Partnering to Improve Care Transitions

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This issue of *Prescriptions for Excellence in Health Care* marks the end of our series of articles devoted to a vitally important but – until recently – generally overlooked systemic problem: transitions of care.

In April of this year, the Obama Administration launched Partnership for Patients: Better Care, Lower Costs, an innovative public-private partnership designed to help improve the quality, safety, and affordability of health care by bringing together the leaders of major hospitals, employers, health plans, physicians, nurses, and patient advocates along with state and federal governments in a shared effort to make hospital care safer, more reliable, and less costly.

The Partnership aims to save lives by stopping millions of preventable injuries and complications in patient care over the next 3 years – a very ambitious goal! If the initiative is successful, the price tag for US health care could be reduced by up to $35 billion, including $10 billion for Medicare.

Today, nearly 1 in 5 Medicare patients discharged from the hospital is readmitted within 30 days. This means that almost 2.6 million of our senior citizens are readmitted to hospitals to the tune of over $26 billion every year. So, it should come as no surprise that one of the Partnership’s 2 major goals is to help more patients heal without complication. Targeting preventable complications during a transition from one care setting to another, the goal is a 20% reduction in all hospital readmissions by 2013 (compared with 2010 data).

In humanistic terms, achieving the goal would mean that more than 1.6 million patients would be spared the suffering from a preventable complication that would land them back in the hospital in less than a month.

The Centers for Medicare and Medicaid Services (CMS) has made a financial commitment to the effort. A new Community-Based Care Transition Program at CMS’ Innovation Center is providing $500 million in funding to community-based organizations that partner with their local hospitals to improve care transition services.

When I first heard about the Partnership, I thought it was a great idea but I was skeptical about the prospects of achieving such a lofty goal. I’m happy to report that my pessimism was fleeting.

Within a few short months of the Partnership’s launch, more than 500 hospitals have pledged their commitment along with physician groups, nursing organizations, consumer groups, and employers. As Partnership members, each of these entities will identify specific steps they will take to improve transitions of care. For instance, the Association of American Medical Colleges has implemented a complementary harm reduction effort – Best Practices for Better Care – a multiyear initiative to improve the quality and safety of health care. More than 200 teaching hospitals and health systems have joined the effort and have pledged to take simple steps such as using surgical checklists for safer surgery and using proven practices to reduce central line infections.

The lead article in this issue, “Engaging Communities in Improving Care Transitions and Reducing Utilization,” describes the development and ongoing success of a community-based care transitions project in Northwest Denver. The second article, “Inherent Risks: A Hospitalist’s Perspective on Hospital Discharge Transitions,” (continued on page 2)
explore care transitions from the perspective of a physician “hospitalist.” The final article, “Medications and Care Coordination: Prevalence, Measurement, and Reduction of Errors,” discusses how hospital-based pharmacists are tackling medication reconciliation as a means to improve transitions from the hospital to the home, nursing home, or long-term care setting.

As always, I welcome questions and comments from readers. I can be reached at david.nash@jefferson.edu.

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For further information on the Partnership for Patients, see http://www.healthcare.gov/news/factsheets/partnership04122011a.html or http://www.healthcare.gov/center/programs/partnership/index.html