Featured Article

Strengthening Patient-centered Transitions of Care

Imagine for a moment that you're a patient with a chronic illness, stuck in the cycle of acute care. You're sent back and forth from the hospital to a skilled nursing facility and back again. How do you feel? Do you recognize the medical team taking care of you? Do you keep having to repeat your history?

Moving between care settings can be confusing and stressful for patients – but it doesn't have to be. Transitions of care provide opportunities for clinicians to engage in patient-centered care that prioritizes collaboration, communication, and community to improve healthcare deliver.

Why are transitions of care hard?

The progression of patients to and from acute and post-acute settings requires a network of clinicians and administrators, and it can be a challenge to effectively connect that network. Effective technology utilization can improve transitions of care, but poor or inconsistent utilization can have a negative impact.

"Technological limitations that hinder access to patient medical records across different care settings can lead to medication errors, misdiagnoses, increased costs, and confusion about treatment plans," says Teizu Wolokolie, MD, Regional Medical Director, Post-Acute Care.

Communication is also another key challenge area. "The real challenge lies in making sure that the whole network is connected or at least available so that there could always be a provider to be called up, either electronically, via chat or telephonically," says Hammad Rizvi, DO, Hospitalist, Senior Vice President, Northeast Group.

Every level of care has a unique mindset so medical teams must be able to communicate across that spectrum. This often presents a challenge, as healthcare can often become siloed and specialties may lack understanding of each other's resources, processes and more.

"I've seen patients consistently experience better outcomes when there is effective communication between transferring and receiving care providers," says Wolokolie.

How do transitions of care impact rehospitalization?

Healthcare must rise to this challenge to provide patient-centered care, particularly for patients with chronic conditions who may get trapped in a cycle of rehospitalization, which can negatively impact outcomes and quality of life.

"Chronically ill patients may be readmitted for the same circumstances multiple times," says Rizvi. "If teams in different settings can connect, even with a complex patient case, they could handle it at the lowest care level possible, and at the end of the day, that's what can promote better patient care."

Reducing rehospitalization rates takes coordinated and comprehensive care at every stage of the patient journey. According to Wolokolie, this can include, "effective coordination of follow-up care with specialists and primary care providers upon discharge, along with medication reconciliation and education of patients and their families."

Reduced rehospitalization not only improves patient outcomes but also reduces the cost of care and the overall cost of healthcare. Avoiding just one hospitalization makes a significant difference.

Why do these transitions matter?

These touchpoints are crucial to patient-centered care in every setting. When transitions of care are not seamless, the experience can have negative impacts on patient outcomes, satisfaction, and quality of life. Conversely, successful transitions of care connect the dots.

"If you can have those providers who know that patient well, you can connect the dots and provide better care for that patient," says Rizvi.

These connections make a big impact. Improving transitions of care can enhance patient experience, strengthen patient safety, improve team collaboration and ensure efficient resource use. "Effective care transitions help prevent common errors like missed appointments, misdiagnoses, and medication disparities while minimizing redundancy in care and avoidable re-hospitalizations," says Wolokolie.

How do we improve transitions of care?

Improving transitions of care takes collaboration across specialties and clinical teams. Community and clinical relationships are key areas of improvement. Putting a face to a name, Rizvi suggests, is a great first step in improving communication across teams.

"It's always helpful to have relationships in order to coordinate care," says Rizvi. "It's much easier if you know the person you're transitioning a patient to."

To strengthen these relationships, teams must communicate effectively and work together to provide patient education that empowers and prepares patients for their journey through the care continuum. Wolokolie says this involves breaking out of silos and strengthening communication among all care providers.

"Different providers have different mindsets, and being able to communicate across the spectrum of care is the most important thing for a patient," says Rizvi. "You need to know the patient's whole story or at least a particular part of the story to treat them. So, if you can't communicate well, you may lose the ability to have the patient at the center of the care plan."

What's TeamHealth doing to address successful care transitions?

TeamHealth is positioned uniquely because of our substantial footprint. This allows our clinicians to communicate easier and more efficiently than may sometimes occur in other models.

"At TeamHealth, we do our best to reassure the patient by familiarizing them with the medical team and maintaining an open line of communication with their providers," says Wolokolie. "This enhances the patient's experience and reduces the likelihood of an unnecessary transfer back to the hospital due to patient requests."

In addition, TeamHealth's vast footprint allows clinicians to better coordinate resources and allows opportunities for a deeper understanding of different care settings.

As a hospitalist, Rizvi credits his brief experience in a skilled nursing facility with his deeper understanding of the different settings. "I was able to work in a skilled nursing facility and see the resources they have," says Rizvi. "Because as a hospitalist, sometimes you assume it would be easier to care for patients at a SNF, but then when you enter that setting you realize and appreciate the unique processes and resources more. That was really eye-opening for me."

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With over 15,000 clinicians serving patients across the full care continuum, we have the depth and breadth of experience to improve healthcare delivery. To learn more about partnering with TeamHealth, please reach out to our team.