

# The Transitions of Care Clinic: Demonstrating the Utility of the Single-Site Quality Improvement Study

Luci K Leykum, MD, MBA, MSc<sup>1,2\*</sup>, Lauren S Penney, PhD<sup>2,3</sup>, Jacqueline A Pugh, MD<sup>2,3</sup>

<sup>1</sup>Dell Medical School, The University of Texas at Austin, Austin, Texas; <sup>2</sup>The South Texas Veterans Health Care System, San Antonio, Texas; <sup>3</sup>UT Health San Antonio, San Antonio, Texas.

A significant literature describes efforts to reduce hospital readmissions through improving care transitions. Many approaches have been tried, alone or in combination, targeting different points across the spectrum of discharge activities. These approaches encompass interventions initiated prior to discharge, such as patient education and enhanced discharge planning; bridging interventions, such as transition coaches; and postdischarge interventions, such as home visits or early follow-up appointments. Transitions of care clinics (TOCC) attempt to improve posthospital care by providing dedicated, rapid follow-up for patients after discharge.<sup>1</sup>

The impact of care transitions interventions is mixed, with inconsistent results across interventions and contexts. More complex, multipronged, context- and patient-sensitive interventions, however, are more likely to be associated with lower readmission rates.<sup>2,3</sup>

In this issue of the journal, Griffin and colleagues<sup>4</sup> report on their TOCC implementation. Their focus on a high-risk, rural veteran population is different from prior studies, as is their use of in-person or virtual follow-up options. While the authors describe their intervention as a TOCC, their model serves as an organizer for an interprofessional team, including hospitalists, that coordinates multiple activities that complement the postdischarge appointments: identification of high-risk patients, pharmacist-led medication reconciliation, dietary counseling, contingency planning for potential changes, follow-up on pending tests and studies, and coordination of primary care and specialty care appointments. The multipronged, patient-sensitive nature of their intervention makes their positive findings consistent with other care transition literature.

Griffin and colleagues' reporting of their TOCC experience is worth highlighting, as they present their experience and results in a way that maximizes our ability to learn from their implementation. Unfortunately, reports of improvement initiatives often lack sufficient detail regarding the context or intervention to potentially apply their findings. Griffin and colleagues applied the Revised Standards for Quality Improvement Reporting Excellence (SQUIRE 2.0) guidelines, a standardized framework for describing improvement initiatives that captures critical contextual and intervention elements.<sup>5</sup>

Griffin and colleagues describe their baseline readmission performance and how the TOCC model was relevant to this issue.

They describe the context, including their patient population, and their intervention with sufficient detail for us to understand what they actually did. Importantly, Griffin and colleagues clearly delineate the dynamic phases of the implementation, their use of Plan-Do-Study-Act cycles to assess and improve their implementation, and the specific changes they made. The Figure clearly puts their results in the context of their program evolution, and their secondary outcomes support our understanding of program growth. Their use of a committee for ongoing monitoring could be important for ongoing adaptation and sustainability.

There are several limitations worth noting. There may have been subjectivity in teams' decisions to refer specific patients with lower Care Assessment Need scores. We do not know why patients did not attend TOCC visits, or why they chose virtual vs in-person visits. This study was conducted within the Veterans Affairs system, where program supports, such as tablets for virtual visits and coordination among services, may be easier to implement than in other settings. Despite these limitations, we see that complex, high-risk patients benefit from a multidisciplinary, multipronged approach to care transitions. Moreover, we learned about barriers encountered during TOCC implementation and how these issues were successfully addressed. Finally, their work suggests that telehealth may be an appealing and promising component of care transition programs, but that patients may not choose this modality solely because of geography.

In this era of multisite collaborative studies and analyses of large administrative datasets, Griffin et al<sup>4</sup> demonstrate that there is still much to learn from a well-done, single-site improvement study.

Disclosures: The authors reported no conflicts of interest.

Funding: Drs Leykum and Penney reported funding from the Department of Veterans Affairs.

## References

1. Nall RW, Herndon BB, Mramba LK, Vogel-Anderson K, Hagen MG. An interprofessional primary care-based transition of care clinic to reduce hospital readmission. *J Am Med.* 2019; 133(6):E260-E268. <https://doi.org/10.1016/j.amjmed.2019.10.040>
2. Leppin AL, Gionfriddo MR, Kessler M, et al. Preventing 30-day hospital readmissions: a systematic review and meta-analysis of randomized trials. *JAMA Intern Med.* 2014;174(7):1095-1107. <https://doi.org/10.1001/jamainternmed.2014.1608>
3. Pugh J, Penney LS, Noel PH, Neller S, Mader M, Finley EP, Lanham HJ, Leykum LK. Evidence-based processes to prevent readmissions: more is better, a ten-site observational study. *BMC Health Serv Res.* 2021; 21:189. <https://doi.org/10.1186/s12913-021-06193-x>
4. Griffin BR, Agarwal N, Amberker R, et al. An initiative to improve 30-day readmission rates using a transitions-of-care clinic among a mixed urban and rural Veteran population. *J Hosp Med.* 2021;16(10):583-588. <https://doi.org/10.12788/jhm.3659>
5. Squire 2.0 guidelines. Accessed September 17, 2021. <http://squire-statement.org>

**\*Corresponding Author:** Luci K Leykum, MD, MBA, MSc;  
Email: [Luci.Leykum@austin.utexas.edu](mailto:Luci.Leykum@austin.utexas.edu); Telephone: 210-563-4527.

**Received:** September 17, 2021; **Revised:** September 17, 2021;

**Accepted:** September 25, 2021

© 2021 Society of Hospital Medicine DOI 10.12788/jhm.3683