

# Transição do cuidado da atenção terciária para a atenção primária: Revisão integrativa da literatura

**RESUMO** | Objetivo: descrever, com base na literatura, quais as estratégias utilizadas na transição do cuidado de usuários do hospital para a atenção primária. Método: trata-se de revisão integrativa realizada a partir de coleta de artigos publicados entre 2016 e 2020 nas bases de dados LILACS, MEDLINE, por meio da PubMed, e Sci-Verse Scopus. Foram selecionados 13 artigos que atendiam aos critérios de inclusão. Resultados: estratégias descritas na literatura, envolvem a ação multidisciplinar, com destaque para a atuação do enfermeiro. Compreendem ações de transição do cuidado, planejamento de visitas e consultas. Conclusão: são estratégias apontadas na literatura para a transição do cuidado: clínica de transição com equipe de atenção primária; cronograma estruturado para visitas domiciliares; avaliação clínica e social; clínicas de cuidado transitório; programa de coordenação do cuidado.

**Descritores:** Transição para Assistência do Adulto; Atenção Primária à Saúde; Continuidade da Assistência ao Paciente.

**ABSTRACT** | Objective: to describe, based on the literature, which strategies are used in the transition of care for hospital users to primary care. Method: this is an integrative review based on the compilation of articles published between 2016-and 2020 in the LILACS, MEDLINE databases, through PubMed, and Sci-Verse Scopus. Thirteen articles that met the inclusion criteria were selected. Results: strategies described in the literature include multidisciplinary actions with emphasis on the role of nurses. They comprise care transition actions, planning of visits and consultations. Conclusion: strategies identified in the literature for the transition of care are: transition clinic with a primary care team; structured schedule for home visits; clinical and social assessment; transitional care clinics; care coordination program.

**Keywords:** Transition to Adult Care; Primary Health Care; Continuity of Patient Care.

**RESUMEN** | Objetivo: describir, con base en la literatura, qué estrategias se utilizan en la transición de la atención de los usuarios del hospital para la atención primaria. Método: se trata de una revisión integradora basada en la recopilación de artículos publicados entre 2016 y 2020 en las bases de datos LILACS, MEDLINE, a través de PubMed y Sci-Verse Scopus. Se seleccionaron trece artículos que cumplieron con los criterios de inclusión. Resultados: las estrategias descritas en la literatura implican una acción multidisciplinar, con énfasis en el papel de los enfermeros. Comprenden acciones de transición asistencial, planificación de visitas y consultas. Conclusión: las estrategias identificadas en la literatura para la transición de la atención son: clínica de transición con equipo de atención primaria; horario estructurado para visitas domiciliarias; evaluación clínica y social; clínicas de atención transitoria; programa de coordinación de cuidados.

**Palabras claves:** Transición a la Atención de Adultos; Atención Primaria de Salud; Continuidad de la Atención al Paciente.

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## INTRODUCTION

The rcare transition concerns one of the domains of health systems integration. <sup>1</sup> Its main benefit is the reduction of hospital admissions and possible readmis-

sions due to complications, since it reduces the cost of health services and increases the quality of life of patients and their families. <sup>2</sup>

Non-performance or failures in the transition of care between the hospital institution and primary care are seen as situations that generate a risk for patient safety, which can impact the care interface, such as, for example, increased morbidity and mortality; the high risk of adverse events due to lack of communication; the delay in the correct time for treatment; and rehabilitation for certain health conditions, generating dissatisfaction for the patient and his family or caregiver. <sup>3</sup>

In the United States, there are different models aimed at different needs of the population, such as the model aimed at patients treated after acute health situations and who need specific guidance and the model aimed at complex cases of primary health care, among others, used in order to reduce readmissions and the worsening of the health situation of users, including chronic conditions.<sup>4</sup> Transitional care is also seen as a robust strategy for reducing morbidity and mortality and readmissions to hospital services in Spain.<sup>5</sup>

When the transitional process between institutions, sectors and professionals does not run properly, the situation can result in the occurrence of adverse events, increasing the length of stay, as well as readmissions and increased costs for the health network.<sup>6</sup> Therefore, the transition of care is directly linked to patient safety, contributing to the reduction of injuries and adverse events.

Multicenter international studies have been developed with the intention of improving the patient care transition process at the interface with the home and the primary health care team.<sup>7,8</sup> Thus, the importance of studies that can contribute to the practice of care becomes evident, and it is in this context that this research was conceived, with the perspective of bringing a theoretical-scientific basis on the subject and showing strategies to qualify the transition and contribute to patient safety. In this sense, the following research question was raised: what are the strategies used in the transition of patient care from tertiary care to primary care, according to the literature? The study aims to describe the strategies used, according to the literature, in the transition of patient care from ter-

tiary care to primary care.

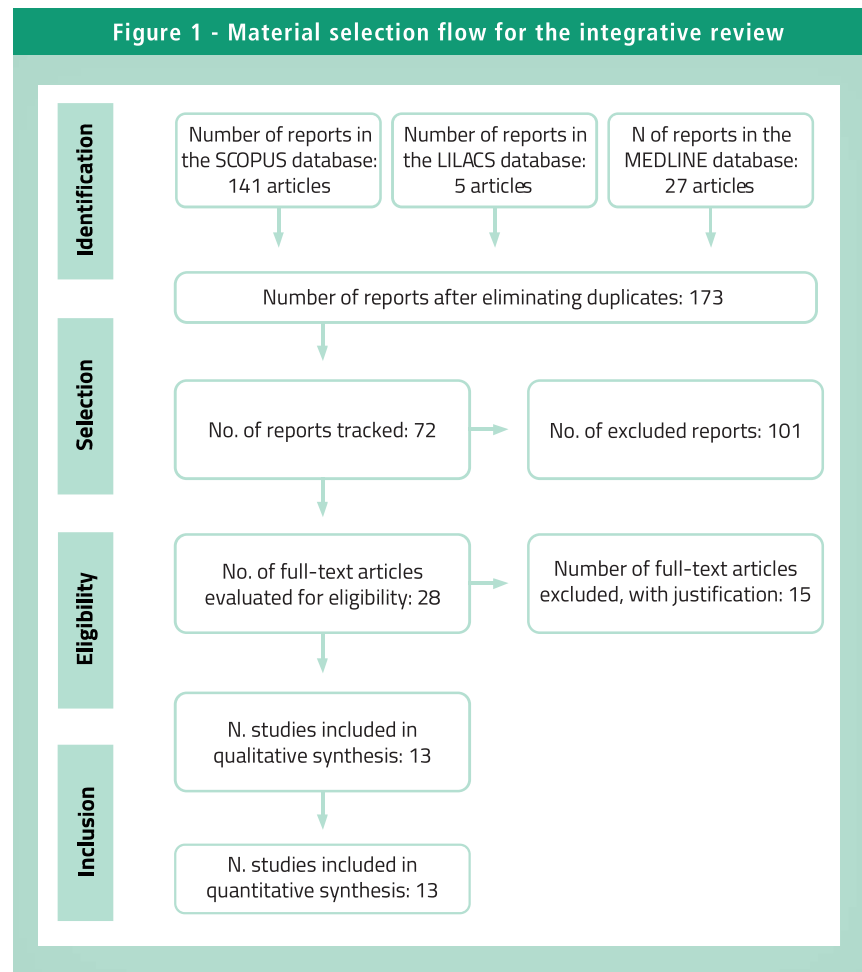
**METHOD**

This is an integrative review.<sup>9</sup> Data collection was performed in January 2021, in the following databases: Latin American and Caribbean Literature on Health Sciences (LILACS), Medical Literature Analysis and Retrieval System Online (MEDLINE) and Sci-Verse Scopus (SCOPUS). Inclusion criteria were: primary studies performed with adult patients, and studies performed with nurses. Studies that addressed the transition of care between psychiatric health institutions

were excluded.

The search strategy was created from the guiding question, and descriptors were established, according to the Medical Subject Headings (MeSH). The search strategy used in LILACS and SCOPUS databases was: “transitional care” AND “primary health care” AND “patient discharge”. In the MEDLINE database, the search strategy with descriptors in English did not obtain results, so the strategy was used: “adulto (adult)” AND “cuidado transicional (transitional care)” AND “atenção primária (primary care)”. The search was filtered for publications from the last five years (2016 to 2020).

**Figure 1 - Material selection flow for the integrative review**



Source: Survey data, 2021.

There was no language restriction.

The article selection process was carried out by two independent researchers. The publication selection flow is described in Figure 1.

To assess the level of evidence, the Melnyk, Fineout-Overholt (2019)<sup>10</sup> framework was used, classified into seven levels: I - systematic review (RS) or meta-analysis of randomized clinical trials (RCT); II - RCT; III – EC without randomization; IV - cohort and case-control studies; V – SR of descriptive and qualitative studies; VI - descriptive or qualitative study; VII - expert opinion.<sup>10</sup>

Thematic analysis was used to analyze the data obtained, following the steps: pre-analysis; material exploration; treatment of the results obtained and interpretation.<sup>11</sup>

## RESULTS

13 articles were selected. The largest number of publications was found in the SCOPUS database (40%), all in English. There was a greater number of publications in the years 2018 and 2020 (both 30.7%). There was a predominance of studies carried out in the United States (69.2%) and with level of evidence IV (61.5%). The summary data of the articles included in the research are described in Table 1.

The study results were listed in three categories: a) Follow-up strategies after hospital discharge; b) safety in the use of medicines; c) strategies for care transition, which are detailed in Chart 2.

## DISCUSSION

As for the follow-up after hospital discharge, with face-to-face consultation, home visits or even telemonitoring, the results point to a reduction in the chances of hospi-

**Table 1 - Synthesis of articles included in the research**

Authors	Year/ country	Type of study	Interventions and control	Outcome	Level of evidence
Elliot K, Klein JW, Basu A, Sabbatini AK <sup>8</sup>	2016 USA	Retrospective cohort, n = 660	Monitoring of patients during segment appointments.	Transient care clinics represent a strategy to improve care and reduce unnecessary use of services.	IV
Donovan JL, Kanaan AO, Gurwitz JH, Tjia J, Cutrona SL, Garber L et al. <sup>12</sup>	2016 USA	Pilot, n = 265	Appointment reminders, alerts on major therapeutic changes, and high medication monitoring.	Older adults who have been discharged from qualified nursing facilities are at high risk of adverse outcomes immediately after discharge.	VII
Li J, Brock J, Jack B, Mittman B, Naylor M, Sorra J et al. <sup>13</sup>	2016 USA	Observational, n = 12 thousand	Project to specify comparators and estimate individual and combined effects of transitional care.	Care needs to be adjusted based on the patient, caregiver, environment or community characteristics.	VII
Andersen UO, Ibsen H, Tobiasen M. <sup>14</sup>	2017 Denmark	Cohort, n = 117	Reassessment of hypertensive patients in a clinic.	Maintaining control of hypertension requires continuous collaboration between patient and healthcare team.	IV
Chakravarthy V, Ryan MJ, Jaffer A, Golden R, McClellon R, Kim J. et al. <sup>15</sup>	2018 USA	Retrospective cross-sectional, n = 1.149	Relationship between 30-day readmission and follow-up appointment status.	Transition clinic with a primary care team holds promise for providing access to services and managing the needs of vulnerable populations.	IV
Ballard J, Rankin W, Roper KL, Weatherford S, Cardarelli R. <sup>16</sup>	2018 USA	Retrospective cohort, n = 1.884	Analysis of the association between implementation of transitional care management and readmission rates of discharged patients.	The primary care-based transition-of-care management process can reduce readmissions, even when overall rates are low.	IV
Hewner S, Sullivan SS, Yu G. <sup>17</sup>	2018 USA	Pilot, n = 6 thousand	Comparison of interventions/ primary care from Medicaid data.	Transitional care requires initiatives to improve the health system.	VII
Marbach JA, Johnson D, Kloo J, Vira A, Keith S, Kraft WK et al. <sup>18</sup>	2018 Canada	Retrospective cohort, n = 496	Comparison between patients who received different care for acute myocardial infarction.	Inclusion of a specific care coordination program is associated with a lower risk of hospital readmission within 30 days.	IV
Hurtaud A, Lallier F, Heidet M, Arnoult C, Dramé M, Canoui-Poitri-ne F. <sup>19</sup>	2019 France	Multicenter prospective cohort, n = 142	Use of hospital discharge summaries.	Compliance with French guidelines on hospital-to-home transitions is insufficient.	IV
Noel K, Messina C, Hou W, Schoenfeld E, Kelly G. <sup>20</sup>	2020 USA	Randomized controlled trial, n = 105	Remote patient monitoring and video visits.	Telehealth can enhance care transitions after hospital discharge, improving patient engagement and medication adherence.	II

tal readmission <sup>8,15-22</sup>, greater adherence to treatment <sup>20</sup>, and greater bond with the primary care health team. <sup>14</sup>

A pilot study investigated the effect of late follow-up of patients, and found that delays in post-discharge follow-up can lead to readmissions, in addition to weakening the transition of care. <sup>12</sup> In another study, authors point out the importance of telephone contact by nurses after discharge, within seven days <sup>24</sup>, and emphasize that systematic visits, after discharge, contribute to maintaining the bond with the service. <sup>14</sup>

Still from the perspective of patient discharge and the care process, an American study <sup>23</sup> describes the cost-benefit for health plans, with the effective transition of care. Likewise, the Australian guidelines manual portrays the country's care transition program, and points out the importance of comprehensive patient assessment, taking into account cultural diversity and the specifics of each individual. <sup>25</sup>

Regarding safety in the use of medication, the care transition process favors adherence to treatment and reduces the risk of following the medication prescription. <sup>13</sup> The World Health Organization (WHO) points out that 40% of errors involving the use of medication at home occur due to failure in discharge guidelines. <sup>3</sup> In this sense, the study points out that the clarity of the information on the discharge note and the confirmation of the patient's understanding of post-discharge care, contribute to reducing the patient's doubts, mitigating the risk of unnecessary readmissions and a companion, and for a better transition of care. <sup>21, 26</sup>

The literature points out as effective the strategies for the transition of care: the use of electronic tech-

Yusof FM, Tan CE21	2020 Malaysia	Transversal, n = 307	Assess the patient's perception of transition quality.	Study shows improvement in transitional care compared to Malays and Indians.	IV
Baecker A, Meyers M, Koyama S, Taitano M, Watson H, Machado M et al.22	2020 USA	Retrospective cohort, n = 26128	Home visit and telecare after hospital discharge.	Home visits and follow-up after discharge can contribute to a decrease in readmissions.	IV
Gallo LC, Fortmann AL, Bravin JI, Clark TL, Savin KL, Ledesma DL et al.23	2020 USA	Randomized, controlled, single-blind clinical trial, n = 560	Visits during hospitalization and telemonitoring after discharge, for the transition of care.	Care transition interactions contribute to the care of high-risk patients.	II

Source: Research data, 2021.

Chart 2 – Categories listed based on data analysis.

Follow-up strategies after hospital discharge	Call center 20,22 Home visit 22 Transition query 8,15 Reexamination 14 Appointment Scheduling Reminders 12
Safety in the use of medicines	Treatment and medication plans 12
Strategies for care transition	Transition clinic with primary care team 15 Structured schedule for home visits 22 Clinical and social assessment 5 Transient care clinics 18 Coordination program 17

Source: Research data, 2021.

nologies and tools to monitor patients after hospital discharge <sup>17</sup>; use of schedule for home visits <sup>22</sup>; carrying out health education actions for patients and companions; integrated action among health team professionals. <sup>16</sup>

**CONCLUSIONS**

The care transition strategies found in this study were: implementation of a transition clinic with a primary care team; structured schedule for home visits; clinical and social assessment; transient care clinics; care coordination programs. The

examples of strategies identified from this study show the performance of multidisciplinary teams, with nurses having a fundamental role in care management. As a limitation of the study, it is pointed out the fact that Brazilian studies were not found on care transition strategies, which is also a suggestion for future studies.

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## References

1. Suter E, Oelke ND, Lima MADS, Stiphout M, Janke R, Witt RR et al. Indicators and measurement tools for health systems integration: a knowledge synthesis. *Int. J. Integr. Care*. 2017;17(6):1-17. doi: 10.5334/ijic.3931
2. Renne S, Nguyen OK, Shoeb MH, Magan Y, Wachter RM, Ranji SR. Hospital-initiated transitional care interventions as a patient safety strategy. *Ann. Intern. Med.* 2013;158:433-40. doi: 10.7326/0003-4819-158-5-201303051-00011
3. World Health Organization. Transitions of care: technical series on safer primary care. Geneva: Department of Service Delivery and Safety; 2016.
4. Hewner S, Chen C, Anderson L, Pasek L, Anderson A, Popejoy L. Transitional care models for high-need, high-cost adults in the United States: a scoping review and gap analysis. *Prof. Case Manag.* 2021;26(2):82-98. doi: 10.1097/NCM.0000000000000442
5. Costa MFBNA, Andrade SR, Soares CF, Pérez EIB, Tomás SC, Bernardino E. The continuity of hospital nursing care for Primary Health Care in Spain. *Rev. Esc. Enferm. USP*. 2019;53:1-8. doi: 10.1590/S1980-220X2018017803477
6. Brasil. Ministério da Saúde. Secretaria de Atenção Especializada à Saúde. Departamento de Atenção Hospitalar, Domiciliar e de Urgência. Atenção domiciliar na atenção primária à saúde. Brasília, DF: Ministério da Saúde; 2020.
7. Cao X, Tian L, Chen L, Jiang X. Effects of a hospital-community partnership transitional program in patients with coronary heart disease in Chengdu, China: a randomized controlled trial. *Jpn. J. Nurs. Sci.* 2017;14:320-31. Doi: 10.1111/jjns.12160
8. Elliot K, Klein JW, Basu A, Sabbatini AK. Transitional care clinics for follow-up and primary care linkage for patients discharged from the ED. *Am. J. Emerg. Med.* 2016;34(7):1230-5. doi: 10.1016/j.ajem.2016.03.029
9. Mendes KDS, Silveira RCCP, Galvão CM. Revisão integrativa: método de pesquisa para a incorporação de evidências na saúde e na enfermagem. *Texto e Contexto – Enferm.* 2008;17(4). doi: 10.1590/S0104-07072008000400018
10. Melnyk BM, Fineout-Overholt E. (Eds.) Evidence-based practice in nursing & healthcare: a guide to best practice. Filadélfia: Wolters Kluwers; 2019
11. Minayo MCS. O desafio do conhecimento: pesquisas qualitativas em saúde. São Paulo, SP: HUCITEC; 2014.
12. Donovan JL, Kanaan AO, Gurwitz JH, Tjia J, Cutrona SL, Garber L et al. A pilot health information technology-based effort to increase the quality of transitions from skilled nursing facility to home: compelling evidence of high rate of adverse outcomes. *J. Am. Med. Dir. Assoc.* 2016;17(4):312-7. doi: 10.1016/j.jamda.2015.11.008
13. Li J, Brock J, Jack B, Mittman B, Naylor M, Sorra J et al. Project ACHIEVE – using implementation research to guide the evaluation of transitional care effectiveness. *BMC Health Serv. Res.* 2016;16:70. doi: 10.1186/s12913-016-1312-y
14. Andersen UO, Ibsen H, Tobiassen M. On the transition from a nurse-led hypertension clinic to hypertension control in primary care: identifying barriers to and factors acting against continuous hypertension control. *Blood Press.* 2016;25(4):263-67. doi: 10.3109/08037051.2016.1156909
15. Chakravarthy V, Ryan MJ, Jaffer A, Golden R, McClenton, R, Kim J. et al. Efficacy of a transition clinic on hospital readmissions. *Am. J. Med.* 2018;131(2):178-84. doi: 10.1016/j.amjmed.2017.08.037
16. Ballard J, Rankin W, Roper KL, Weatherford S, Cardarelli R. Effect of ambulatory transitional care management on 30-day readmission rates. *Am. J. Qual. Med.* 2018. doi: 10.1177/1062860618775528
17. Hewner S, Sullivan SS, Yu G. Reducing emergency room visits and in-hospitalizations by implementing best practice for transitional care using innovative technology and big data. *Worldviews Evid. Based Nurs.* 2018;15(3):170-7. doi: 10.1111/wvn.12286
18. Marbach JA, Johnson D, Kloo J, Vira A, Keith S, Kraft WK et al. The impact of a transition of care program on acute myocardial infarction readmission rates. *Am. J. Med. Qual.* 2018;33(5):481-6. doi: 10.1177/10628606187554702
19. Hurtaud A, Lallier F, Heidet M, Arnoult C, Dramé M, Canouï-Poitrine F. Real-life implementation of guidelines on the hospital-to-home transition for older patients: a cohort study in general practice. *Age Ageing.* 2019;49(1):46-51. doi: 10.1093/ageing/afz143
20. Noel K, Messina C, Hou W, Schoenfeld E, Kelly G. Tele-transitions of care (TTOC): A 12-month, randomized controlled trial evaluating the use of Telehealth to achieve triple aim objectives. *BMC Fam. Pract.* 2020;21(1):1-18. doi: 10.1186/s12875-020-1094-5
21. Yusof FM, Tan CE. Perceived quality of transitional care between public hospital and public health care clinic in Negeri Sembilan, Malaysia: a pilot study. *Malays. J. Public Health Med.* 2020;20(1):90-101. Disponível em <http://mjphm.org/index.php/mjphm/article/view/555/92>
22. Baecker A, Meyers M, Koyama S, Taitano M, Watson H, Machado M et al. Evaluation of a transitional care program after hospitalization for heart failure in an integrated health care system. *JAMA Netw. Open.* 2020;3(12):1-12. doi: 10.1001/jamanetworkopen.2020.27410
23. Gallo LC, Fortmann AL, Bravin JI, Clark TL, Savin KL, Ledesma DL et al. My Bridge (Mi Puente), a care transitions intervention for Hispanics/Latinos with multimorbidity and behavioral health concerns: protocol for a randomized controlled trial. *Trials.* 2020;21(1):1-26. doi: 10.1186/s13063-019-3722-8
24. Lindquist LK, Love HC, Elbogen EB. Traumatic brain injury in Iraq and Afghanistan veterans: new results from a national random study. *J. Neuropsychiatry Clin. Neurosci.* 2017;29(3):254-9. doi: 10.1176/appi.neuropsych.16050100
25. Australia. Transition Care Programme guidelines. 2nd ed. Sydney: Australian Government Department of Health; 2021.
26. Rattray NA, Sico JJ, Cox LM, Russ AL, Matthias MS, Frankel RM. Crossing the communication chasm: challenges and opportunities in transitions of care from the hospital to the primary care clinic. *Jt. Comm. J. Qual. Patient Saf.* 2017;43(3):127-37. doi: 10.1016/j.jcjq.2016.11.007