The Burden of Chronic Disease

In the United States, the traditional model of healthcare delivery is divided into discrete episodes of care. Patients frequently move between multiple settings and providers without a dedicated person or team assuming responsibility for maintaining quality of care or managing the transitions-of-care process. Without a single point linking healthcare systems and providers, the efficiency of care coordination during a transition is reduced. This lack of effective coordination can have serious consequences, many of which can likely be reduced or avoided. These consequences include:

- Gaps in quality of care due to:
  - Lack of patient education and patients who don’t adequately understand their condition at discharge
  - Inadequate communication and medical follow-up among providers between sites of care
  - Medication issues

- Exponential increases in healthcare costs as a result of:
  - Duplicate therapy
  - Readmissions
  - Adverse drug events

The situation is compounded by the fact that patients with multiple chronic conditions use health services at higher rates than other patients. Because of poor coordination of care, these patients often receive duplicate testing, conflicting treatment advice, and prescriptions that are contraindicated. These factors seem to play a role in the correlation between the growing number of chronic conditions and the increasing percentage of preventable hospitalizations and readmissions.

**THE HIGH COST OF CHRONIC CONDITIONS**

Patients frequently require care in more than one setting for a single episode of illness. This need is exacerbated because approximately half of all Americans suffer from one or more chronic diseases. Caring for these patients can result in an even higher utilization of healthcare resources and spending.  

- 75% of total healthcare spending in the United States, approximately $1.7 trillion, is for people with chronic conditions
- Healthcare spending for people with chronic conditions is nearly 6 times higher than for people without chronic conditions
Healthcare Reform Funds New Initiatives

The US government has allocated almost $1 trillion as part of the 2010 healthcare reform legislation for projects and initiatives aimed at improving overall quality and coordination of care.

These efforts include:

- Reducing avoidable hospital readmissions through enhanced transitions of care
- Providing incentives for reducing preventable hospitalizations
- Reducing payments to hospitals for excess hospital readmissions
- Broadening the use of health information technology (HIT) that will facilitate provider communication
- Developing standards for reporting on quality improvement and performance measures relating to the meaningful use of HIT
- Testing value-based payment modifiers through the National Pilot Program on Payment Bundling

Recommendations for Transitions-of-Care Initiatives

- Identify patients who will likely need care transitions in the near future
- Collaborate with patients and their caregivers in pretransition planning
- Identify patients who are suffering from advanced chronic conditions and are likely to need hospitalization and post-acute care services
- Give patients and caregivers tools and resources that will help them participate in developing their transition care plans (e.g., patient transfer checklist for patients admitted to a hospital)

Quality Insights of Pennsylvania Transitions-of-Care Project

Quality Insights of Pennsylvania is currently working on a community-based, cross-setting project that promotes efficient transitions between hospitals, skilled nursing facilities, home health agencies, and physician offices. The goal of the project is to reduce unnecessary hospitalizations and readmissions and improve coordination across the continuum of care.

The project’s transitions-of-care interventions focus on:

- Care transition coaching
- Discharge interventions
- Postdischarge follow-up
- Transition management communication
- Medication self-management
- Personal health records
- Patient-transition care plans

Key Programs and Initiatives

US policy agencies and healthcare societies are increasing their support for research and initiatives designed to help establish transitions-of-care best practices.

Some programs and projects currently under way to improve transitions of care within the US healthcare system include:

| **Hospital Readmissions Reduction Program** | a program that authorizes the Centers for Medicare & Medicaid Services to track national and hospital-specific data on the readmission rates of Medicare-participating hospitals |

| **National Medicare Pilot Program** | a bundled reimbursement plan aimed at improving quality and reducing spending for an episode of care that begins 3 days prior to hospitalization through 30 days posthospitalization |

| **Health information technology initiatives** | projects centered on developing and integrating technology that enables healthcare providers to maintain, store, and share patient medical information via electronic medical records and electronic health records |

| **Accountable care organizations** | partnerships between local entities and providers that are held accountable for reducing costs and improving quality of care for Medicare beneficiaries assigned to them |

| **Project Better Outcomes for Older Adults through Safe Transitions (BOOST)** | a national initiative led by the Society of Hospital Medicine, the project is a comprehensive tool kit for improving transitions of care in hospitals |

| **Project Re-Engineered Discharge (RED)** | led by a research group at Boston Medical Center that develops and tests strategies for improving hospital discharge processes |

| **Geisinger health system** | a nonprofit, physician-led, integrated health system headquartered in Pennsylvania that applies an interdisciplinary, team-based quality-improvement model to enhance transitions of care |

| **National Transitions of Care Coalition (NTOCC)** | a coalition of more than 30 associations and organizations dedicated to addressing the issues and challenges surrounding transitions of care, including quality of care coordination and communication |
References