NATIONAL QUALITY FORUM

Emergency Department Quality of Transitions of Care

Discussion Guide for Multistakeholder Web Meeting

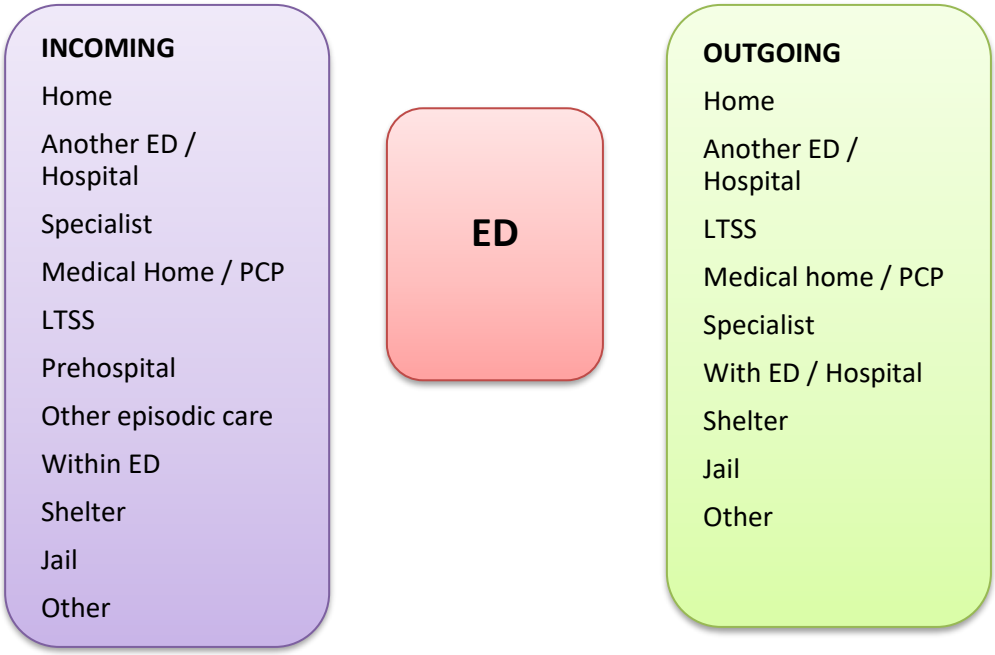
Quality of Care Transitions

Transitions of Care refer to the movement of patients between health care locations, providers, or different levels of care within the same location (Coleman, 2006) as their conditions and care needs change. Specifically, they can occur:

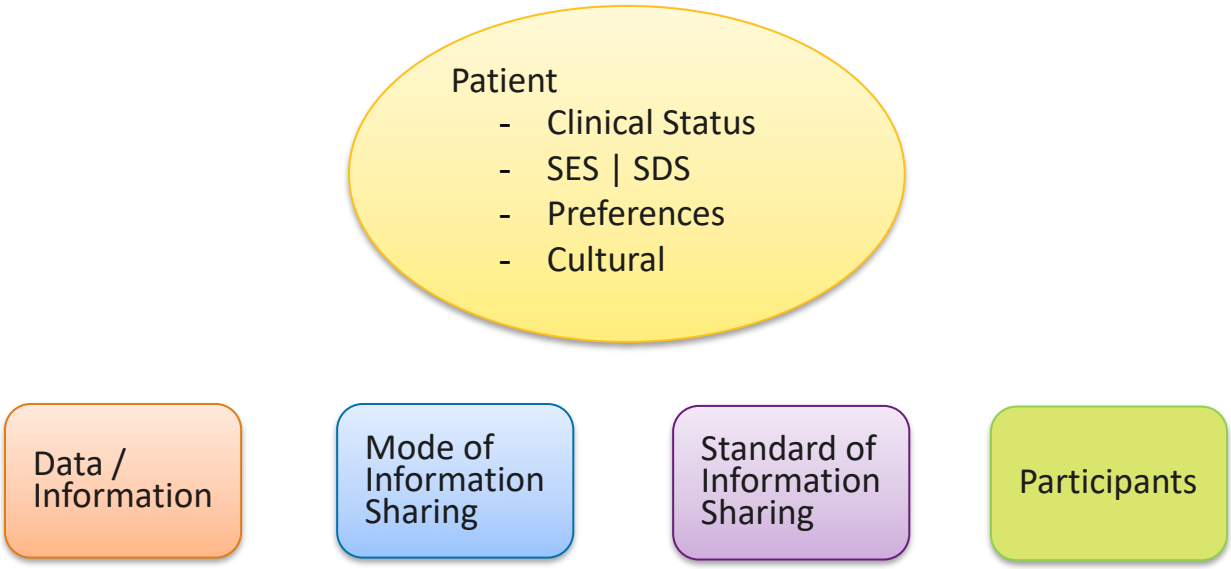
- Within settings; e.g., primary care to specialty care, or intensive care unit (ICU) to ward.
- Between settings; e.g., hospital to sub-acute care, or ambulatory clinic to senior center.
- Across health states; e.g., curative care to palliative care or hospice, or personal residence to assisted living.
- Between providers; e.g., generalist to a specialist practitioner, or acute care provider to a palliative care specialist.

A patients experience in an "ED episode of care" may include different settings of care which either provide information to the ED or for which the ED provides information to. The discussion will focus on the following ED transitions of care and within them what are the elements that support quality.

Scenarios for ED Transition Types (illustrative, not exhaustive)



Transition Key Elements



Discussion questions

1. What are the **essential data** needed to support a transition?
2. What **modes of information transfer** support a transition?
3. What **standardized processes** support information sharing / transition?
4. Who are the key **participants** in an effective transition?
5. Are there specific **patient attributes** to focus on for particular transition types?
6. How should transition **information be shared with the patient**, and how does that differ by patient attributes?