



# Transitional Care Management: Connecting to Care

Why care collaboration at key turning points is  
critical throughout the care continuum

# Transition of Care Overview



Transitional care encompasses a broad range of services and environments designed to promote the safe and timely passage of patients between levels of health care, across care settings, and amongst various providers. Care settings can include a range of points of care such as hospitals, long-term care facilities, rehab centers, skilled nursing facilities, and home healthcare. Providers can include a variety of care team members such as physicians, specialists, nurses, care/case managers, pharmacists, visiting nurses, nutritionists, interpreters, and transportation assistants.

A well-executed transition of care is essential to delivering the best patient-centered care throughout the care continuum. Each turning point should include the communication of a comprehensive care plan that ensures continuity and coordination of care. However, during the transfer of care, care delivery may become fragmented and disjointed. The National Transitions of Care Coalition (NTOCC) evaluated current practices and identified the following problems as main catalysts to the ineffectiveness of transition of care:

- Breakdown in communication amongst all the providers of the patient's broader care team
- Insufficient understanding about a patient's ability to adhere to the treatment and plan
- Lack of procedures and processes for managing the transition at each turning point

These problems can lead to adverse events, low satisfaction, and high readmission rates. Failures of care coordination can increase costs by \$25 billion to \$45 billion annually, according to JAMA.

# Challenges in Transition of Care

---

## Communication Breakdown

A study conducted by Academic Medicine estimated that 80 percent of serious medical errors involve miscommunication during the hand-off between medical providers. Providers do not always effectively or completely communicate important information between themselves, to the patient, or to the patient's family members or personal caregivers. Whether verbal, recorded, or written, the communication methods utilized are not suitable for ensuring a smooth transition. The Center for Transforming Healthcare's hand-off communication project highlighted several risk factors relating to communication:

- Expectations differ between senders and receivers of patients in transition
- Culture does not promote successful hand-off (e.g., lack of teamwork and respect)
- Hand-off procedure does not require accountability and follow-through
- Not enough time was available for the hand-off at the transition point
- Standardized procedures for conducting a successful hand-off are lacking

When several providers and/or care settings are involved, errors can easily multiply if there is not a thorough transition plan developed and discussed before, during, and after the turning point. When an error occurs, the various providers (and the patient) may not know who best to contact in order to resolve the issue in a timely manner.

## Insufficient Understanding about the Patient

If a proper risk assessment is not conducted prior to planning the transfer or discharge, the forthcoming transition of care is already at risk for failing. It is necessary to understand a few salient points about the patient's individual situation such as:

- What is the number, frequency/timing, and reasons for prior readmissions?
- What is the number, frequency/timing, and reasons for prior trips to the ED?
- What is the level of health literacy and proficiency with the English language?
- How does the patient currently practice self-care (e.g., medications taken, diet adjustments, exercise/lifestyle modifications, etc.) on a daily basis?
- Will the patient be able to adhere to the forthcoming treatment plan?
- Will the patient be able to secure reliable transportation to follow-up appointments?

When providers disregard the patient's respective realities when setting up the transfer of care, the resulting transition of care may be inadequate or inappropriate for the patient's actual situation. If a family member or personal caregiver is not included in the transitional care planning, critical insight into the patient may be overlooked as the patient might not fully communicate the expectations identified for each transition point.

# Challenges in Transition of Care

---

## Lack of Procedures and Processes

According to the Joint Commission Center for Transforming Healthcare, the consequences of substandard hand-offs may include delay in treatment, inappropriate treatment, adverse events, omission of care, increased hospital length of stay, avoidable readmissions, increased costs, inefficiency from rework, and other minor or major patient harm.

Without a clearly defined and communicated hand-off plan, each provider might not be aware of one's respective role in the transition of care at that particular transfer point. Also, each provider might not have a solid understanding of the broader next steps and the impact of not following the agreed-upon procedures and process at each turn.

Intra- and inter-hospital patient transfers are necessary to provide the patient with the appropriate care due to the stage in one's condition. Transitions may unfortunately fail patients due to the staff's immediate focus on planning for discharge vs. setting the stage for the continuation of care. Drawbacks may include:

- Managing the transition may be a low level priority for providers and relegated to the least-experienced team member.
- Last-minute tests/consultations can delay the plan and the medication list.
- Patients (and their caregivers) may feel rushed thru a "checkout" process vs. being adequately prepared for how care will be provided – whether at a different setting or upon return home.
- The transition itself might be too closely tied to a point in time if it fails to include periodic assessments of the patient's evolving condition during and after the transition point.

The main aim off all such transfers is maintaining the continuity of care without creating additional stress for the patient and putting the patient at risk for infection or other adverse events. There is not always clear ownership of the transition and the burden of ownership may be placed onto the patient if the patient is leaving the facility – regardless of the patient being prepared to schedule and arrange the transfer, schedule and follow-up appointments, or maintain the treatment plan.

Before the patient has left any care setting, a plan for the patient to access convenient follow-up care needs to be in place to ensure that the patient remains supported, even when the patient is being transferred to another facility. Ongoing check-ins are especially needed in the first 30 days post-discharge in order to minimize the risk of costly and unnecessary readmissions.

A focused transition plan will help minimize errors and omissions, improve the experience for the sending and the receiving providers, and ensure that the patient's care, safety and overall experience remains core to everyone's subsequent actions.

# Opportunity

With the increase in the aging population, these challenges will only multiply. Now is the time to improve care collaboration in order to deliver the best patient-centered care at each turning point.

How can this be accomplished? Enter the world of virtual care. With a virtual care communication platform, providers and patients use technology to communicate and collaborate before, during, and after critical transfer points. Video-based check-ins can help drive verbal and visual confirmation of the transition plan.

Each provider and care setting involved can benefit from using a virtual care platform. The core (or current) set of providers team can ensure that the broader care team members – specialists, care/case managers, pharmacists, visiting nurses, nutritionists, interpreters, and transportation assistants – is included in the video-based conversations and ongoing emails, texts, and SMS communications about expectations and next steps.



Remote family members and personal caregivers can also participate in the video calls so all involved are both aware of and aligned with the various roles and next steps in the upcoming transition. A comprehensive transition program which engages patients (and their respective caregivers) can help reduce readmissions.

Engaged patients are less likely to be readmitted. In a pilot with >350 chronic heart failure patients, a Philadelphia hospital was able to reduce its 30-day readmissions by 10% by using email and text message reminders with patients for follow-up appointments.

Including patients' caregivers into the discharge process can minimize hospital readmittance. In a study published in the Journal of the American Geriatrics Society, integrating caregivers during discharge planning resulted in a 25% reduction in the risk of elderly patients being readmitted to the hospital within 90 days of discharge and a 24% reduction in the risk of readmission within 180 days.



# Conclusion

---

Providers can use virtual care technology to better communicate and manage the process of transitional care as patients move between levels of health care, across care settings, and amongst providers.

Once a patient has been transferred or discharged, providers can also continue to use the platform to monitor and motivate patients – even after the patient is residing in another setting or has returned home.

- Due to busy schedules and various locations, clinicians may not be able to routinely follow-up with their patients who have been transferred to a SNF or LTCF. These providers can use virtual care technology to answer the onsite staff's questions and check-in with their patients.
- Using a video platform can replace or augment many in-person follow-up appointments, helping providers deliver care in a more convenient and cost-effective manner. By helping at-home patients easily participate in virtual visits, providers can address medication reconciliation concerns in real-time while continuing to monitor and motivate adherence to the treatment and self-care plan. Virtual visits minimize the risk of no-show's, in turn minimizing the risk of patients' returning to the hospital. Improving care satisfaction and outcomes for all.

## About Synzi

Technology is advancing, impacting the way we live and presenting new opportunities to improve the delivery of healthcare. Synzi leverages these innovations every day, developing state-of-the-art solutions that make it possible for healthcare professionals to do what they do, only better.

Our patient program management platform works on everyday devices such as smartphones, tablets, and laptops. Providers and patients can use video, email, text, and SMS to engage with each other, ensuring all potential touchpoints in the transition process are covered. Designed for reliable connectivity, the platform works in low-bandwidth and cellular environments.

With Synzi, the communication lines for all stakeholders involved will be improved, allowing for a smoother transition of care across care settings or between various providers. Follow-up care is more convenient, comfortable and cost-effective for the patient and the broader care team. Synzi's virtual care platform can help your organization better manage the transition of care and provide your patients with optimal patient-centric care at every turning point.

To learn more, visit our website at:  
[www.synzi.com](http://www.synzi.com)