

Transitions of Care



What is meant by “Transitions of Care”?

The movement of patients between health care locations, providers, or different levels of care within the same location, as their conditions and care needs change



- **Across health states:** e.g., palliative care to hospice, or personal residence to assisted living
- **Between providers:** e.g., PCP to a psychiatrist, or acute care provider to a palliative care specialist
- **Within settings:** e.g., primary care to specialty care team, or intensive care unit (ICU) to ward/department
- **Between settings:** e.g., inpatient hospital to outpatient care, or ambulatory clinic to senior center

Source: NTOCC

Where are Transitions of Care in your Care Pathways?

Care Pathway

Screening & Assessment	Level of Engagement	Level of Service Criteria/Cost	Service Bundle	Length of Care/ Time to Tx	Target Parameters
Adult Male, 25yrs old Substance Addicted (nicotine) Depressed High Blood Pressure Unemployed Homeless	Maintenance/Relapse Prevention <hr/> Action <hr/> Preparation <hr/> Precontemplation & Contemplation	Low Intensity/\$ <hr/> Moderate Intensity/\$\$ <hr/> High Intensity/\$\$\$	Medication Cog. Beh. Therapy Smoking Cessation Care Management Supported Employment Assistance Housing Assistance	Low Intensity 0-9 Months <hr/> Moderate Intensity 9-18 Months <hr/> High Intensity 18 -28 Months	Smoking Cessation or Reduction BP w/in Normal Range PHQ-9 Score <10 Appt's Kept No Hosp. & ED Use Employment Housing Satisfaction

Care Transitions =

1. Across health states
2. Between individual providers
3. Within settings between departments/teams
4. Between settings



Care Transition (CT) Elements & Associated Metrics

Elements

1. Medication Management
2. Transition Planning
3. Client & Family Engagement
4. Information Transfer
5. Follow-Up Care
6. Healthcare Provider Engagement
7. Shared Accountability across Providers & Organizations

Metric Examples

1. Prescriptions filled by client
2. Number of CT meetings between CMH/hospital
3. Number of CT meetings with client/family/CMH/Hospital staff
4. CCD shared between providers
5. Appt scheduled within 7 days of hospitalization
6. Number of no-shows
7. Existence of & Metrics defined in BAA/MOU



Care Transition Target Metrics

Follow-up within 7 Days of Hospital Discharge

- All clients admitted to the hospital will be seen by a BH professional within seven days of discharge from the hospital

Numerator = # clients seen within 7 days

Denominator = all clients admitted to the hospital

Clients admitted to the hospital will have at least one Care Transition meeting

- All clients admitted to the hospital will have at least one Care Transitions meeting attended by ABC Hospital and XYZ staff

Numerator = # clients admitted to hospital how at least one CT meeting

Denominator = # clients admitted the hospital

Other metrics could be created based on what you and your Transition of Care partner decide!



Care Transition Data Dashboard

TRACKING PROGRESS AND ADJUSTING TREATMENT APPROACH

<p>Click here for Patient Tracking Spreadsheet Template resources</p> <p>1) EVERY time this worksheet is used, ensure all other versions of the template are CLOSED, and press "Ctrl+F" to refresh the page.</p> <p>2) Do NOT use the Caseload Overview if fewer than 2 ACTIVE patients are entered on the Patient Tracking worksheet.</p> <p>3) Do NOT change the number of rows or columns. If you need to make any changes to the table whatsoever (other than sort and filter), use the de-identified template provided at the link to the left.</p> <p>4) Be aware that at least one PHQ-9 score must be entered for a given record in order for that record's GAD-7 scores to display properly in the Caseload Overview.</p>																					
Treatment Status								Transitions of Care Status				PHQ-9				GAD-7				Psychiatric Case Review	
<p>⚠ The most recent contact was over 1 month (30 days) ago</p> <p>🔴 The next follow-up contact is past due</p>								<p>✅ CT Meeting Occurred, F/U provided w/in 7 days</p> <p>🔴 CT Meeting didn't happen; Not seen w/in 7 days</p>				<p>✅ The last available PHQ-9 score is at target (<5 or 50% decrease from initial score)</p> <p>🔴 The last available PHQ-9 score is more than 30 days old</p>				<p>✅ The last available GAD-7 score is at target (<10 or 50% decrease from initial score)</p> <p>🔴 The last available GAD-7 score is more than 30 days old</p>					
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Date Next Follow-up Due	Number of Follow-up Contacts	Weeks in Treatment	Date of Admit to ABC Hosp	Date of D/c from ABC Hosp	CT Meeting	7 day f/u appt	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Case Review Note
#N/A	Active	Beverly B	11/1/2016	11/12/2017	11/25/2017	0	3	11/15/2017	11/15/2017	11/15/2017	yes				No Score	-100	4274300%	10/24/2016	0		
View	RP	John Doe	1/15/2016	11/16/2016	12/16/2016	12	53					20	0	-100%	11/16/2016	14	1	-93%	11/16/2016		11/1/2016
View	Active	Susan Test	5/20/2016	1/2/2017	1/16/2017	10	35					22	15	-32%	1/2/2017	18	14	-22%	1/2/2017	Flag for discussion & safety	9/15/2016
View	Active	Joe Smith	11/1/2016	1/8/2017	1/22/2017	5	11					15	9	-40%	1/8/2017	11	7	-36%	1/8/2017		10/24/2016

FREE UW AIMS Excel® Registry (<https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data>)



XYZ CMHC & ABC Hosp: Transitions of Care Pathway

