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Transitional care during COVID-19 pandemic in Japan: Calls for new strategies to integrate traditional approaches with information and communication technologies

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SUMMARY Transitional care is indispensable in successfully transitioning patients from hospital to home and preventing adverse events during this process. There were restricted services in several hospitals for minimizing the spread of COVID-19. Therefore, hospitals could not provide adequate transitional care that possibly resulted in poor post-discharge outcomes in patients. Some hospitals have now combined infection prevention with face-to-face opportunities, *i.e*., requiring reservations for transitional care consultation and restricting pre-discharge conferences. Several hospitals started providing pre-discharge conferences using apps, where patients/family caregivers and care teams could have face-to-face discussions about medical and nursing care plans, goals, and preferences. However, building a relationship between patient/family and medical/nursing staff and providing decision-making, psychological support, and risk assessment generally performed in person are still in demand. New hybrid strategies should be developed and evaluated to provide transitional care while using online systems and minimal face-to-face support during the pandemic.

Keywords COVID-19, discharge, transitional care

1. Introduction

Transitional care is indispensable to successfully guide patients from hospital to home and to prevent adverse events in this process, making it essential for efficient medical and nursing practice (*1,2*). One of the most important components of excellent transitional care is active involvement of patients and family caregivers (*1,3,4*). Previous studies show that their involvement has improved physical and mental outcomes for the person who is discharged from the hospital and improves continuity of care (*5*).

In the traditional transitional care system, family caregivers frequently visited the hospital and acquired face-to-face services, including information sharing about continuous care and treatment, medical/nursing care education, and participation in medical decision-making. Many hospitals have restricted in-person visits to minimize the spread of Coronavirus disease 2019 (COVID-19) for the safety of the patients, visitors, and staff. As a result, provision of adequate transitional care is hampered, possibly resulting in poor patient outcomes after discharge. New hybrid strategies are required for transitional care involving patients and family caregivers during the COVID-19 pandemic in Japan, and they need to be developed and evaluated.

2. Traditional transitional care system in Japan

In Japan, a new healthcare reimbursement scheme was introduced to the universal healthcare coverage system in 2008 to provide transitional care. Discharge planning nurses (DPNs) are crucial professionals of the interdisciplinary team on transitional care because they assist patients with severe conditions, including those with terminal cancer or cognitive impairment, who are highly dependent on medical and long-term care, and arrange their transfer to a local medical institution or their homes (*6*).

"Creating a plan for transitional care with patient or family caregivers' involvement" is included in requirements before processing hospital bills. Hospital staffs, including DPNs, are required to discuss patients' medical conditions and life after discharge and create a transitional care plan with associated professionals. DPNs provide transitional care strategies by combining individual care, family caregivers, and a multidisciplinary collaborative team approach.

3. Current status of patients and family caregivers' involvement in transitional care during COVID-19

During the COVID-19 pandemic, from March 2020, many hospitals prohibited inpatient visitation, even for family members or friends. As of January 2021, these restrictions continue at many hospitals. Therefore, family caregivers are unable to visit patients during hospitalization and, thus, may not fully understand their status. One frontline DPN reported that family caregivers, particularly the elderly, were confused about patients' hospital discharge and service adjustments due to limited shared decision-making or information for medical and nursing care plans after discharge, which might have increased caregivers' anxiety and resulted in discharge refusals.

Many patients with terminal illness or caregivers opted for discharge to their home to prioritize their time together. For example, some hospitals were restricted from holding face-to-face discharge conferences with patients, families, and multidisciplinary specialists. Therefore, the DPNs reported that these patients and caregivers might not have been able to make adequate decisions regarding care plans, including their goals and preferences after discharge.

4. New strategies for a smooth transition from hospital to home with COVID-19 measures

To counter the COVID-19 pandemic, new strategies should complement the traditional transitional care system.

Reducing person-to-person contact and providing services in a socially distant setting are important infection prevention measures. As an alternative, if relatives cannot visit a patient during palliative and end-of-life care, many hospitals already use Information and Communication Technology (ICT), including tablets or smartphones (*7*). However, introduction of ICT for consultation on transitional care, discharge counseling, and post-discharge follow-up is a new approach. Some hospitals have now combined infection prevention with face-to-face opportunities, *i.e*., requiring reservations for transitional care consultation, limiting the number of visiting family members, and restricting pre-discharge conferences of multidisciplinary team members. Several hospitals started a "new normal" conference using apps, such as Zoom or FaceTime (*8*), which are expected to continue, where patients/family caregivers and care teams can discuss medical and nursing care plans, goals, and preferences face-to-face.

Using the nurse-led telemonitoring system at X hospital enhanced patients/family caregivers' follow-up after discharge (*9*). This system allows nurses in the hospital and patients and caregivers to communicate through a TV screen that the older persons are familiar with, rather than a computer or smartphone. They provide the service mainly in the first one to two weeks immediately after discharge from the hospital, when the patient's condition is likely to change, and various difficulties are likely to arise. This service effectively compensates for the lack of pre-discharge medical and nursing guidance and decision support in a pandemic situation.

However, building a relationship between family caregivers and medical/nursing staff, decision-making, psychological support, and risk assessment generally performed in face-to-face communication is still demanding. The future challenge is how to promote and involve patients and caregivers in their transitional care after discharge while aiming at preventing infection because especially the time spent between patients and their families in the terminal period is extremely important. Transitional care staff, including DPNs, should not wait for the pandemic to converge. New hybrid strategies should be developed and evaluated to provide transitional care while using online systems and minimal face-to-face support during the pandemic.

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References

1. Coleman EA, Parry C, Chalmers S, Min SJ. The care transitions intervention: Results of a randomized trial. Arch Intern Med. 2006; 166:1822-1828.
2. Towers AM, Killett A, Handley M, Almack K, Backhouse T, Bunn D, Bunn F, Dickinson A, Mathie E, Mayrhofer A, Mikelyte R, Goodman C. Producing "Top Tips" for care home staff during COVID-19 pandemic in England: rapid reviews inform evidence-based practice but reveal major gaps. Journal of Long-Term Care. 2020; 151-166.
3. Coleman EA, Boult C; American Geriatrics Society Health Care Systems Committee. Improving the quality of transitional care for persons with complex care needs. J Am Geriatr Soc. 2003; 51:556-557.
4. Naylor MD, Shaid EC, Carpenter D, *et al*. Components of comprehensive and effective transitional care. J Am Geriatr Soc. 2017; 65:1119-1125.
5. Gibson MJ, Kelly K, Kaplan A. Family caregiving and transitional care: A critical review. *https://www.caregiver.org/sites/caregiver.org/files/pdfs/FamCGing_TransCare_CritRvw_FINAL10.31.2012.pdf* (accessed October 7, 2020).
6. Holliman D, Dziegielewski SF, Teare R. Differences and similarities between social work and nurse discharge planners. Health Soc Work. 2003; 28:224-231.
7. Association for Palliative Medicine of Great Britain and Ireland. COVID-19 and palliative, end of life and bereavement care in secondary care: Guidance to aid care, Version 6: 17 January 2021. *https://apmonline.org/wp-content/uploads/2021/02/COVID-19-Palliative-and-*

End-of-Life-Care.pdf (accessed February 1, 2021).
8. The Cancer Institute Hospital of JFCR. Come join us for an online conference. *https://www.jfcr.or.jp/hospital/conference/cancer/pdf/online.pdf* (accessed October 8, 2020) (in Japanese)
9. Yoshimasa O. Using ICT to monitor patients in their own home from the hospital. New Medical World Weekly. 2020. *https://www.igaku-shoin.co.jp/paperDetail.do?id=PA03377_03* (accessed September 24, 2020).

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