

## Transition to Nowhere

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### The Case

A 75-year-old man with a history of prostate cancer, poorly controlled myotonic dystrophy, hypertension, and chronic kidney disease was admitted to the hospital with anuric acute kidney injury in the setting of angiotensin receptor blocker overdose. The patient initially required intensive care unit admission for urgent hemodialysis before having a return of renal function to his previous baseline. Discharge planning efforts created a series of challenges.

The patient was new to this health system (having recently moved to the area), had no primary care provider established yet, and needed close follow-up care. The inpatient team desired a 1-week follow-up appointment to check renal function, potentially re-start medications held during hospitalization because of the renal failure, and ensure entry into the primary and specialty care systems. The next available primary care appointment was in 6 weeks, and the urgent care clinic only offered same-day appointments, leaving no way to schedule a visit there prior to discharge. The patient was instructed to call the urgent care clinic in 1 week for a same-day appointment. However, he never made it to the clinic. Nearly 2 weeks later, he presented to the emergency department with poorly controlled hypertension. Once his renal function was assessed and found to be back to baseline, his previously held antihypertensives were re-started, and he was sent home once again with the original primary care appointment now only a few weeks away.

### The Commentary

This "transition to nowhere" scenario illustrates gaps in the continuum of care that may frustrate inpatient teams, despite their best effort to facilitate appropriate primary care follow-up.

Care transitions is a hot topic in health care, with innovations in health care policy and payment reform driving change at a rapid pace. It is well accepted that poorly executed care transitions are associated with increased adverse medication events, hospital readmissions, and health care costs.<sup>(1)</sup> The prolonged duration of this vulnerability to hospital readmission has led to a new term, the "post-hospital syndrome."<sup>(2)</sup> How might recent developments involving health care policy, payment reform, systems innovations, and patient engagement apply to this case from the perspectives of patients, providers, and health care

systems?

From the patient perspective, barriers to an effective care transition could include poor understanding of the reason for hospitalization, difficulty self-managing medical conditions, low health literacy, lack of access to a telephone or transportation, functional deficits, sensory deficits impeding information transfer at the time of discharge, or lack of caregiver support. Busy inpatient teams are unlikely to have time to assess and address all of these areas at the time of hospital discharge.

From the provider perspective, barriers to an effective care transition often include poor knowledge and/or availability of interventions to reduce hospital readmissions. For instance, tools that stratify patients for the risk of readmission, such as the Yale-New Haven Hospital Center for Outcomes Research and Evaluation (CORE) Readmission Risk Calculators mobile application could have triggered more intensive postdischarge support for this patient.<sup>(3)</sup> This tool incorporates information readily available at the point of care, including patient demographics, medical history, physical examination, and laboratory data, to predict risk of 30-day readmission for heart attack, heart failure, or pneumonia. The proposed postdischarge intervention in this case involved only a single component (i.e., an urgent care visit) among the array of options that have increasingly become available for postdischarge follow-up ([Table](#)).

From a systems perspective, evidence suggests that transitional care models can overcome barriers to effective transitions. Multicomponent interventions appear to be most impactful in reducing hospital readmission rates.<sup>(4)</sup> Transitional care models, which generally include two or more interventions (e.g., telephone contact within 48 hours of hospital discharge and outpatient follow-up visits within 2 weeks of hospital discharge) have an impressive return on investment, with per member per month savings up to \$343 with Coleman's Care Transitions Intervention.<sup>(5)</sup> Recent developments in health care policy, including the Community-based Care Transitions Program within the Affordable Care Act, have been associated with a decrease in the 30-day all-cause readmissions rate among Medicare beneficiaries from 19% in 2007–2011 to 17.5% in 2013.<sup>(6)</sup> Other factors potentially driving these improvements include payment reforms, most notably the CMS [Centers for Medicare and Medicaid Services] readmission penalty that withholds up to 3% of Medicare payments for hospitals with excess readmissions. Transitional care management (TCM) codes and the newly approved chronic care coordination codes, also from CMS, provide reimbursement for outpatient practices to perform care coordination. New models of care, including the Patient-Centered Medical Home (PCMH), and new types of health care workers (such as transitions coaches, transition navigators, and care managers) who often operate within the PCMH and across the "medical neighborhood" <sup>(7)</sup> are well positioned to implement this care coordination function.

It may be argued that the patient in this case should not have been discharged without a better follow-up plan. This raises a crucial question: Who bears responsibility for his care upon discharge? From a medico-legal perspective, both hospitalists and primary care physicians share legal responsibility for patient care after discharge.<sup>(8)</sup> However, this case presents a special challenge since the receiving outpatient physician did not have a prior relationship with this patient, and hence no clear legal responsibility for coordinating his care after discharge.

One solution to this "transition to nowhere" could involve a systems approach that addresses gaps in the continuum of care by combining intensive transitional care management with timely access to primary care.

The inpatient team in this case could have been supported by a hospital-based transition navigator (9) to assist with functions including readmissions risk stratification, identification of barriers to an effective transition, and activation of a transition management team led by an outpatient care manager. Instead of relying on an outpatient visit as the sole postdischarge intervention, the outpatient transition management team could conduct a home visit or a telemedicine visit utilizing self-taken blood pressure measurements, augmented by clinical pharmacist-led medication reconciliation, prior to the outpatient visit. Appropriate outpatient access for high-priority post-hospital visits could be ensured by primary care that is first contact, continuous, comprehensive, and coordinated (10), such as the PCMH model. Accountable care organizations (ACOs) would be incentivized to support this combination of intensive transitional care management and timely access to primary care in order to achieve shared savings.

A cultural shift in medical education away from individual physician–patient interactions and toward team-based, interprofessional models of care (11) is upon us. The need to include training to facilitate effective care transitions (12,13) is a critical and often overlooked aspect of successful systems approaches to reducing readmissions. For the ongoing outpatient care of the patient in this vignette, a team-based approach means that access and continuity do not need to be mutually exclusive. By ensuring that appropriate systems are in place to overcome gaps in the continuum of care, his "transition to nowhere" can be transformed to a "bridge to better care."

### Take-Home Points

- Barriers to effective care transitions include patient factors (i.e., ability to self-manage medical conditions), provider factors (i.e., familiarity with best practices in care transitions), and systems factors (i.e., availability of postdischarge supports).
- Evidence supports multicomponent rather than single interventions to reduce hospital readmission rates.
- New models of care such as the Patient-Centered Medical Home that include new types of health care workers (including transition navigators and care managers) are well positioned to provide appropriate access and care coordination after hospital discharge.

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## Table

**Table. Comparison of Post-Hospitalization Care Settings for Community-Dwelling Patients According to Access and Continuity.**

Outpatient Follow-Up Care Setting	Access Continuity	
	TRADITIONAL MODELS	EMERGING MODELS
Office visit	+/-	+
Urgent care	+	-

**Outpatient Follow-Up Care Setting    Access Continuity**

**TRADITIONAL MODELS**

**EMERGING MODELS**

Emergency department	+	-
Patient-Centered Medical Home (PCMH)	+	+
Postdischarge clinic	+	-
Transitional care models	+/-	-
Telemedicine	+	+/-

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