

Improving Care Transitions Means More Than Reducing Hospital Readmissions

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Hospital readmissions are not only expensive, avoidable, and dangerous, but are also indicative of the most dysfunctional elements of US health care. The Patient Protection and Affordable Care Act places great emphasis on reducing preventable readmissions by building care systems that are patient-centered and that remove arbitrary silos of care. Hospitals that perform poorly on this measure will experience significant financial penalties beginning this fiscal year. In the short term, decreasing readmission rates will eliminate waste and enhance patient recovery from major illness. However the real vision is to ensure that vulnerable patients, particularly the chronically ill, benefit from coordinated, patient-centered systems that maintain functional independence, improve quality of life, and provide comfort without the trauma, expense, and displacement that unnecessary hospitalization often entails. The commentaries published in this issue of the NCMJ portray some of the most significant barriers to smooth transitions and reducing readmission rates and describe some of the nascent North Carolina and national solutions that demonstrate promise in real world situations.

HB is a 76-year-old man who was admitted to the hospital because of weakness and shortness of breath. He has a long history of atrial fibrillation and his heart rate had been well controlled on a high dose of diltiazem combined with metoprolol and digoxin. He was on warfarin (the blood thinner) to prevent a stroke. It was discovered during this hospitalization that his heart rate was falling into the 20s, causing his severe weakness and leading to a gathering of fluid in his lungs. As a result, his diltiazem medication was cut in half and the digoxin was stopped. HB's heart rate came back to normal and he felt well. When he went home, he thought his warfarin was the medicine stopped rather than the digoxin, even though it was written down, so within 3 days he came back to the hospital, weak with a heart rate of 36 and unable to speak or move his right hand. Without the warfarin, he had had a small stroke. Warfarin was restarted and the digoxin was stopped and his condition improved. He went home, where he lives alone, but he had some persisting weakness and he fell. His daughter knew of a good assisted living facility and arranged for HB to stay there until he felt stronger. The facility called HB's outpatient doctor who put him on the medicines he was on before his 2 hospitalizations, as he hadn't been informed of the hospital admissions during

or after. HB passed out during his 3rd day at assisted living and was readmitted to the hospital with a heart rate of 24 and fluid in his lungs.

One of the first nationwide payment initiatives established by the Patient Protection and Affordable Care Act (PPACA) is the Hospital Readmissions Reduction Program. Starting this fiscal year, all hospitals in the US that accept Medicare payment will be evaluated using 30 day readmission rates after an index admission for the primary diagnoses of heart attack, pneumonia, or congestive heart failure [1]. Poorly performing hospitals—those who have higher readmission rates among comparable patients—will receive cuts in Medicare reimbursement for all diagnostic related groupings at a rate of 1% for the first year of unsatisfactory performance, a number that will escalate to 3% by the third year of the program. Why would the most comprehensive health care bill enacted in 50 years place such major emphasis on a simple trip back to the hospital? Because readmissions are not only expensive, avoidable, and dangerous but are also indicative of the most dysfunctional elements of our health care systems. As the story of HB illustrates, many readmissions are the direct result of the silos that institutions have built that separate inpatient, outpatient, and intermediate care settings (eg, nursing homes and rehabilitation facilities). In the context of major illness, we have allowed this divided approach to isolate patients as they traverse the care continuum and we have failed to make patient safety and well-being the paramount goal when locations and levels of care change. It has been estimated that as many as one half to two-thirds of all hospital readmissions are avoidable [2-5]. Thus, by creating substantial financial incentives to prevent readmissions, the framers of the PPACA have determined that from the outset of its implementation, patient centeredness, care coordination, and smooth transitions across all health care settings are

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extremely high priorities for a nurturing, modern, and safe health care system.

What are some important elements of excellent care transitions known to reduce readmissions, reduce emergency room utilization, and improve patient safety? Naylor's Transitional Care Model, Coleman's Care Transition Intervention, Jack's Project RED, Hopkins Guided Care Model, and several disease specific programs have identified strategies that help frail and at-risk patients achieve these goals [6-12]. On the inpatient side before the hospital discharge, patients and receiving caregivers need to be thoroughly educated about medications, warning signs of clinical worsening, and self-management skills. This teaching needs to be appropriate and understandable and should incorporate techniques such as "teach-back" to assess adequate understanding. Care managers, who are usually skilled nurses or other highly trained personnel, bridge transitions between settings. Tasks for the care managers include outpatient medication reconciliation, reaffirmation of warning signs, and extended telephone contact for 1 to 2 months after discharge. The effect of the care manager is enhanced by facilitating and assuring that outpatient services arrive, by making at least one home visit to assess the situation, and by providing some after-hours access to help patients cope with fear and uncertainty. On the ambulatory care side, other important factors include timely outpatient follow-up during which the primary care provider resumes guidance of the patient's care in a medical home setting. This visit should include prompt receipt of the patient's personal health record either electronically or through the patient, clear presentation of urgent contact options, and assiduous coordination with the care manager to avail the patient of the community services necessary to recover and attain the best possible quality of life.

The commentaries published in this issue of the NCMJ describe early applications of many of the above solutions in real world environs. Nelson and colleagues show how a community engagement approach brought several key organizations and stakeholders together to build an effective transitions program [13]. This Community Connections initiative managed to align health system goals of decreased utilization with client goals of improved quality of life by listening carefully to the ideas of community participants, and then creating an infrastructure for mutually reinforcing activities to meet the needs identified by Connections' constituents. An important element of this program is the realization that readmissions and emergency room use were symptoms of patient frailty and lack of resources. The emphasis on quality of life and maintaining independence demonstrates that this group fully embraces the true value of an excellent community transitions program. Future data are likely to confirm the aspired goals. Watkins describes Forsyth Medical Center's Hospital to Home Program and documents components of the program as well as improved outcomes in the 2.5 years since inception [14]. Important observations in this com-

mentary include superior physical and mental functioning in the intervention group and a one-third decrease in hospital admissions. By providing an average of 2.7 navigator visits, 3.5 telephone calls, and 16 hours of home care assistance per client over an average enrollment of 63 days, the program reached the triple aim of patient satisfaction, higher quality, and lower cost. Finally, DuBard and colleagues describe the transition efforts of Community Care of North Carolina, the state's flagship medical home program designed to optimize quality and reduce costs for 1.2 million Medicaid patients. In this piece, the authors give a sense of the mammoth scope needed to create a statewide transitions program and demonstrate the strengths and challenges attributable to variance in regional roll-outs, resources, and methodologies. It is both impressive and hopeful that a perceptible decrease in admissions has already been achieved [15]. Trygstad's accompanying sidebar clearly describes the gaps in medication reconciliation and adherence related to transitions and aptly points out adherence inconsistencies among high-risk, frail patients that don't necessarily abate in the post-transition interval. He also explains the emerging role of network-based pharmacists in combating these gaps in medication adherence [16]. Lattimer's commentary lists many of the resources available through the National Transitions of Care Coalition. Many of these materials were used to design the early efforts featured here [17].

Despite the many hopeful programs dotting the North Carolina health care landscape, complex transition problems for extremely vulnerable patient groups remain. Goins describes the unique conditions and administrative barriers in nursing homes that often fuel high readmission rates and failed transitions [18]. Poole sheds light on the particular difficulties of those who suffer severe and persistent mental illness and Lin illustrates the obstacles in primary care and specialty provider relationships [19-20]. However, even among difficult special populations, there is a ray of hope. Noel's article about the MemoryCare Program shows us how the transition needs of chronically ill patients change over time. Designed as a community support program for patients with Alzheimer's disease, MemoryCare teams participate in disease management planning, caregiver training, counseling, and support for each enrolled family. They also provide guidance and medical assistance in managing difficult behaviors, coordination of available community resources, and counsel families regarding end of life decision making. Particularly notable is the acknowledgment and support of caregivers and the recognition that geographic transitions, aggressive hospital care, and polypharmacy are often harmful rather than helpful in advanced disease [21].

On face value, the Hospital Readmission Reduction Program of the PPACA alerts us to the necessity for transitions to reliably include better discharge planning while avoiding overuse of acute care settings. However, the overarching goal of this law is to demolish health care silos and institute patient-centered care, regardless of health care

setting. For the literal among us, the short-term prospects of reduced admissions, elimination of waste, and enhanced recovery may suffice. But the real vision is to ensure that vulnerable patients, particularly the chronically ill, benefit from systems that maintain functional independence, enhance quality of life, and provide comfort without the trauma, expense, and displacement that unnecessary hospitalization so commonly entails. **NCMJ**

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