Philanthropy Profile

Care Transitions: An Essential Part of the Delivery of Health Care

The aging of the residents of the United States, the intensity of chronic illnesses, shorter hospital stays, and a situation with proportionately fewer caregivers will increasingly affect the ways that individuals receive care. Patients are no longer just "discharged" from the hospital; rather, they "transition" from one care setting to another, whether the transition is from the hospital to the home, to a subacute or postacute nursing center, or to a long-term care facility.

Care transitions is that key part of the process of care where extra effort needs to be expended to ensure the continuity of care as a patient moves through the system of care, "rest-stopping" at appropriate destinations on the health care journey. While ensuring continuity is important for all patients, it is particularly important for the elderly and individuals with disabilities, who often have complex medical needs and require access to the health care system more frequently.

Ineffective care transitions manifest themselves in unnecessary hospital utilization and associated expenses. The *New England Journal of Medicine* reported, in a study of Medicare beneficiaries, that almost 20% were readmitted within 30 days and that 34% were readmitted within 90 days [1]. Hospital costs for these unnecessary readmissions were estimated to be $17.4 billion. These affect not only the individual, but also the entire system, including providers and payers.

The concept of care transitions is particularly relevant in this era of health care reform, as it relates to quality of care as well as cost. This practice will be increasingly important as health care reform redesigns how services and resources will comprehensively support the patient. As our nation seeks to provide patients with the appropriate services at the appropriate times, the concept of care transitions will be essential to establish accountable care systems, which will provide longitudinal support for patients. This will require great choreography between organizations to ensure optimal transition between settings, so that maximum stability is provided for patients as they pass from one provider to the next.

The Duke Endowment, which was established in 1924, has been dedicated to improving the health of the citizens of the Carolinas. Since 2008, when the endowment made its first grant in this area, the topic of care transitions has expanded nationally, as providers recognize the importance of optimal transition, so that patients do not have to begin over with each interaction, thus compromising any health gains they have achieved.

While this work is still relatively new, the endowment and its grantees have learned much in a short period.

First, there is no need to reinvent the wheel. A number of effective established models already exist. Examples include the Care Transitions program (http://www.caretransitions.org), the transitional care model (http://innovativecaremodels.com/care_models/21/overview), Project RED (Re-engineered Discharge; http://www.bu.edu/fammed/projectred/), and Project BOOST (Better Outcomes for Older Adults Through Safe Transitions; http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm). They provide recipes for implementation, as well as tools for application. In addition, the National Transitions of Care Organizations (http://www.ntocc.org/Home/tabid/36/Home/tabid/36/Default.aspx) and the Long Term Quality Alliance (http://www.ltqa.org) provide tremendous resources to assist organizations and communities.

Second, collaboration inside and out is important. While organizations are proficient in managing care while a patient is part of that organization, challenges ensue when patients are handed off to the next provider. It is critically important to ensure seamlessness from one setting to another.

Third, identifying at-risk patients is essential. Patients who are at greatest risk are likely to benefit most from participation in a formal care transitions program. Factors for organizations to consider in establishing criteria include excessive emergency department visits, excessive hospital readmissions, risk due to polypharmacy issues, and other factors that make patients vulnerable to potential readmissions.

Lastly, data collection and analysis are critical. In addition to the individual indicators measured by each collaborating organization, it is important for all transition partners to agree on universal indicators to track the success of the effort.

Care transitions will be increasingly important, particularly given the complex medical issues with which individuals contend, the growth of the elderly and the disabled populations, and the continued implementation of health reform. This nascent specialty will continue to expand to meet the needs of patients in the best possible way. There are many excellent resources for organizations and many opportunities as the health care industry continues its revolutionary evolution. NCMJ

References

1. Jenck SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. N Engl J Med. 2009;360(14):1418-1428.

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