Gaps in poorly managed care transitions from hospitals to home and other post-acute care facilities often mean patients end up back in the hospital. For recurring readmissions, hospitals can face CMS penalties and patients may experience a less than optimal recovery.

Dr. Mark V. Williams, chief transformation and learning officer and chief of the Division of Hospital Medicine at the University of Kentucky, is researching the best ways to plug these gaps, reinforce continuity and coordination, and reduce provider burden. His findings are expected to publish in March 2019.

Williams spoke on the subject at the American College of Physicians Internal Medicine in 2017. His talk, "Strategies to Decrease Readmissions: Challenges and Opportunities," discussed the fact that some patients are more at risk than others and certain hospitals face inherent disadvantages in reducing readmissions.

To level the playing field, Williams is heading a study called ACHIEVE (Achieving Patient-Centered Care and Optimized Health in Care Transitions by Evaluating the Value of Evidence). Funded by the Patient-Centered Outcomes Research Institute (PCORI), the 52-month study examines which transition services already in place are most effective for helping patients and their caregivers transition to other levels of care without complications. Additionally, the study evaluates which evidence-based "transitional care components" are most effective across a broad range of settings and community demographics.

"This study will provide tools for hospitals, community-based organizations, patients, caregivers, clinicians and other stakeholders to help them make informed decisions about which transitional care services are most effective and how best to implement them in their own community," Williams states in the NIH grant study abstract.

Hospitals across the nation participating in the ACHIEVE study will see a network diagram of their referral patterns and post-acute utilization. The study will also conduct site visits and provide standardized surveys for patients and caregivers to detail their experience through the hospital discharge process and transition to at-home care.

ACHIEVE will show need for community services

Many patients with complex diagnoses face challenges when adhering to their care management plan following discharge. These patients often rely on the help of others for transportation and medication management, and some do not have supplemental Medicare coverage which causes them to miss follow-up appointments and run the risk of

rehospitalization, poor recovery and health complications.

To address these risks, providers should utilize partner resources to address community-based challenges, Williams said. He suggested providers partner with community agencies to provide additional services in cases where patients may not have a family member or caregiver to rely on.

One person in the audience at the American College of Physicians Internal Medicine meeting noted that many community services organizations have limited funds. Williams agreed, but said the ACHIEVE study will demonstrate how providing such services will result in reduced costs to the healthcare system and better outcomes for the patient. In turn, this may prompt community organizations to re-prioritize how they allocate the money available to them.

Data will illuminate value-based opportunities and trends

As health care continues to evolve, patient data helps providers determine their strengths and weaknesses in this new era of value-based care. Initiatives like bundled payments, which aim to reduce costs and improve patient outcomes, will require large amounts of data to demonstrate success or failure. To implement care transition strategies that work seamlessly to support initiatives such as bundled payments, then, it is crucial for hospital organizations to have a strong partner who is well-versed in the analysis and consumption of large data sets.

One important tool ACHIEVE will provide is a detailed caregiver survey matched with actual patient data. This will show how certain challenges (i.e. transportation) affect outcomes. It will also illuminate strengths that can be used as opportunities for cost-savings and efficiencies when building teams for bundled payment initiatives.

“Hospitals can use this to develop their own interventions,” Williams noted.

Some hospitals may find opportunity for interventions in unusual places. One doctor in the audience said he works in a hospital where the extra bed in the room is almost always is available, and doctors encourage caregivers to come in and spend the night with loved ones recovering from joint replacements. That way, the caregiver will know exactly what challenges they will face when the hospital discharges their loved one.

Communication and connection for optimal care

Williams noted that some of the biggest hurdles doctors face in providing proper patient

care during a transition are *scribbled notes and poor discharge summaries*.

“There are patients who have been in the hospital for a month, and there is just a paragraph of sketchy information for the handoff,” Williams said. He noted that documentation continues to eat up a doctor’s day, with the latest statistics showing that doctors spend 40 percent of their time documenting patient information.

Simple coordination and communication among provider offices goes a long way toward ensuring the patient journey is streamlined, timely and effective.

“Why aren’t we paying primary care providers to communicate with hospitals about their patients in the hospitals?” Williams posed.

The bottom line? Without communication across the care continuum, value-based care will face challenges when delivering on its promise of reducing costs, improve patient experience and outcomes. To truly deliver toward value, keeping all stakeholders informed and truly engaged is essential to optimize care coordination across the continuum.

Aiming to ACHIEVE patient-centered care

By evaluating the critical period that can make or break a patients’ recovery after hospitalization, Project ACHIEVE hopes to identify best practices in care transitions that matter most to patients and caregivers, and reduce readmissions and hospital utilization. With the collected data, healthcare organizations can improve care transitions and reinforce the promising foundation of value-based care that benefits hospitals and patients alike.