

## Successful Care Transitions Programs: Positioning Patients as Active Partners

It is a simple, powerful concept: patients should be at the center of **patient-centered care planning**. However, despite acknowledging the patient's importance and the need for timely communication, effective, coordinated transitions of care that accomplish this are rare. **Often poor outcomes** are the result, as transitioning providers lack key medical information and patients' and families' self-management abilities are often limited by a lack of understanding and knowledge. Ultimately, these failures are given many labels: patient non-compliance, provider error, poor hospital care coordination and more. The reality is that unwanted outcomes such as preventable readmissions, or unnecessary admissions, must be reduced. What if providers included the patients and their families as active members of the care team and provided a "hub" of communication to drive a coordinated discharge effort? Then a patient-centered and effective discharge plan would be the rule and not the exception.

*"Adverse events often occur during care transitions, most often with complex, chronically ill, and vulnerable patients.<sup>1</sup>"*

Recent changes to the healthcare delivery system have further complicated the inherent care coordination and communication challenges between hospitals, providers, patients and caregivers. The stark reality is that Dr. Welby is gone for good and the experience of **having a single provider managing a patient across the continuum is no longer the prevailing model of care in the US**. The primary care doctor has been replaced with the model of siloed specialist care. The emergence of the hospitalist movement in specific has

*"... some observers have worried that such [hospitalist] services may complicate discharge transitions to primary care physicians, particularly for the most frail patients.<sup>2</sup>"*

## Successful Care Transitions Programs: Positioning Patients as Active Partners

added to the complexity of hospital care transitions, with admission and discharge coordination becoming a topic of much discussion. Add other specialists to the care model and the number of providers and care settings in which a patient may receive treatment, especially as they age and their care needs become more complex, quickly mounts. As former National Coordinator for Health Information Technology David Blumenthal notes: “The average 65 year-old with five chronic conditions has 14 doctors and is on multiple medications...<sup>3</sup>”

Not surprisingly, the Dartmouth Health Atlas<sup>4</sup> demonstrates more care often results in paradoxically worse outcomes. As patients see more hospitalists and specialists, and have fewer primary care visits and evaluations, the fragmentation of care and lack of coordination becomes increasingly more problematic. Providers delivering care may also not have accurate and timely patient information to create and implement effective care plans. The patient is often given multiple care plans, prescriptions and instructions with no overlying theme or coordination of care. Too often, these care plans are not patient centered and fail to account for a patients’ or families’ needs or abilities.

*“Failure to identify issues such as health literacy, cultural barriers, and educational issues are factors that may lead to higher rates of rehospitalization, particularly in vulnerable populations.”<sup>5</sup>*

Let’s examine the discharge process itself as an example of care fragmentation and the challenge of care transitions. All hospitals face pressure to open beds and often deal with the reality of multiple patients being discharged at roughly the same time of day. The discharge visit may also be the first time the nurse or physician actually meets the patient. It is not surprising that discharging providers often fail to engage the patient’s primary care physician, the patient and/or their caregivers in shared decision making and the development of a post-discharge care plan. Add the pressure to be “efficient” in the discharge

## Successful Care Transitions Programs: Positioning Patients as Active Partners

process and the resulting confusion and outcome is not unexpected - instructions may not be clear or comprehensive, factual errors can occur,

*"We know that if doctors work as teams it is a whole lot better than when they don't talk to each other...and when there isn't a coordinated strategy. So those are part of the underlying efforts that will be implemented as part of comprehensive reform."<sup>6</sup>*

patients and families are often hesitant to actively participate and the plan may not account for key personal factors influencing the patient's ability to effectively carry out the provided plan. The success of an effective discharge plan is greatly reduced. As a 2007 JAMA article by Kriplani et al. concluded,

"Deficits in communication and transfer at hospital discharge are common and may adversely affect patient care."<sup>7</sup>

### *Reform Redefines Need for Care Transition Programs*

New CMS reforms are raising the stakes for hospitals to achieve better patient outcomes and improve care transitions in a cost-effective manner. Preventing readmissions has escalated from a weakly visualized and implemented effort to a top priority. Better coordination of care transitions by hospitals and ACOs is integral to this effort and to avoid impending penalties associated with poor performance. Hospitals and ACOs must develop care transition programs to appropriately align patients, families, community services and providers on a single timely care plan that gives the patient (and by extension, the hospital) a greater chance at a successful transition. Dr. Jane Brock, CMO, MEDICARE Transitions Project, succinctly addresses the most critical process gap: **"The most fundamental problem is the lack of a common platform for a group of disparate providers to come together."**<sup>8</sup> Providers want to deliver the best care to their patients. In our current healthcare delivery model this requires a new concept, that of a care coordination hub, to enable the creation of collaborative, patient-specific care plans understood by all members of the care team, including the patient and caregiver.

## Successful Care Transitions Programs: Positioning Patients as Active Partners

New technology platforms are available to support evidence-based best practices and program development with a thorough understanding of the care transition process. By utilizing these emerging care coordination technology platforms as a central component of their care transitions, health care providers, facilities, patients and caregivers can collaborate as effective partners. As Kripalani et al also concluded, “Interventions such as computer-generated summaries and standardized formats may facilitate more timely transfer of pertinent patient information to primary care physicians...”<sup>9</sup>

### *Essential Components of a Care Coordination Hub*

As we previously noted, effective, timely patient-centered care is much discussed but seldom practiced; the right process and technology solution will reduce this unfortunate reality. An effective care coordination platform must place the patient’s specific needs at the center of the **hub**, allowing patients and caregivers both access and the ability to become an effective partner in their own care. Enabling an evolving plan that considers the unique needs and abilities of the specific patient and includes the provider teams that care for the patient upon transition greatly enhances the probability of ongoing compliance. **Encouraging patients to participate as active care team members and providing access to their medical information and care plans increases the likelihood of reaching their goals of staying out of the hospital by 50%.**<sup>11</sup>

*“Less than half of our study patients were able to list their diagnoses, the name(s) of their medications, their purpose, or the major side effect(s). Lacking awareness of these factors affects a patient’s ability to comply fully with discharge treatment plans”<sup>10</sup>*

A care coordination hub must also provide a platform for assessing a patient’s risk of readmission or admission. It is this level of risk, or risk profile, which should in turn drive the creation of a detailed care plan that is accessible and understandable for providers and patients. A primary care physician or care

## Successful Care Transitions Programs: Positioning Patients as Active Partners

transition coach cannot singlehandedly manage all patients, nor can hospitals afford to staff clinicians to manage every patient with the same post-acute care plan. Risk-driven resource allocation facilitates the assignment of the clinician, or combination of clinicians, best suited to partner with the patient to create a care plan that can be successfully implemented.

To increase the likelihood of a successful transition, a care coordination platform must both include the patient, family caregiver and primary care physician and position them to have greater influence in the care transition

*“The average 65 year-old with five chronic conditions has 14 doctors and is on multiple medications...”*

process, both as the discharge is taking place and in the crucial hours and days after discharge. Medication plans, appointment schedules, symptom guidelines with treatment protocols and clear instructions on how to respond to changes in clinical condition can be formatted in a manner that is both easy to understand and effectively perform. Creating step-by-step instructions with required accountability and transparency

ensures that a patient will have the timely support and resources they may need to position themselves for success.

Patients are often aware of the fact that something is wrong, yet fail to act. Frequently this is because they are unsure of what to do and simply do not want to “bother” anyone. A proper care coordination platform combines a rapid response to changes in medical conditions with evidence-based, protocol-driven care that can be implemented in a coordinated and effective manner. Symptoms and signs of disease exacerbation can be addressed in a systematic care plan that provides all care team members, including the patient, with clear directions. This eliminates “guessing” and delays in care, and bases treatment not on subjective interventions but evidence-based protocols. Appropriate, timely care delivery mitigates further exacerbation of symptoms while ensuring effective treatment in the most cost-effective care setting, often before emergency care or hospital admissions are required.

## Successful Care Transitions Programs: Positioning Patients as Active Partners

Once a patient feels confident in their role as an active, informed participant in their own care plan, the opportunity for the hospital and providers to deliver the most effective and efficient care becomes a reality.

### *Perfect Care Transitions: Collaborative Care Models Combined with IT*

Given the importance ascribed to successful collaboration in transitions of care and preventing readmissions, care coordination platforms that improve the efficiency and effectiveness of care plan collaboration are of growing importance. For patients and care givers, this means a real chance to be an active member of their own care team – to actually be the **center** of the medical plan. For providers, it affords a tool that will enhance their ability to give the excellent care they truly want to deliver in a manner that will not add to their long list of tasks and burdens. For hospitals, accountable care organizations and other health care organizations, a collaborative platform gives the opportunity to be proactive not only in improving patient care transitions, but by placing the organization at the forefront of clinical solutions that will serve them well in this challenging health care environment. With the right IT solution and attention to the power of a collaborative care model, providers, organizations and patients will truly become partners working to achieve long term success in a cross-continuum model of care. The patient will finally be the center of patient-centered care.

# Successful Care Transitions Programs: Positioning Patients as Active Partners

## About the Author:

John Loughnane, MD is a graduate of the University of Massachusetts Medical School. He completed a residency in Family Practice at the University of Washington (Seattle) Medical Center. Dr. Loughnane's clinical experience includes primary care, hospitalist medicine, and extensive clinical and administrative experience in palliative care medicine. Dr. Loughnane served as Chief of the Quincy Medical Center's Hospitalist service where he developed the "Transitions in Life Care" program that was awarded the Beacon Hospice Excellence in Hospice and Palliative Care Award in 2009. He was also named Quincy Medical Center's Physician of the Year in 2008. Currently, Dr. Loughnane serves as Director of Palliative and Hospice Medicine at Commonwealth Care Alliance and as Medical Director for Boston Community Medical Group (BCMG) where he coordinates BCMG's inpatient service at Boston Medical Center. He is board certified in family medicine and hospice and palliative care medicine.

## About Care Team Connect:

Utilizing evidence-based best practices, Care Team Connect is a technology platform in which hospitals, community providers, family members and patients collaborate to improve outcomes in ways that can also reduce healthcare costs. By localizing how information and tasks are shared among care team members, Care Team Connect creates transparency and accountability while also leading the way toward a patient-specific model of care. Easy to use and backed by extensive education, training and follow-up support, Care Team Connect is designed to optimize healthcare performance throughout the continuum of care. Care Team Connect offers consulting services to implement the technology platform as well as for those developing their care transition programs sans a technology platform. To learn more, visit [www.careteamconnect.com](http://www.careteamconnect.com).

# Successful Care Transitions Programs: Positioning Patients as Active Partners

## References:

- <sup>1</sup> Halasyamani, L., Kripalani, S., Coleman, E., Schnipper, J., van Walraven, C., Nagamine, J., Torcson, P., Bookwalter, T., Budnitz, T. and Manning, D. (2006), Transition of care for hospitalized elderly patients—Development of a discharge checklist for hospitalists. *Journal of Hospital Medicine*, 1: 354–360. doi: 10.1002/jhm.129
- <sup>2</sup> Mor V., Besdine R. Policy Options to Improve Discharge Planning and Reduce Rehospitalization. *Journal of the American Medical Association*. 2011 Jan; 305(3): 302-303.
- <sup>3</sup> Blumenthal, David. *Technology Review*. Available at: <http://www.technologyreview.com/computing/23546/>
- <sup>4</sup> The Dartmouth Atlas of Health Care available at: <http://www.dartmouthatlas.org/>
- <sup>5</sup> Greenwald, J., Denham, C., Jack, B. The Hospital Discharge: A Review of a High Risk Care Transition with Highlights of a Reengineered Discharge Process, *Journal of Patient Safety*, 3: 2, June 2007.
- <sup>6</sup> Sebelius, K. Remarks made at the ASA/NCOA Meeting March 15, 2010. Available at <http://www.youtube.com/watch?v=s5XoHWtgEzw>
- <sup>7</sup> Kripalani S et al. Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians: Implications for Patient Safety and Continuity of Care. *JAMA* 2007 297(8):831-841.
- <sup>8</sup> Dr. Jane Brock, as quoted in Kanaan, Susan B. (2009) **Homeward Bound: Nine Patient-Centered Programs Cut Readmissions**. Retrieved from: <http://www.chcf.org/publications/2009/09/homeward-bound-nine-patientcentered-programs-cut-readmissions>
- <sup>9</sup> Kripalani S et al. Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians: Implications for Patient Safety and Continuity of Care. *JAMA* 2007 297(8):831-841.
- <sup>10</sup> Mayo Clinic Proc. 2005; 80(8): 991-994 Available at: <http://www.mayoclinicproceedings.com/content/80/8/991.full.pdf>
- <sup>11</sup> Coleman E et al. Preparing Patients and Caregivers to Participate in Care Delivered Across Settings: The Care Transitions Intervention. *J Am Geriatr Soc* 2004;52:1821-22.