Editorials

Transitions of Care: Optimizing the Handoff from Hospital-Based Teams to Primary Care Physicians

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In a recent study of Medicare beneficiaries who had been hospitalized, nearly one in five was readmitted within 30 days of discharge, and those with conditions such as congestive heart failure or chronic obstructive pulmonary disease had even higher rates of readmission.[1] This results in an estimated cost of more than $17 billion to the federal government.[1] A systematic review of interventions to improve the handover of patient care from hospital-based teams to primary care physicians found that multicomponent interventions that include medication reconciliation, use of electronic tools to facilitate communication, and shared involvement in coordinating follow-up care reduce rehospitalizations and improve patient satisfaction.[2] Because the average length of hospitalization is four days for most general medicine patients, primary care physicians and hospital-based teams must partner from the moment of hospitalization to optimize the transition plan.

The effectiveness of hospital-based care transition programs is unclear. Although some programs reduced 30-day rehospitalization rates,[3,4] a systematic review found that no single intervention is reliably helpful, and successful readmission reduction programs generally occur only in single institutions.[5] However, it seems that programs that focus on the whole patient rather than a specific diagnosis are more successful in reducing readmissions.[6] This concept is in keeping with the focus of primary care physicians. To solve the challenge of care transitions, the primary care physician should have a prominent role at three times: at admission, immediately after discharge, and at the postdischarge follow-up visit. For physicians who manage or participate in the hospital care of their patients, this task occurs naturally. This commentary addresses the role of primary care physicians who are not directly involved in the hospital care of their patients.

At the time of hospitalization, the primary care physician should contact and maintain communication with hospital-based clinicians. Ideally, an automated admission-discharge-transfer notification would be sent to the primary care physician via an electronic medical record system; however, other modes of communication from hospital-based clinician to primary care physician (e.g., telephone calls, e-mails, text messages, facsimile) may help start the dialogue. The primary care physician should discuss any concerns about the care plan, medications, medical history, and any social or family dynamics that may affect care, and should obtain an estimated date and destination of discharge.

Although connecting with hospital-based clinicians at the time of admission is important, primary care physicians can have the most impact after the patient has been discharged, when postdischarge problems may be compounded without appropriate care coordination. To bridge the gap between discharge and follow-up, the primary care physician or a staff member with clinical knowledge can contact the patient 24 to 72 hours after discharge. This reconnects the patient and physician, and lets the patient know that his or her primary care physician has resumed care. The following items should be addressed:

- Any ongoing symptoms
- Self-care plans developed by the hospital team
- Medications, particularly any that are new, or that have been changed or stopped
- Arrangements for aftercare services (e.g., visiting nurse, home physical therapy)
- Scheduling of and transportation to follow-up visits

During the follow-up visit, the physician should focus on issues exclusive to the hospitalization. For example, the face-to-face encounter can be used to assess how the patient is recovering and to review the postdischarge care plan. Using patient engagement techniques such as "teach back" can ensure the patient's understanding of self-care plans.[7] The physician should also conduct a thorough medication review and ensure that the patient understands any changes to the medication regimen. In addition, there may be outstanding issues to be addressed, such as test results that were pending at the time of discharge[8] or follow-up tests that were recommended during the hospitalization.[9]

Caring for hospitalized patients and arranging their discharge plans have become increasingly complex, and patients may wonder what will happen to them next. Evidence-based information on understanding and improving care transition gaps may help health care organizations establish bundled programs for transition of care.[10] Primary care physicians should have a prominent role in the transition of their hospitalized ▶

patients. Although these steps may require additional time and resources in an already busy practice, they are critical to keeping patients safe and healthy at home after discharge. Recent additions to *Current Procedural Terminology* codes 99495 and 99496 for transitional care management may support the primary care physician's care transitions efforts, and participation in alternative payment models (e.g., bundled payments, accountable care organizations) may provide the infrastructure for a successful office-based care transition program.

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REFERENCES

1. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program [published correction appears in *N Engl J Med*. 2011;364(16):1582]. *N Engl J Med*. 2009;360(14):1418-1428.
2. Hesselink G, Schoonhoven L, Barach P, et al. Improving patient handovers from hospital to primary care: a systematic review. *Ann Intern Med*. 2012;157(6):417-428.
3. Hansen LO, Greenwald JL, Budnitz T, et al. Project BOOST: effectiveness of a multihospital effort to reduce rehospitalization. *J Hosp Med*. 2013;8(8):421-427.
4. Jack BW, Chetty VK, Anthony D, et al. A reengineered hospital discharge program to decrease rehospitalization: a randomized trial. *Ann Intern Med*. 2009;150(3):178-187.
5. Hansen LO, Young RS, Hinami K, Leung A, Williams MV. Interventions to reduce 30-day rehospitalization: a systematic review. *Ann Intern Med*. 2011;155(8):520-528.
6. Dharmarajan K, Hsieh AF, Lin Z, et al. Hospital readmission performance and patterns of readmission: retrospective cohort study of Medicare admissions. *BMJ*. 2013;347:f6571.
7. Schillinger D, Piette J, Grumbach K, et al. Closing the loop: physician communication with diabetic patients who have low health literacy. *Arch Intern Med*. 2003;163(1):83-90.
8. Roy CL, Poon EG, Karson AS, et al. Patient safety concerns arising from test results that return after hospital discharge. *Ann Intern Med*. 2005;143(2):121-128.
9. Moore C, McGinn T, Halm E. Tying up loose ends: discharging patients with unresolved medical issues. *Arch Intern Med*. 2007;167(12):1305-1311.
10. Kim CS, Flanders SA. In the clinic. Transitions of care. *Ann Intern Med*. 2013;158(5 pt 1):ITC3-1. ■