

POLICY FORUM

Care Transitions

Introduction

An 82-year-old patient with a combination of problems lies uneasily in a hospital bed. The object of concern of a team of specialists and supporting clinicians and therapists, she is due to be transferred to a nursing care facility for what is hoped to be rehabilitation and eventual discharge. Meanwhile, the thoracic surgeon, who has replaced one of her heart valves, argues for a specific drug regimen, to reduce the risk of clots; a pulmonologist worried about the regimen's effects on breathing suggests a different drug for the clotting; a nephrologist sees problems arising because of the multiple drug therapies that have been administered during the previous weeks; a palliative care specialist is concerned that the potential for another valve replacement will be considered; the nursing staff sees problems with bed sores emerging, as well as the potential for infections; and the discharge planner is concerned that an opening in a nearby facility will be missed. This scenario was played out in much the same way a week before, as a different team considered the transfer. At one point during this week's discussion, a chief resident watching it all was heard to mumble, "What this patient needs is a doctor."

That may be true. And it may have, at one time, been normal for the patient's primary care doctor to have orchestrated the processes and resolved the conflicts. But for many patients, there is no single doctor who can coordinate the complex processes of health care that, more and more, are necessary to address the multiple acute care episodes experienced by patients with chronic illness, who are often fragile. The options for promoting, preserving, or restoring health have become so numerous that many parts of our nonsystem have little idea of what the other parts are doing. The answer to this emerging problem is to focus on these transitions of care as the weakest links in our health care delivery system—to see them as the critical connections that are necessary to allow us to reap the benefits of the complex technological advances we have seen in medicine.

We want to think that, amid this complexity, the individual patient and his or her illness are the focus of all the technology and knowledge, and that the normal course of action cooperatively builds on each special element to produce the best possible outcome. But that is not necessarily the case. The growing complexity has created real problems. The more complicated the care, the more each element needs to communicate with the others, to assure that what is done or not done for a patient in one place or by one specialist or caregiver does not interfere with what is done elsewhere.

The reality is that we have learned so much about how to treat so many different illnesses and how to extend life so far that we necessarily have generated a multidimensional lattice of specialty services that somehow must be managed for the benefit of the patient. Patients come to doctors' offices and get referred to hospital clinics or are admitted for surgeries or for care of severe illnesses; they arrive in emergency departments with life-threatening illnesses or injuries that require hospitalization or transfer to a specialty care center; they enter long-term care facilities, then go into a hospital for a procedure or a spell of intense care, when a disease manifests itself, then go back to that or another facility or home, to recuperate or to die. The multiple levels of care mean that patients move between and among them, with all possible combinations of origin and destination. Each transition requires that the patient be handed off from one set of practitioners to another. Without a coordinating primary care doctor there to help manage

that transition, we must focus on systems to make the transitions safe. This issue of the NCMJ describes some but not all of the efforts underway to make these handoffs effective and efficient and harmless. These efforts are bringing us to the point where the transition is seen as a normal part of the overall care process, not as an interruption. This change is only just happening. There is a need to make sure that different organizational and professional cultures and patterns are made to work in concert, and not at odds—so that communications are complete and interpretable—even to the point where the words one caregiver uses need to be “translated” effectively to another.

We talk constantly about centering the system on the patient. One of the biggest tests of this philosophy comes during the process of shifting the patient’s care from one place or team to another. It is easy to lose our sense of patient centeredness when institutional boundaries are crossed and the emphasis shifts to the negotiation between them. Retaining that patient focus is possible if we recognize the dangers of the transitions and if we develop conscious and planned procedures to not just hand off, but to trade one set of caring hands for another. NCMJ

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