

## COMMENTARY

## Care Transitions for the 21st Century

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It is not uncommon to hear both hospital-based and community-based physicians lament difficulties in communication at times of care transitions, as physicians must transfer important clinical history both into a distinct hospital record on admission and then into a separate community health record on discharge. With rapid advances in information technology, particularly communication technology, physicians on both sides of the acute care and primary care divide have hoped for similar revolutions in clinical information technology to assist with communication. However, aside from clinical information systems deployed in integrated delivery systems, change has been slow and fragmented. Having the needed information communicated to the patient's health care home in a systematic, efficient, and timely manner has proven to be difficult. Without effective communication systems in place, problems have occurred with the lack of primary care notification of admission and discharge, timely completion and transmission of discharge summaries, and incomplete communication of important follow-up items such as pending tests. Despite evidence suggesting that an available discharge summary was associated with a relative risk of 0.74<sup>1</sup> for a 30-day rehospitalization, the availability of a discharge summary at follow-up has repeatedly been demonstrated to be low (12% to 34% at time of first follow-up).<sup>2</sup>

Older modalities such as fax, telephone/pagers, and e-mail continue to be used by hospitalists and other inpatient physicians despite issues with security, especially with e-mail. In an era in which "closed loop" communication, where key

clinical information is repeated back by the recipient for confirmation, has become a standard practice, these modalities often fail to provide confirmation of receipt.

Current solutions for hospitalist and inpatient physicians, especially those operating outside of integrated delivery systems, include commercial products often connected to charge capture or business management software applications that fax, message, or transmit web-based information entered into these systems to the patient's primary care physician.<sup>3,5</sup> For example, one national hospitalist management group has developed an internal web-based practice management tool with built in communication functions that notify and transfer information to their primary care physician clients.<sup>6</sup> In addition, regional-level health information exchanges are also available to facilitate communication with primary care physicians. Their functionality ranges from providing secure e-mail messaging to serving as repositories and offering electronic results delivery services from hospitals, physicians, radiology offices, and commercial laboratories.<sup>7,9</sup>

Federal legislation including the Affordable Care Act (ACA) and the Health Information Technology for Economic and Clinical Health (HITECH) legislation (colloquially referred to as "meaningful use") has created a favorable environment for improved care transitions facilitated by novel technology for the future. The two laws create a number of sizable incentives in the form of both rewards and penalties to encourage providers and health systems to adopt technology that will likely positively impact care transitions. Principally, by applying hospital penalties

for relatively excessive rehospitalization rates, the ACA has made rehospitalization and failed care transitions a prominent quality metric that is pushing hospitals to reconsider best practices around discharge communication. Additional sections of the ACA support diverse experiments in more robust care transition support including the enlistment of community-based organizations (through the Community-based Care Transitions Program); pilot testing of bundled payment episodes crossing acute, post-acute, and community care; and the support for best practice interventions to improve care transitions through the ACA's Hospital Engagement Networks (HENs).

Synergy between the ACA and HITECH in support of improved technological support for care transitions is embedded in evolving support for the patient-centered medical home, which will serve as a patient data hub, bringing together information from diverse areas of health care delivery to facilitate coordinated care guided by a generalist physician. The importance of the medical home to coordinated care is reflected by the National Quality Forum's recommendation that the health care home should serve as the "central point" for coordination and continuity of care. It is expected that increasingly the medical home will utilize a comprehensive electronic health record capable of not only basic storage functions (i.e. storage of patient demographics, clinical problems, clinical notes, medication history, and diagnostic data) but also patient management functions (i.e. test and prescription ordering, storage of medical history, clinical decision support).<sup>10</sup> Specific

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requirements for health care entities as defined in the HITECH legislation are summarized at [https://www.cms.gov/EHRIncentivePrograms/30\\_Meaningful\\_Use.asp](https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp). While the ultimate scope of the ACA remains subject to political action following the recent US Supreme Court decision, it is likely that persistent interest among both payers and providers in accountable care structures, bundled payment models, and the medical home will be associated with further growth of these models in coming years. Hopefully, tighter linkages across care settings implicit in these models will facilitate improving communication at times of care transition.

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