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Op-Ed: After hospital care, the test begins

Even for a healthcare professional, a patient's care following discharge can be overwhelming.

<http://www.latimes.com/news/opinion/commentary/la-oe-swan-post-hospital-care-20130509,0,3384867.story>

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BethAnn Swan, Dean and Professor at the Jefferson School of Nursing at Thomas Jefferson University, Philadelphia PA.

In 2011, my husband, Eric, a trial attorney, was felled by a brain stem stroke just before he was to board a flight at O'Hare in Chicago. He was just 53 years old with no prior health conditions or problems. From the outset, we knew his recovery and rehabilitation would be long and difficult. We didn't know that his transition to post-hospital medical care would be just as challenging.

I'm the dean and a professor at the Jefferson School of Nursing at Thomas Jefferson University in Philadelphia, and I'm a registered nurse. I thought my training and access to resources would aid in managing my husband's care. Instead, our experience showed me the many flaws in the world of medical "care coordination" and "transition management." And it made me more concerned about how anyone can deal with the demands put on them by our healthcare system.

There were appointments to schedule with seemingly impossible-to-reach specialists, lost medical records and a billing error that landed us in collection for \$23,312. There were 10 pages of discharge guidelines, seven prescription medications and 29 pages of accompanying instructions. What we did not have, however, was an actual comprehensive care plan, much less a contact within the system who could help us coordinate my husband's extremely complicated care once he was home.

Although my background and professional contacts made things easier, the vast majority of patients are not so lucky. Recently, the Robert Wood Johnson Foundation released a report, "The Revolving Door: A Report on U.S. Hospital Readmissions." A lot of readmissions, the report found, are the result of problems with care transition.

One in 5 elderly patients is readmitted to the hospital within 30 days of discharge. Some are readmitted for an anticipated follow-up procedure, while others find themselves back in the hospital for an unrelated cause. Yet data suggest that 76% of these readmissions are preventable, and poor care transitions are most certainly to blame. According to the study, "They are the result of a fragmented system of care that too often leaves discharged patients to their own devices, unable to follow instructions they didn't understand, and not taking medications or getting the necessary follow-up care." Readmissions, of course, negatively affect our health as patients, and they cost Medicare \$17 billion a year.

Why is this happening? The report offers countless reasons, though not all are easy to solve.

Particularly in situations like Eric's, patients can become overwhelmed, both with their health condition and with the logistics of care. Though care needs to be continuous once a patient leaves the hospital, many patients are not given a detailed discharge plan so that they know exactly what they need to do to preserve their health.

Some of the patients polled for the foundation report were not ready to change their behaviors, such as smoking cigarettes or clocking in long days at the office. But others were simply unable to help themselves. Data show that more than half of patients could not accurately recall their diagnoses upon discharge, and nearly as many did not understand the medications prescribed for them. As a result, they don't recognize warning signs when a condition worsens or realize when a dosage is incorrectly prescribed. The lucky patients have a family member or friend who can serve as a caregiver, but too many have no support once they're home.

While the patient struggles to manage his own care, there is a distinct lack of communication between hospitals and doctors serving that patient. After a patient leaves the hospital, fewer than 1 in 5 sees any direct communication between the hospital and the individual's primary-care physician. The lack of communication, according to medical providers who participated in the foundation's study, results from confusion concerning who is "in charge." Patients with chronic conditions often see multiple doctors, and there is no protocol on who should take the lead. Likewise, there is no one professional identified for the patient to contact with any post-discharge questions.

There is no end to the factors that cause preventable hospital readmissions, and it's a subject that is finally getting the attention it deserves. Beginning last year as part of the *Affordable Care Act*, hospitals that do not meet certain guidelines in preventing readmissions are fined. It's a start, but we need further reform so that patient care and transition systems inside and outside the hospital are handled in a kind, sensible, thorough and realistic manner. We need to change "patient-centered care" from a trendy phrase to true coordination that prepares a patient and his family for the outpatient care required once home — and whatever it takes to keep that patient at home instead of back in a hospital bed.

Beth Ann Swan is dean and professor at the Jefferson School of Nursing at Thomas Jefferson University. This is adapted from an article in the November issue of Health Affairs.