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COORDINATION OF CARE

Optimizing Care Transitions: Adapting Evidence-Informed Solutions to Local Contexts

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Ensuring safe and high-quality care transitions across the care continuum continues to be a global health policy priority. The urgency of this priority will continue to grow, given our aging population and the associated social and economic burden. Within this subset, older adults with complex medical conditions are at a higher risk for experiencing inadequate care transitions because of the frequency of interactions and lack of a coordinated care plan. Inadequate transitions often result in poorer outcomes, including an increased risk in the first 90 days postdischarge of a return visit to the emergency department and/or readmission to the hospital,[1] adverse medication events,[2] functional decline,[3] and patient and caregiver dissatisfaction.[4]

To mitigate the inherent risk of poor outcomes associated with care transitions across the health care spectrum, there has been a reemergence and evolution of interventions[5,6] and guidelines.[7] The impact of interventions to improve care transitions ranges from promising to no statistically significant impact on health service utilization (for example, emergency room visits, length of stay, readmission rates), quality of care (for example, medication errors, inappropriate care, delays in care), and patient satisfaction.[6] The study reported by Scott et al. in their article, "Understanding Facilitators and Barriers to Care Transitions: Insights from Project ACHIEVE Site Visits," in this issue of *The Joint Commission Journal on Quality and Patient Safety,* was intended to identify the specific components and the contributing factors of effective care transition interventions.[8] The Achieving Patient-Centered Care and Optimized Health In Care Transitions by Evaluating the Value of Evidence project (referred to as Project ACHIEVE) is a national endeavor in the United States that brings together recognized leaders in health care, experienced researchers, patients, and caregivers to evaluate and determine which combination of care transition services is the most effective for certain patient populations within particular system and community contexts. The Scott et al. article provides the results of the first phase of Project ACHIEVE, in which 22 participating organizations across the United States delineated the facilitators of and barriers to implementation of transitional care services.

This comprehensive data set, which was gathered from semistructured individual and group interviews, observation, and document review, in one- to two-day site visits, elucidated key themes around the variation in transitional care approaches that emerged in cross-site analysis, with the majority of sites having multiple fragmented approaches or no formal approach. The key facilitators of, and barriers to, effective transitional care were described. To further illustrate the emergent themes, the Scott et al. article provides case studies demonstrating the variability among the sites, a "heat map" of frequency for the facilitators and barriers across the sites, and narrative excerpts from the interviews.

Although most of the findings in this study are not new, they would appear to represent a depiction that is consistent with the literature, in terms of what—despite best efforts to date—still needs to be done to achieve effective care transitions. Clearly, efforts that enhance the timely transfer of relevant information will improve the quality of care and eliminate the need for patients and families to take on the burden of coordinating care between various providers and services. One of the individuals interviewed commented that patients confronting fragmented transitional care are discharged "feeling as if they've been dropped off a cliff."[8(p. 442)]

The variability in the transitional care services that were provided—that is, in the "fidelity" of the intervention—across the participating sites needs further attention. This means looking at how best to reconcile the tensions inherent in trying to standardize transitional care services and in tailoring services to meet the needs and preferences of individual patients (and their caregivers when present). Further, the need to forge strong partnerships within the community and extend transitional services beyond the hospital, with a greater focus on social determinants of health, is paramount. Transformational solutions are required to provide alternatives to going to the hospital in the first place, being readmitted for exacerbations for recurrent chronic conditions, not being able to self-manage because of poor discharge instructions, and not being able to access services—the list goes on. Efforts to ensure that appropriate organizational and policy levers are in place include setting strategic priorities and accountabilities and designing appropriate funding models alongside other incentives that support effective transitional care services across the continuum and health and social sectors.

Finally, attention needs to be afforded to engaging those to whom care is provided to codesign transitional care interventions, regardless of where they are in the health care system. For example, there are promising signs that the Patient-Oriented Discharge Summary tool, which is used to engage

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patients and caregivers in a series of codesign activities, is increasing patient and caregiver satisfaction and improving clinical outcomes.[9]

Clearly, there is not one simple solution to ensuring effective transitional care. Multilevel efforts are required from government, community agencies, health care organizations, and health care professionals to authentically engage patients and their caregivers to ensure that they experience smooth and high-quality care as they make the transition through services across the care continuum.

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