TRANSITIONS OF CARE 2.0

TRANSITIONS OF CARE

Assessment and Implementation Tool Kit

Introduction

ACMA recognizes that improving care transition processes may be a difficult journey, whether you are a single care entity or a large multi-system. While Social Determinants of Health (SDOH) implications were addressed in the original 2019 Transitions of Care (TOC) standards release, the impact on health-related outcomes post-COVID-19 pandemic highlighted the need to revise the TOC Standards and Assessment tools to include additional SDOH assessments, strategies, and solutions.

In response, ACMA assembled thought leaders from across the continuum, representing health plans, academia, community, and acute care sectors to address the health care challenges related to Social Drivers of Health. Subsequently, both the TOC and the TOC Assessment were revised to expand strategies and solutions that address and incorporate SDOH.

The TOC Standards provide a common framework for effective, high quality, and efficient care transitions in all health care settings. The TOC Standards, when combined with the organizational assessment, help organizations assess, quantify, and identify opportunities around care transition processes applied across any care setting. Utilization of the TOC Standards and Assessment will promote improved patient outcomes. Updated TOC Standards and associated resources may be found at www.transitionsofcare.org.

In addition, the TOC website provides resources for TOC/SDOH-sensitive quality measures to guide data collection, which is especially important in value-based care models. Each TOC Standard identifies optimal process and outcome measures.

Now more than ever, addressing the vital resources needed for SDOH indicators (e.g., food, transportation, access), building and maintaining health care, and community relationships are essential to ensure smooth transitions across the continuum. Interoperability remains a challenge but is fundamental to supporting the bidirectional communication essential to smooth care transitions.

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Tool Kit:

The goal of the 2.0 Tool Kit is to offer education and guidance to assess, measure, and improve care transitions while taking into account SDOH. The content of the Tool Kit includes best practices, references, and resources to guide TOC professionals in their journey to improve care transitions.

To support organizations in their efforts to improve TOC, a Tool Kit was developed. The Tool Kit has four components:

1. Transition of Care (TOC) standards
    - The ACMA TOC standards provide a framework, applicable across all settings, to implement and evaluate a process to improve care transitions.
2. RACI Chart
    - A RACI chart clarifies accountability for each task, milestone, or decision in a project. RACI charts support collaboration on complex projects with multiple stakeholders.
3. SMART goals
    - SMART goals is a framework for setting goals that are specific, measurable, achievable, realistic, and time bound.
4. Other (for example PDSA Cycle)
    - The Plan – Do – Study - Act (PDSA) is a way to test a change that is implemented.

See Appendix for individual tools.

Who is this Tool Kit for?

The TOC Standards are applicable to any care setting and this Tool Kit is intended for any health care entity working to improve care transitions. Some care models that may find this information useful include:

- Acute Care Hospitals
- Community Health Agencies
- Integrated Health Systems
- Accountable Care Organizations
- Skilled Nursing Facilities/Long-Term Care
- Critical Access Hospitals
- Patient-centered Medical Homes
- Home Health Agencies
- Payors / Health Plans
- Behavioral Health

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TOC Performance Improvement Project:

1. Review the 2.0 TOC Standards on the https://transitionsofcare.org/.
2. Review any current organizational TOC measures/outcomes utilized in your organization.
3. Identify an Executive Sponsor and Key Stakeholders.
4. Download the TOC self-assessment tool from the TOC website.
5. Gather key stakeholders to participate in the 2.0 Transition of Care Standards Assessment.
6. Review results of the TOC Assessment.
7. Determine opportunities related to each TOC Standard.
8. Develop RACI chart.
9. Establish SMART goals.
10. Complete PDSA cycle.

TOC Tool Kit Case Study

Christine is an interim director at a 200-bed community hospital, which is part of a large system. She was engaged for a six-month contract to assess the case management department's strengths and opportunities around care transitions.

As a member of the American Case Management Association, Christine had previous experience as a leader in several organizations. Christine recalled hearing about the revised 2.0 TOC Standards from the last ACMA conference. She understood the TOC Standards/Assessment might help provide a method for assessing the status of care transitions at this hospital.

Christine reviewed the TOC website (https://transitionsofcare.org), the five TOC Standards, and associated metrics. She reviewed pilot case studies, a 2.0 TOC White Paper, and an implementation Tool Kit. Christine recognized that these were the resources she could use to assess the department's current state.

She downloaded the TOC Assessment tool from the website. After reviewing the information, she called a meeting with her peers in the ACO, home health, and community partners to discuss the self-assessment tool. Each of these care management leaders reported through separate divisions. The consensus was for each leader to complete the TOC Assessment for their respective areas and then compare results.

Each leader reviewed the TOC metrics on the website and identified the metrics they were accountable for managing. After a group review, they recognized a wide variation in the metric collection, as well as duplication of similar metrics. The post-acute leader had a dashboard to track metrics, but they were all receiving data from various sources and the reports were inconsistent.

After the TOC Assessment had been completed by all leaders, they met to compare their results. There were many competing priorities, and at first, each leader preferred to focus on a different standard. After conferring with their respective leaders, a recommendation to form an organization-wide steering committee was made by the Chief Medical Officer (CMO). The CMO served as the executive sponsor and provided regular updates regarding the project across all divisions.

After review, the committee agreed to focus on Standard 3, Perform and Communicate a Medication Reconciliation at each care transition, for each division. Key stakeholders from the pharmacy, physician leaders, quality and safety committee, performance improvement care coordinators, and key community partners were included to discuss the results of the assessment. The committee reviewed the initiatives outlined in Standard 3, as well as the Phase II tactics outlined in the TOC Tool Kit. The scope of their focus would be three initiatives under Standard 3.

The committee understood that medication reconciliation, communication, and community access are extremely important to patient safety, especially during transitions across care settings. Phase III tactics were reviewed, and a commitment was made to review quarterly progress, develop standard dashboards to monitor progress, and share best practices.

What began as a departmental assessment opportunity grew to become an organizational and community commitment to improving medication reconciliation and communication across their system of care.

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2.0 Tool Kit Resource

RACI Matrix Example

Definitions	
Responsible (R)	Individual(s) responsible to complete the task or deliverable work
Accountable (A)	The accountable party who ensures project is deemed complete
Consulted (C)	Individual(s) who provides input based on how it will impact their project work or their domain of expertise on the deliverable
Informed (I)	Individual(s) who needs to be kept in the loop on project progress, rather than into the details of every deliverable

Example: Mark each task/tactic as an "R," "A," "C," or "I" to identify who should be doing what for each task, milestone, or decision.

Project Activity/ Tactics or Deliverable	Executive Sponsor	Project Manager/ Leader	Nursing	Case Management	Quality/ Performance Improvement	Chief Medical Officer/ Physicians	Pharmacy	Post-Acute Partners
Formation of TOC Case Management Steering Committee								
Review Focus priority areas								
Download/ print self - assessment tool from TOC website								

Identify/ assemble entity subject matter expert (SME) to complete assessment								
Identify existing value-based care programs that currently exist within your organization (ACO, Bundled payment)								
Compare assessment scores by each TOC standard • Acute care • Entities within the organization (Home Health, SNF, ACO, Rehab, Ambulatory CM, etc.) • Identify and include key community stakeholders								
Identify (TOC) standard(s) with the greatest opportunity • Hospital • Entity • System • Community								
Prioritize areas for improving care transitions • Hospital • Entity • System • Community								
Select TOC Measure(s) to monitor improvement • Hospital • Entity • System • Community								

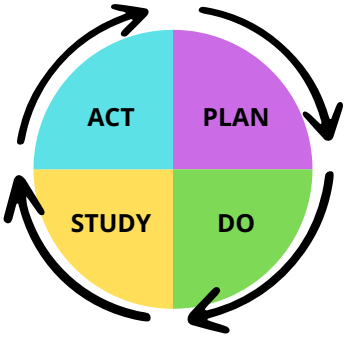
Identify practices to refine • Entity • System • Community								
Identify strategies to implement the change • Hospital • Entity • System • Community								
For each strategy, identify who will be accountable for the implementation and outcomes								
Communicate the plan; consider all key stakeholders								
Implement the plan								
Measure, review progress quarterly								
Monitor progress, revise as needed								
Complete a TOC post-assessment at 6 month or yearly interval								

Example of SMART Goal(s)

S SMART	**M** MEASUREABLE	**A** ATTAINABLE	**R** RELEVANT	**T** TIMELY
What do you want to accomplish?	How will you know when you have accomplished your goal?	How can your goal be accomplished?	Why is this goal important?	When will you reach this goal?
Evidence of medication reconciliation on date of discharge is complete	90% or > every patient will have a medication reconciliation completed at time of hospital discharge	Bedside RN ensures, prior to discharge, as part of process to check that MD has completed a medication reconciliation and that this has been reviewed with the patient and a copy is given to the patient or to next level caregiver	Ensure that the patient has the correct medication list (both prescribed and non-prescribed) and the patient/caregiver are aware and can speak to the list. This is a patient safety goal	Reinforced education with all key stakeholders (i.e., physician, physician extenders, bedside nurses), and completion in the discharge checklist with verification upon discharge using the "teach back" methodology with the patient/caregiver

TOC Performance Improvement Project:

The PDSA Cycle (Plan-Do-Study-Act) is a systematic process for gaining valuable learning and knowledge for the continual improvement of a product, process, or service. Also known as the Deming Wheel, or Deming Cycle, this integrated learning - improvement model was first introduced to Dr. Deming by his mentor, Walter Shewhart of the famous Bell Laboratories in New York (PDSA, 2024).



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