2024

# Continuity of Care

Telligen QI Connect™
Partnering to improve health outcomes through relationships and data

HQIC
Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

# WHY IS THIS IMPORTANT?

Americans are getting sicker and living longer with more chronic illnesses compared to the late twentieth century. Continuity of care is concerned with the quality of care over time.[1] Continuity of care is the delivery of a seamless service through integration, coordination and the sharing of information between different providers (i.e. hospital, outpatient clinic, home health, long-term care).[1] Care transitions are the processes that create continuity of care as an individual passes through the care continuum. The healthcare community has opportunities to improve continuity of care by strengthening resources during transitions of care ensuring the patient remains in the center of the work.

To prevent readmissions, continuity of care and coordination of care are vitally important for individuals with chronic conditions and for everyone else who interacts with the healthcare system. Creating standard processes for hospital discharges and preventing hospital readmissions will decrease healthcare dollars spent and improve continuity of care.

# BACKGROUND

Ineffective care transition processes can lead to:[2]

- Adverse outcomes for patients including medication errors, clinical progression of illness, lack of post-discharge follow-up and avoidable emergency department visits
- Decreased patient and staff satisfaction
- Inappropriate use of resources
- Financial penalties through reduction in reimbursement from the Centers for Medicare & Medicaid Services (CMS) and other insurers

Between multiple sites of care and multiple types of providers, care is often disjointed and fragmented. Nearly 20% of Medicare patients are re-hospitalized within 30 days of discharge.[3] According to Jencks, Williams, and Coleman (2009), the cost of readmissions to the healthcare system is an estimated $17.4 billion in spending annually by Medicare alone.[4]

Five of the 32 questions in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) ask patients about their experience with discharge planning, symptom education and additional help after discharge from the hospital. This highlights the national importance of care coordination.

The complexity of care transitions highlights the critical need for quality improvement in healthcare. By addressing root causes, providers can develop targeted strategies to mitigate risks. Implementing evidence-based guidelines, enhancing patient monitoring and ensuring continuous education for healthcare professionals are essential steps to reduce these events and promote safer, more effective care.

# PREPARING FOR CHANGE

The Plan-Do-Study-Act (PDSA) cycle provides a sound framework for quality improvement. Plan by mapping the current process to identify gaps, identifying who will be involved, and confirming what resources may be needed. Do the work by implementing a change or intervention and collecting data on the results as you go. Study the data – were the desired results achieved? Act on the results – accept or adjust the implemented change. Alongside this framework, Telligen recommends utilizing its comprehensive Quality Improvement Workbook, which provides valuable resources to support your team's quality improvement efforts. Additionally, Telligen quality improvement facilitators developed the Readmission & Multi-Admission Patient Reduction Workbook to help develop an individualized, multidisciplinary program with goals, process and outcome measures aimed at preventing hospital readmissions and reducing multi-admission patient utilization.

---

[1] https://pubmed.ncbi.nlm.nih.gov/17018200/
[2] https://www.hospitalmedicine.org/clinical-topics/care-transitions/?gclid=CNzbq8uMvr8CFUlqfgodfL0Ahg
[3] https://psnet.ahrq.gov/primer/readmissions-and-adverse-events-after-discharge
[4] Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *N. Engl. J. Med.* 2009;360:1418–28. [PubMed] [Google Scholar] [Ref list]

# HOSPITAL DISCHARGE

**CONTINUITY OF CARE**

## FROM ADMISSION TO DISCHARGE

When a patient is admitted to the hospital, the admission assessment provides the first opportunity to evaluate potential discharge needs. Information such as whether the patient lives alone or if family is available to assist may indicate additional needs at discharge. The admission assessment, daily conversations with the patient and family and an effective discharge planning tool provide opportunities to discuss preferences regarding discharge disposition and facility/service provider choice. Using a standardized discharge tool, such as IDEAL Discharge Planning from the Agency for Healthcare Research and Quality (AHRQ), and process will ensure a smooth transition to the next site of care with key pieces of information included.

## RESOURCES

AHRQ – Care Transitions from Hospital to Home: IDEAL Discharge Planning

Society of Hospital Medicine – Why is it important to improve care transitions?

Re-Engineered Discharge (RED) Toolkit

---

### EFFECTIVENESS CHECKS

1. Audit for the specific change you were aiming for.
2. Collect and analyze the data.
3. Share findings, opportunities and successes with staff, leadership and if possible, with patients.

**Based on your data findings, if the change seen did not lead to the desired improvement, re-evaluate the root cause and consider launching another PDSA cycle.**

For additional information and resources, visit Telligen's Hospital Resources page.

# READMISSIONS

**CONTINUITY OF CARE**

## ENHANCING CARE TRANSITIONS REDUCES READMISSIONS

Reducing readmission rates through improved care transitions requires an evidence-based approach that incorporates adequate communication, optimized workflows and institutional commitment to improving patient outcomes. By initiating the discharge planning process early in a patient's hospital stay, the care team can appropriately identify risks to a successful discharge.

Telligen has developed the Readmission & Multi-Admission Patient Reduction Workbook to provide evidence-based guidance as you and your hospital address readmissions and multi-admissions. Download the workbook and complete answers as you and your team work through the process.

## RESOURCES

| | |
|---|---|
| AHA – Preventable Readmissions Change Package | Project BOOST – Implementation Guide to Improve Care Transitions |
| AHRQ – Readmissions and Adverse Events After Discharge | University of Pennsylvania: Penn Nursing – Transitional Care Model |
| IHI – Reducing Avoidable Readmissions Worksheet | |

### EFFECTIVENESS CHECKS

1. Audit for the specific change you were aiming for.
2. Collect and analyze the data.
3. Share findings, opportunities and successes with staff, leadership and if possible, with patients.

**Based on your data findings, if the change seen did not lead to the desired improvement, re-evaluate the root cause and consider launching another PDSA cycle.**

For additional information and resources, visit Telligen's Hospital Resources page.