EDITORIAL

Eric A. Coleman, MD, MPH[1]
Mark V. Williams, MD[2]

[1] Care Transitions Program, University of Colorado at Denver and Health Sciences Center, Denver, Colorado

[2] Division of Hospital Medicine, Northwestern University, Chicago, Illinois

Executing High-Quality Care Transitions: A Call to Do It Right

As a hospital practitioner, you have undoubtedly experienced the frustration of witnessing how easily the excellent care you provide can unravel as the patient goes out the door. Patients are admitted acutely ill, and largely attributed to your clinical acumen, they are discharged "tuned up" and stable to return home. Days later, however, you may learn that your best-laid discharge plans were not properly executed, and the patient returned with yet another exacerbation. Clearly this scenario represents a major setback for the patient and family caregivers. Possibly dismissed as another episode of "patient noncompliance," such readmissions are now being recognized as system failures and reflect a discharge process that has been described as "random events connected to highly variable actions with only a remote possibility of meeting implied expectations" (Roger Resar, MD, Senior Fellow, Institute for Healthcare Improvement).

Once an area that received relatively little attention, transitions out of the hospital has been identified as a priority area in need of action by a confluence of recent research and national activities. Recognizing the expanding evidence for lapses in quality and safety, many esteemed organizations, including the Joint Commission, the Centers for Medicare and Medicaid Services and their accompanying Quality Improvement Organizations, the Institute for Healthcare Improvement, the Institute of Medicine, National Quality Forum, the Medicare Payment Advisory Committee, the American Board of Internal Medicine Foundation, the National Transitions of Care Coalition, the American College of Physicians, the Society for General Medicine, and the Society for Hospital Medicine, are currently focusing their efforts on how to optimize transitions. All have articulated the need for further clinical investigation that can offer greater insight into the nature of the problems that arise during this vulnerable period and what the potential solutions are.

In this edition of the *Journal of Hospital Medicine*, 3 teams of investigators have responded to this need, making timely, important, and unique contributions to advance the field.[1–3] Specifically, each of these articles further raises awareness that a patient's transition out of the hospital often unfolds quickly in a fast-paced, chaotic manner, placing many competing demands on clinicians, patients, and family caregivers. Not surprisingly, such competing demands can contribute to deficits in quality and safety. The authors of these studies all directly identify the central role of communication among clinicians as well as between patients and clinicians in ensuring successful handoffs, further affirming the Joint Commission's finding that inadequate communication is the leading cause of sentinel events.[4] In this respect,

DOI 10.1002/jhm.276
Published online in Wiley InterScience (www.interscience.wiley.com).

communication is more than simply the transfer of information; rather, it involves the need to ensure comprehension and provide an opportunity to have a 2-way dialogue. Importantly, these articles share a common approach in fostering our understanding of the perspective of patients and family caregivers with a particular focus on disadvantaged populations.

Kripalani and colleagues conducted a comprehensive review of the state of the science for those key hospital discharge issues that pertain to hospitalists. They identified a number of challenges including communication between hospital- and ambulatory-based clinicians, medication reconciliation, timely hospital follow-up, and engaging patients in self-care. For each of these priority areas, the authors provide pragmatic recommendations for improving care that could be implemented within the current state of practice, either individually or as a "bundle" of interventions.

Recognizing that patients are often the only common thread across different sites of care, Strunin and colleagues demonstrate the value of including the voice of the patient in helping clinicians to understand the challenges and larger context in which they attempt to follow through with discharge instructions. Strunin et al. found that among a range of factors that contribute to adherence problems, many were nonmedical. Fortunately, a number of these are modifiable and point to the need to both prioritize recommendations to patients and to simplify them whenever possible. The authors' findings resonate with a growing literature that examines the hospital discharge process from the patient's perspective.[5–10]

Flacker and colleagues surveyed older patients to gain greater insights into their information needs at discharge. From a process standpoint, they demonstrated that a posthospital survey was feasible and acceptable to older patients. In and of itself, this finding has important implications in the context of national efforts aimed at implementing performance measurement and accompanying public reporting. It also may reflect patients' eagerness to be contacted after discharge; hospitalization is a major event in patients' lives, and attentive follow-up is appreciated. The authors found that more than half of patients did not recall being asked about how they would care for themselves on returning home from the hospital. Although there may be a variety of explanations for this finding, it nevertheless points to an immediate area for intervention.

TABLE 1
Research Agenda for Transitions of Care

1. Greater recognition of the integral role of family caregivers
2. Empirically define the appropriate follow-up interval
3. Define physician accountability for patients referred to home health on hospital discharge
4. Delineate the role of the hospitalist in the advanced medical home
5. Develop the ability to examine episodes of care

Collectively, these 3 articles set the stage for a proposed clinical investigation agenda aimed at optimizing transitions out of the hospital (see Table 1). These 5 recommendations have the potential to ensure that the gains patients make in our hospitals are maintained long after discharge.

1. **Greater Recognition for the Integral Role of Family Caregivers.** The patient and family caregivers should be integrated into health care professionals' efforts to improve care coordination across settings. Family caregivers have been "silent partners" in health care delivery, functioning as de facto care coordinators. During care handoffs, family caregivers make important contributions to ensuring quality, safety, and adherence to patient preferences; their role needs to be formally recognized and supported. An important initial step would be standardizing the approach to defining the types and intensity of the roles family caregivers play to facilitate improved communication. One proposed working definition is the "**FACED**" classification developed by one of the authors (E.C.). Modeled after the TNM system used in cancer, each letter of FACED refers to a different contribution made by a family caregiver: **F** = Financial; **A** = Advocacy; **C** = Care coordination; **E** = Emotional support; and **D** = Direct care provision. A simple numeric rating system could be developed whereby 0 = does not contribute in this area and 3 = makes significant contribution to this area. Such a straightforward approach would readily inform all members of the health care team about the caregivers' roles and capabilities and how they can optimally collaborate in the care plan.

2. **Empirically Define Appropriate Follow-Up Interval.** At present, patients are given rather arbitrary and generic instructions for when to obtain follow-up with their outpatient primary care physician or specialist. Surgical patients are often instructed to follow up with their surgeon, and yet most of the readmissions of these patients are attributable to medical conditions

(personal communication, Steven Jencks, MD, Centers for Medicare and Medicaid Services). Furthermore, a significant number of discharged medical and surgical patients are readmitted to the hospital within 30 days without any outpatient contact with a health professional. One may envision an evidence-based tiered approach whereby patients are assigned a hospital readmission risk score at the time of discharge that then determines the timing of their follow-up appointment. Using this framework, the highest-risk patients may be encouraged to receive follow-up within 24-72 hours, whereas lower-risk patients may be able to wait 14-21 days. Of course, there will need to be sufficient access to outpatient physicians, who will need to be available, to ensure the success of this strategy.

3. **Define Physician Accountability for Patients Referred to Home Health on Hospital Discharge.** Communication problems between the hospital and the home health care agency are a source of aggravation for both parties, not to mention patients. Typically, a hospitalist provides the initial order for services and then expects subsequent home care coordination to be managed by an outpatient physician. Unfortunately, in some cases the patient may not have an outpatient physician or the patient's primary physician may be unaware of the recent hospitalization and thus unwilling to assume management of an unfamiliar care plan. As a result, home care nurses often cannot identify a physician to respond to their questions or concerns. At the center of this problem lies a lack of understanding of where the responsibility of the ordering hospitalist ends and the outpatient physician assuming care begins. Recognizing the profound costs of failed home health care leading to hospital readmission, the nation's Quality Improvement Organizations launched a national campaign in 2006 to address this problem. Hospitalists should engage in this effort and not punt the entire responsibility to home health agencies—imagine if hospitals and hospitalists were financially penalized if a patient was readmitted.

4. **Delineate the Role of the Hospitalist in the Advanced Medical Home.** Modeled after a concept with origins in pediatrics, the American College of Physicians and American Academy of Family Physicians are promoting the "advanced medical home" as a new care model that aims to provide comprehensive ambulatory care with an explicit focus on care coordination.[11] The Centers for Medicare and Medicaid Services is planning to initiate a demonstration of this approach. What has not been adequately underscored is how the advanced medical home will communicate essential clinical information with the hospitalist and what, if any, will be the role of the hospitalist in relation to a patient's medical home? Ideally, the medical home approach will alleviate many of the current access problems that impede timely follow-up.

5. **Develop Ability to Examine Episodes of Care.** Patients with complex conditions often require care from different practitioners in multiple settings. From the vantage point of health care professionals, these may appear to occur as merely a string of individual interactions, including hospital admissions and discharges. However from the patient's perspective, the experience is more appropriately characterized as a journey across an aggregated episode of care. The National Quality Forum is currently exploring how to measure quality of care delivered across such an episode of care. Additionally, the Centers for Medicare and Medicaid Services is developing a new assessment tool that will transcend acute and post–acute care settings, the Continuity Assessment Record and Evaluation (CARE). This tool will potentially enhance our ability to measure care across a predefined episode. Measurement can further pave the way for payment reform designed to align incentives toward higher-quality care transitions. Currently, professional fees for coronary artery bypass grafting surgery are bundled across an episode, including hospital and post–hospital care settings. Extending this approach to a wider array of conditions and services could encourage new perspectives on the timing of discharge and the use of post–hospital care venues. For example, under bundled payment, incentives might support a plan to keep a patient in the hospital an extra 1 or 2 days in order to obviate a transfer to a skilled nursing facility and the concomitant risks of transfer-related problems. Further, bundled payment may allow for the provision of additional services not currently covered, including transportation, as identified by Strunin and colleagues.[3]

Hospitalists are well positioned to offer leadership in these high-leverage areas and thereby make a unique contribution to the quality and safety of care transitions. By so doing, they are poised to reaffirm their professionalism,[12] ensuring that the excellent care that they provide in the hospital is sustained well into the future.

Address for correspondence and reprint requests: Eric A. Coleman, Director, Care Transitions Program, University of Colorado at Denver and Health Sciences Center, Denver, CO; E-mail: Eric.Coleman@uchsc.edu, http://www.caretransitions.org

REFERENCES

1. Flacker J, Park W, Sims A. Discharge information and older patients: do they get what they need? *J Hosp Med.* 2007;2: 291-296.
2. Kripalani S, Jackson A, Schnipper J, Coleman E. Promoting effective transitions of care at hospital discharge: a review of key issues for hospitalists. *J Hosp Med.* 2007;2:314-323.
3. Strunin L, Stone M, Jack BWM. Understanding rehospitalization risk: can the hospital discharge be modified to impact recurrent hospitalization. *J Hosp Med.* 2007;2:297-304.
4. The Joint Commission. Sentinel event statistics. Available at: http://www.jointcommission.org/SentinelEvents/Statistics/. Accessed August 7, 2007.
5. Weaver FM, Perloff L, Waters T. Patients' and caregivers' transition from hospital to home: needs and recommendations. *Home Health Care Serv Q.* 1998;17:27-48.
6. vom Eigen K, Walker J, Edgman-Levitan S, Cleary P, Delbanco T. Carepartner experiences with hospital care. *Med Care.* 1999;37:33-38.
7. Harrison A, Verhoef M. Understanding coordination of care from the consumer's perspective in a regional health system. *Health Serv Res.* 2002;37:1031-1054.
8. Coleman EA, Eilertsen TB, Smith JD, et al. Development and testing of a measure designed to assess the quality of care transitions. *Int J Integrated Care.* 2002;2:e02.
9. Levine C. Rough crossings: family caregivers odysseys through the health care system. New York: United Hospital Fund of New York; 1998.
10. Ellers B, Walker J. Facilitating the transition out of the hospital. In: Gerteis M, Edgman-Levitan S, Daley J, Delbanco T, editors. Through the Patient's Eyes: Understanding and Promoting Patient-Centered Care. San Francisco: Jossey-Bass; 1993:204-223.
11. Barr M, Ginsburg J, American College of Physicians. The advanced medical home: a patient-centered, physician-guided model of health care. p. 1-22.http://www.acponline.org/hpp/adv_med.pdf Accessed August 7, 2007.
12. Project of the ABIM Foundation A-AFaEFoIM. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med.* 2002;136:243-246.