

Transitions of Care Work Group



Transitions of Care Framework

Developed by the HIMSS Transition of Care Work Group (TOCWG) within the HIMSS Care Coordination Task Force for the HIMSS Ambulatory Information Systems (AIS) Committee.

Motivations for This Work

The TOCWG was initially chartered by the HIMSS AIS Committee to (1) identify the factors that impact the success of transitions of care (TOC), and (2) specify the information sets that are essential to those factors. We ultimately chose to refer to these factors as the **elements** for successful transitions. The framework includes a total of 16 elements (see Appendix #1).

Given the extent of specialization in the US healthcare system, compounded by the diverse array of settings in which care can be delivered, transitions of care are required in a large portion of the episodes of care today. However, transitioning a patient from one locus of care to another – whether within the same facility or across a continent – represents one of the most dangerous procedures in healthcare, in terms of patient safety. In this light, it is not at all surprising that improved information sharing within transitions is one of the major requirements in meaningful use within the federal EHR Incentive Program. Such priority concepts as care coordination, continuity of care, patient-centered care, all will succeed only with continuous TOCs that include the exchange of essential patient information.

After considerable analysis, even among the diverse range of transitions that take place, the TOCWG has concluded common process elements are indeed part of EVERY transition, which help frame the data/information sets essential to the continuity and safety of care delivered by the receiving facility. In addition, the work group believes this framework can be of considerable value to care program developers, health IT developers, quality and safety managers, researchers and providers working on this critical connecting issue in today's healthcare system.

Deciding on Illustrated Transitions

The range and number of prototypical TOC scenarios are extensive. Rather than attempt to construct an inventory of as many scenarios as possible, the TOCWG chose to identify four that reflect the current care priorities of Centers for Medicare and Medicaid Services and other national healthcare policy-setting groups. These scenarios, illustrate how the framework can be applied (see Appendix #2):

1. Hospitalist discharges patient from community hospital to home after pneumonia.

This scenario involves the patient being discharged to home, the arrangement for needed aftercare services and med orders, and the engagement of the patient's primary care physician.

2. Patient makes appointment (self-referral) to a specialist.

While this is not really a transition of care in the strict sense, it is an event in which a healthcare provider will initiate service to a patient and will require a basic patient data set to begin service delivery.

3. Hospital discharges an 86 year-old patient to skilled nursing facility (SNF) after surgery for hip fracture.

This scenario involves the transition of an individual who is already under care and has a complex episode with continuing care requirements for full-time services of an external provider.

4. Primary care physician refers patient to specialist.

This scenario involves a patient whose primary physician has determined that additional services are need from an external provider. This scenario is a *referral*, not simply a consult request.

Conclusion

The work group's framework appears to assist with the analysis of these four scenarios.

The current version of the framework is simply a starting point, an important distinction emphasized by the work group members.

To fully validate the overall effectiveness of the framework, it should be applied to a broader range of transitions; a step the work group believes will result in additional elaboration of the framework.

The work group members recommend more extensive user instructions in the next version of the framework material, which would be developed by the new committee members. However, the current version can now be used with adjustments made by the user as needed.

Call to Action

The work group has always felt that this work is of special significance to the care transformation priorities of healthcare today. The work is far from finished, and the work should be continued by the successor committee to the expiring AIS Committee.

The workgroup also feels the framework has progressed to the point where it would be appropriate to invite other healthcare professional associations such as the American Medical Association (AMA), American Nurses Association (ANA), American Heart Association (AHA), American Health Care Association (AHCA), and others, to help develop an industry-wide framework for Transitions of Care. This work should also proceed to engage with data-oriented groups, such as Health Level Seven (HL7), Integrating the Healthcare Enterprise (IHE), Standards and Interoperability (S&I) Framework, and others that can help establish relevant data standards for TOC scenarios.

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