Transitions of Care

HIT Steering Committee

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Agenda

Transitions of Care - Challenges

- **Multiple summary of documents requirements** – Hospitals send multiple documents and forms through manual and electronic workflows in order to meet multiple regulatory, quality improvement requirements.
- **Timeline to share documents** – Hospital transition of care documents have inconsistent expected timeframes for delivery to Community Providers from 24 hours to 30 days.
- **Document length** – Primary care providers (PCPs) are overwhelmed when receiving hundreds of pages of forms. Providers must repeatedly review extensive documents and often must rely on the patient for information.
- **Inconsistency of information sent** – Multiple forms and lack of data standardized elements among hospital senders creates confusion and significant burden for Community Providers for reviewing the key patient information. The information sent in an inconsistent order, as well as transport method (i.e., secure email, fax, paper) causes significant burden for providers and care teams to extrapolate the key information for follow up services.
- **Identifying community provider and care team** – Sender often does not know who the appropriate coordinator is in the community. Maintaining current practice locations and provider information is a challenge on both sender and receivers.
- **Workflow and operations** – There are a lack of knowledge of processes for which documents, forms, and information is needed for which use case.
- **Lack of resources** – Both senders and receivers have limited resources and bandwidth to support efficient care transitions with the lack of concise medical information shared across settings.

Transitions of Care - Approach

In 2020, RIDOH in collaboration with EOHHS held working sessions with Rhode Island community health care partners (including hospitals, community providers, nursing facilities etc.) to discuss and develop recommendations on Transitions of Care expectations for RIDOH, with a goal to:

- Develop a Continuity of Care product that meets patient safety objectives and supports implementation of Transitions of Care Best Practices across care settings.
- Considers payer mandates and incentives related to EMR's and transitions of care
- Recognizes identified technological challenges and opportunities to reduce provider burden

Transitions of Care – Use Cases

Use Case #1
ED/Hospital Discharge to Community Providers

- Communicating information to community care team providers (e.g., PCP, specialists, behavioral health)
- Info includes care transition plan to care team providers, summary of care, discharge summary

Use Case #2
Hospital to Non-Hospital Facility (LTC, SNF, HHA, etc)

- Communicating care summary and care transition plan for patient transfer from setting to settings (e.g., hospital discharge to rehab facility or skilled nursing facility (SNF))

Use Case #3
Non-Hospital Facility to Community Providers

- Communicating medical/service history across clinical and community providers

Use Case #4
Non-Hospital Facility to ED

- Communicating patient health history to inform emergency department upon patient arrival

Recommended Actions For RIDOH

Regulations	• No additional regulations needed
Directive & Guidance	• Provide publicly available directive guidance to Configure a common set of priority data elements at the top of all transitions of care documents
Implementation Resources	• Identify new, additional HIT RIDOH staff resources to drive the remaining ToC use case alignment, implementation, and ongoing coordination
Alignment	• Continue alignment across agency effort to support communication and coordination • Continue to align RIDOH regulations (e.g., discharge planning regulations) and periodically review new or relevant regulations for alignment; and identifying action plan for addressing misaligned regulations • Continue alignment with other ToC use cases • Include ToC in the State HIT Roadmap including the need for staff implementation of the recommendations • Stay informed on national policy alignment or impacts
Convening	• Continue convening regularly scheduled larger stakeholder meetings to work on additional use cases • Convene a Community Provider technical working group around a single style sheets presenting the aligned data elements

RIDOH Guidance from July 2021 - Priority Data Elements and Order

Recommended "Summary of Care to Community Providers" Admit/ED Discharges (human readable)
1. Patient Demographics
2. Encounter Location Type of Discharge (ED or Hospitals)
3. Admission/Discharge Dates and Time
4. Disposition (where patient discharged to)
5. Diagnoses (all hospital diagnoses at discharge)
6. Procedures (surgeries and invasive procedures, not detailed notes)
7. Pending Labs at discharge
8. Medications (summary of medications reconciled at discharge, discharge meds, start/stop from prior med list that patient came in on) detailed medication list lower in document
9. Diagnostic testing (short list of completed tests, labs, imaging tests - limit lookback on # of days and separate lab values from pending lab values
10. Provider Discharge Instructions and follow-up – care (to patient)

Letter to hospitals demonstrating compliance to guidance

- Discharge documents that have been revised to include the re-ordered Transition of Care (TOC) priority elements
- List of channels (such as electronic – EHR, non-electronic - Fax) and corresponding formats (paper, C-CDA)
- Corresponding list of recipients for each discharge document
- Corresponding timing for each discharge document (e.g., Upon discharge, within 24 hours of discharge, etc.)
- HIPAA-redacted copy of the Hospital's Continuity of Care (CoC) form with priority data elements identified and re-ordered per RIDOH's guidance
- Any feedback that was gathered from recipients of this information regarding transition of care challenges.

Questions