populations<sup>40</sup></li> </ul>	<ul style="list-style-type: none"> <li>Like the PACIC, has good coverage of a high number of important domains but does not assess care involvement, single point of contact/case manager, and consistency of contact<sup>41</sup></li> <li>Needs further examination to determine why women reported lower quality of care than men<sup>41</sup></li> </ul>
<b>Medical Home Care Coordination Survey (MHCCS)</b>	<ul style="list-style-type: none"> <li>Highlights the importance of care coordination and addresses the issues in CC within PCMH in outpatient settings<sup>42</sup></li> </ul>	<ul style="list-style-type: none"> <li>Needs additional study of the “Self-Management” and “Home Healthcare” domains that were statistically rejected in the original research<sup>42</sup></li> </ul>
<b>Partners at Care Transitions Measure (PACT-M)</b>	<ul style="list-style-type: none"> <li>Patient-reported questionnaire for older adults</li> <li>Has a component to capture the immediate postdischarge period and a second component to assess the experience of managing care at home</li> </ul>	<ul style="list-style-type: none"> <li>Needs further data from additional participants to expand the generalizability of its findings<sup>37</sup></li> </ul>

### *Models of Understanding Care Transitions*

A variety of models seek to improve care transitions using fundamental principles, including several that demonstrate consistent effectiveness when systematically tested. We outline these models below and also highlight some of their limitations. Similar to care transitions measures, these models do not explicitly address SDOH as these models predated the prevalence of research on SDOH in literature, and it is imperative that SDOH are integrated with the clear and deliberate goals of social equity and justice and elimination of social determinants of health.

<b>Table 2: Care Transitions Models</b>		
	<b>Principles</b>	<b>Limitations</b>
<b>Patient Centered Medical Home (PCMH)</b>	<ul style="list-style-type: none"> <li>Focuses on patient-centered care coordinated by the patient's primary care physician to facilitate a collaborative environment for all care team members<sup>43</sup></li> </ul>	<ul style="list-style-type: none"> <li>No evidence of overall cost savings<sup>44</sup></li> <li>Low strength of evidence of a reduction in hospital admissions<sup>44</sup></li> </ul>
<b>Care Transitions Framework (CTF)</b>	<ul style="list-style-type: none"> <li>Builds on the PCMH previous adaptations of the Consolidated Framework for Implementation<sup>50</sup> Research (CFIR) for process redesign for efficiency and cost reduction<sup>45</sup></li> <li>The stated purpose of the framework is to "guide research and evaluation of care transitions implementation within a broad range of organizational settings to address questions of how, why, and where care transitions interventions succeed or fail to achieve intended outcomes, and whether the framework components can be replicated and scaled to other settings." It originally focused on transitions from hospital to ambulatory care settings but evolved to include community-based service organizations, which can play a central role in a successful transition to the home<sup>45</sup></li> </ul>	<ul style="list-style-type: none"> <li>Issues related to implementation include trouble engaging hospital staff to fully understand the program's goals and scope of services (especially when making referrals), lack of patient awareness of the program, and eligibility criteria changes throughout the program<sup>46</sup></li> </ul>
<b>Care Transitions Model (CTM)</b>	<ul style="list-style-type: none"> <li>A short-term model that relies on "a systems' care team" and introduces the concept of a "Transitions Coach"<sup>47</sup></li> <li>The Coach assists the patient in developing self-care and advocacy skills and strives to restore higher levels of patient autonomy and transparency<sup>48,49</sup></li> <li>The Coach performs a more supportive role than in other models<sup>48</sup></li> <li>Conservative estimates reflected cost savings<sup>48</sup></li> </ul>	<ul style="list-style-type: none"> <li>Need for more widespread testing/application to see long-term outcomes in various settings<sup>48</sup></li> </ul>
<b>Transitional Care Model (TCM)</b>	<ul style="list-style-type: none"> <li>Builds upon the PCMH</li> <li>Nurse-led, team-based intervention</li> <li>Focused on improving care, enhancing patient and caregiver outcomes, and reducing costs among vulnerable, chronically ill, older adults identified in health systems and community-based settings</li> <li>Patients who participate in the TCM have fewer rehospitalizations in the 6 months following discharge<sup>50</sup></li> </ul>	<ul style="list-style-type: none"> <li>Intervention has been shown to not reduce difficulty with activities of daily living<sup>51</sup></li> </ul>
<b>INTERACT (Interventions to Reduce Acute Care Transfers)</b>	<ul style="list-style-type: none"> <li>INTERACT is a toolkit designed to assess acute changes in condition in nursing home residents</li> <li>High implementation of the program reduces hospitalizations up to 24%<sup>52</sup></li> </ul>	<ul style="list-style-type: none"> <li>Low or moderate INTERACT use had statistically insignificant changes in hospitalizations and ED visit rates<sup>53</sup></li> </ul>

In addition, new, innovative care transition models are constantly being developed and tested, such as the PATient Navigator to rEduce Readmissions (PARTNER)<sup>54, 55</sup>—a care transitions model focused on assisting institutions that

serve racial and ethnic minorities to increase support for patients (and caregivers) as they prepare to transition out of the hospital to a new care setting. PARtNER offers assistance in two ways—a community health worker serves as patient navigator while a patient is hospitalized/being discharged, and a peer coach (via telephone) guides the patient through any health-related social needs for up to 7 weeks post discharge.

#### *Consensus Guidelines Summarizing Fundamental Principles*

Beyond model development, professional associations have also collaborated to form consensus standards. The Transitions of Care Consensus Conference was developed jointly by the ACP, Society of Hospital Medicine, Society of General Internal Medicine (SGIM), American Geriatric Society (AGS), American College of Emergency Physicians, and Society for Academic Emergency Medicine. SGIM, AGS, and the Society for Post-Acute and Long-Term Care Medicine (formerly known as the American Medical Directors Association or AMDA) also collaborated to create the *SGIM-AMDA-AGS Consensus Best Practice Recommendations for Transitioning Patients' Healthcare from Skilled Nursing Facilities to the Community*<sup>56</sup>. These consensus standards describe necessary components for efficient implementation, including coordinating clinicians, care plans/transition records, communication infrastructure, standard communication formats, transition responsibility, timeliness, community standards, and measurement<sup>56, 57</sup>.

## **Rationale**

- 1. ACP recommends that health care professionals engage in conversations with patients and families around factors that influence patient goals during care transitions.**
  - a. Factors important during care transitions include protective factors (patient and caregiver values [e.g., cultural, religious, and spiritual support systems]), level of frailty, functional impairment, cognitive impairment (including dementia and delirium), medical comorbidity and complex needs (e.g., end-stage organ failure), mental health, and prognosis and life expectancy.
  - b. ACP encourages the collection of more robust data on costs and on care transition outcomes of interventions, including outcomes on the health care professional and patient, and caregiver satisfaction with the transition.
  - c. Care transitions often represent changes in a patient's clinical, cognitive, or functional status and provide opportunities to evaluate goals of care, code status, and other long-term goals.

Each patient's unique needs, circumstances, and desires should be sought and considered when devising a culturally competent care transition plan. This includes understanding patient and family expectations for recovery at the next site of care (e.g., how often they will be seen by a physician, who oversees arranging follow-up appointments, and who will review test results). Engaging and helping prepare the patient/caregiver to self-advocate creates patient empowerment and improves health outcomes<sup>58</sup>. Care transition navigators, coaches, and guides can assist with setting patient-centered goals.

Maximizing patient/caregiver involvement through the affirmation of the patient's dignity, individuality, and participation in care planning and informed

decision making are fundamental values that contribute to successful care transitions. Encouraging the patient/caregiver to take charge of understanding and executing their treatment plan increases communication and collaboration among all members of care teams. Understanding the schedule of events (e.g., upcoming tests, follow-up appointments, anticipated changes in medications or treatments) around care transitions allows each patient to contribute to their care and recovery, which improves patients' health, the experience of care, and economic outcomes<sup>59</sup>.

User-friendly forms of communication are key to patient/caregiver engagement and empowerment; for example, using literacy-appropriate language in directions and summaries of the transition of care plans. Cultural sensitivity and humility, particularly the availability of health records and instructions in a patient's preferred language, are important to maintain this principle<sup>60</sup>. Additionally, in 2017, the College highlighted the need for patient and family education, engagement, and health literacy efforts and called for materials to reflect the linguistic and cultural characteristics of patients in "Patient Safety in the Office-Based Practice Setting."<sup>58</sup> The combination of the aforementioned efforts is made relevant to patient-centered goals by increasing cultural competency and strengthening the physician-patient relationship.

**2. ACP recommends that successful care transition interventions (e.g., model, framework, or standard) address SDOH with the goal of decreasing health inequities.**

- a. ACP urges the Centers for Medicare & Medicaid Services and the National Center for Health Statistics to establish adequate ICD-10-CM nomenclature and payment for SDOH codes.
- b. ACP supports incorporating SDOH into payment model design, including risk adjustment methodology.
- c. ACP supports extensive research to determine transitional care measures that consider SDOH.

Although there are many definitions of SDOH, most include these key elements: socioeconomic status, education, health literacy, employment/job security, nutrition/food security, housing, and access to quality health care at an affordable cost. As explored in "A Comprehensive Policy Framework to Understand and Address Disparities and Discrimination in Health and Health Care: A Policy Paper From the American College of Physicians," research has shown that Black, Indigenous, Latinx, Asian American, Native Hawaiian, Pacific Islander, and other persons in the United States experience disparities in health and health care associated with their race, ethnicity, religion, and cultural characteristics and identities<sup>61</sup>.

Within care coordination and care transitions, SDOH demonstrate specific impacts on successful care. Unplanned health care utilization after a care transition can be related to lack of adequate social support or limited access to what patients need to maintain their health (e.g., nutrition, medications, rehabilitation therapy). Moreover, it is difficult to identify SDOH risk factors readily in the EHRs to anticipate patients' needs.

As noted above, care coordination and care transitions are being evaluated and measured through models that predate the focus on SDOH. As SDOH become better understood and integrated into health care models, tools that help bridge the care transition gap will increase in relevance if they too

incorporate measures and risk adjustment for SDOH. Integrating individual-level SDOH into EHRs via ICD-10-CM can assist in risk assessment and predicting health care utilization and health outcomes<sup>62</sup>.

It is also important to consider the implications of including SDOH risk adjustments in models. While it is important not to penalize those who care for historically and presently underserved and medically complex patients, it is also crucial to effectively incentivize and reward improved care. For those who provide care to these patients, many must work against unaddressed system-level problems and processes that are out of their control. SDOH should never be utilized as an excuse for poor performance metrics. Instead, research and piloting payment models should incentivize and reward care, which reduces health inequities.

**3. ACP recommends expanding the scope of transitional care activities to include the total care trajectory during an episode of illness (e.g., the journey the patient experiences from the start of medical care to the end of the episode).**

- a. ACP believes that the entirety of the total care team (e.g., physician, care coordination support staff, home health providers, pharmacists, social workers, rehabilitation therapists, case managers, etc.) must collaborate to achieve these goals.
- b. ACP recommends that the total care team identify follow-up appointments (including specialty care) and any prior authorizations (for testing or therapies) that started elsewhere in the total care trajectory.

It is important to note that physicians can and should not facilitate these complex coordination efforts alone; other members of the total care team should ensure that the work is accomplished. Knowledge of the patient's total care trajectory can enrich the patient-clinician relationship, increase patient retention, and decrease greater health care costs by directing unnecessary ED trips to primary care or specialty care clinicians. The total care team must first identify where a patient resides on their overall care trajectory at the time of intake. Obtaining a full and accurate medication list is crucial for optimal care, given potentially different formularies (e.g., hospitals vs. outpatient facilities) and patient medication modifications based on access (e.g., transportation) and changing needs (e.g., increasing/decreasing dosage). Important elements of comprehensive total care include bidirectional communication across settings, the inclusion of the entirety of the care team, long-term continuity of care, and ease of returning to the community.

**4. ACP recommends clear communication among all members of the clinical care team as critical for optimal care transitions. Communication must highlight the most critical information, summarize the most important points, and avoid information overload.**

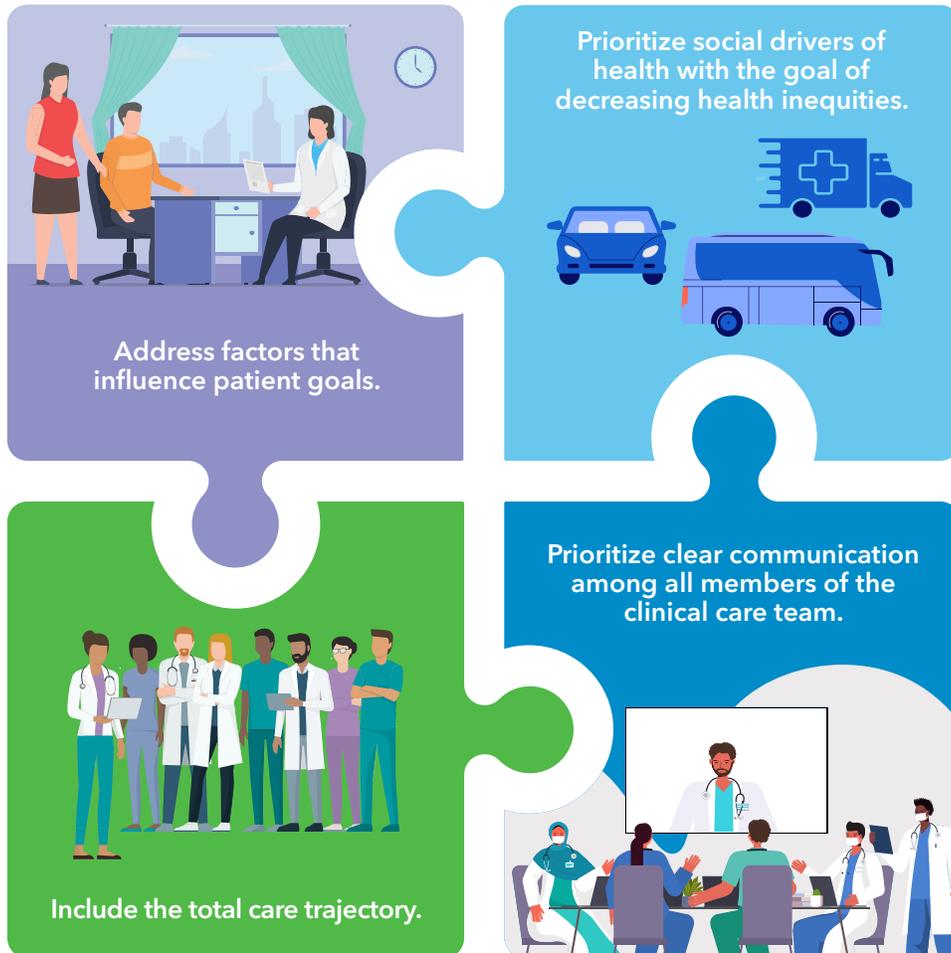
- a. ACP believes that one member of the total care team should be designated the "point person" to oversee care coordination.
- b. ACP supports avoiding information overload and providing written documentation of any information communicated, which ensures that patients/caregivers are equipped and prepared to execute discharge instructions.
- c. ACP believes physicians should encourage the preparation of a centralized source of information (e.g., transition folder and online

portal) in the patient's preferred language and communicate with the patient and necessary parties what to expect before, during, and after a transition in both verbal and written form. An electronic central repository can be an additional asset to patient care coordination, and in certain cases, the patient/caregiver can be the central repository.

In ACP's paper *Principles Supporting Dynamic Clinical Care Teams*, a clinical care team "consists of the health professionals—physicians, advanced practice registered nurses, other registered nurses, physician assistants, clinical pharmacists, and other health care professionals—with the training and skills needed to provide high-quality, coordinated care specific to the patient's clinical needs and circumstances."<sup>20</sup> A team-based approach to care transitions requires defining roles for each team member (regardless of location), including the patient/caregiver. Specifying which care team member manages which tasks at which facility is superior to merely relying on titles alone and assuming task assignments. One member of the total care team should be designated the "point person" to oversee care coordination. The "point person" could be the patient's primary care physician, a senior coordinating physician, nonphysician health care professional, coordination support staff (e.g., care navigators), or a specialty physician, depending on the patient's needs. Coordinated specialty engagement (e.g., specialists, hospitalists) is critical to supporting the patient. The "point person" should be responsible for communication with the specialty care teams involved in the patient's care and work with them to make sure that all needed follow-up appointments and tests are scheduled, including the designation of a primary care physician.

Once discussed within the total care team, information should be communicated with the patient/caregiver and any other necessary parties to develop clear expectations of each person's role. In more complex situations (e.g., situations of diagnostic uncertainty, clinical urgency, or transmission of sensitive information), direct physician-to-physician conversation can help to facilitate the transition. In all transition conversations between the total care team, members should invite reports of errors and miscommunication during care transitions and treat them as concerns that must be dissected in order to promote systemic changes in improving patient safety. Known best practices for discharge communication, such as "teach-back," are also encouraged.<sup>63</sup> Patients and their family members/caregivers must also understand their responsibilities. To ensure patient preparedness, the point person identified should review all necessary information with the patient/caregiver (and other family members if necessary) and provide a paper and/or digital copy of instructions (preferably both) to all parties in their preferred language. While in certain cases the patient/caregiver may function as the central repository of information, considerations such as medical literacy and information retention (memory) should not be lost, especially when dealing with multiple chronic conditions or in the case of a traumatic health event. Efficient information management means sharing among all parties; however, the lack of Certified Electronic Health Record Technology/Health Information Technology interoperability is a major barrier, while safety and privacy considerations remain.

Researchers have described key aspects of information management to address during care transitions: information underload, information overload, information scatter, conflicting information, and erroneous information<sup>64, 65</sup>. The most relevant and action-oriented information needs to rise to the top of information dissemination to the patient/caregiver. It can be difficult to manage the balance of providing key information needed to transition patients successfully without overwhelming the patient/caregiver with “data dump” fatigue. Avoiding information overload and providing written documentation of any information communicated ensures that patients/caregivers are equipped and prepared to execute discharge instructions. Interoperability, mutual respect, and a culture of shared accountability all have an impact on safety, privacy, and ultimately the health and well-being of the patient.



## **Council of Subspecialty Societies Member Organizations**

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