The Evolution and Devolution of Hospital Care

By Jerald Winakur, MD, MACP, CMD

I entered medical school in 1969. Through a quirk of fate, I found myself part of an experimental program in medical education, the “Clinical Program,” as it was called. It was an off-the-wall endeavor, but I was forged by it. From my first day of medical school — before I had taken classes in anatomy or physiology, pathology or pharmacology — I was placed into clinical clerkships that traditional students do not enter until their third year of training. And since I knew nothing of the culture of medicine, its doctors or hospitals, my sole identification was with my patients.

That first day I duly reported for my assigned clerkship: general surgery at the Philadelphia General Hospital (PGH). PGH, a city-financed facility for the underserved, had evolved from “Old Blockley,” established in 1732 as an almshouse for the poor, the sick, the elderly, and the insane. William Osler, the Father of Internal Medicine, during his time at Penn (1884–1888) regularly made rounds there. Historians consider Old Blockley to be the first hospital in what would become the United States.

The surgery ward at PGH was a huge open space with large windows all around, though by 1969 they were covered in deep grime and only let in dim, gray light. Hand-cranked hospital beds lined two long opposing walls, with a painted metal nightstand by each one. Folding partitions would be placed around a bed when necessary, such as during examinations, therapeutic administrations, or a patient’s death. At each end of the ward was a large table, the hub of nursing activity. Nurses, aids, and trainees worked 24/7 in the ward with the patients.

I remember that the patients, if they were well enough, would socialize with each other, assist each other, and often

How to “ACHIEVE” Better Transitions

By James E. Lett, II, MD, CMDR

This is the epoch of Value Based Payments (VBP). Some in the medical community consider them wonderful, while others may feel they are evil. Regardless of our feelings, they are here to stay for the foreseeable future. Within that VBP framework, the true financial determinants and the components of our “report card” are reportable measures. These measures purport to determine the adequacy or quality of our clinical care. Further, just how well we clinicians perform on these measurements determines whether we are paid and how much. All this is now ingrained into our practice lives.

Quality measures, including those judging “success” in care transitions, are created, approved, shaped, defined, and prioritized from sources such as the Centers for Medicare & Medicaid Services, the Joint Commission, the National Association for Healthcare Quality (NAHQ), the National Quality Forum (NQF), and many others.

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(Disclosure: The author sits on the NQF Post-Acute Care and Long-Term Care Workgroup, and there are patient advocate organizations represented.) I can attest to the efforts of all these entities to represent the perspective of patients and families.

As clinicians we have become intimate with the programs that disseminate and manage the measurements regarding transitions. Thus the Hospital Readmission Reduction Program (HRRP), the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, and Protecting Access to Medicare Act of 2014 (PAMA) are familiar programs and acronyms to us. But it is my personal opinion that those who bear the burden of transitions — the patient, the families, and the caregivers — would recognize no more than one of the organizations (most often CMS) involved in determining a successful transfer. Additionally, I would venture that a poll of those involved in transitions on the patient side would reveal a total lack of awareness of the existence of the programs driving transitions such as HRRP, IMPACT, and PAMA.

Based on my personal and professional experience, the current state of care transitions receives a failing grade. As was repeatedly told in medical school, when things are failing, go look at the patient. Thus, it is time to look at the patient, my esteemed colleagues! Where are the things are failing, go look at the patient.

As I was reviewing the PCORI investigators concluded, “Clear accountability, care continuity, and caring attitudes across the care continuum are important outcomes for patients and caregivers. When these outcomes are achieved, care is perceived as excellent and trustworthy. Otherwise, the care transition is experienced as transactional and unsafe, and leaves patients and caregivers feeling abandoned by the health care system.”

My first thought upon reading these concerns from patients and families was denial. It can’t be possible that the patients I care for could ever feel that they weren’t valued and respected, that they don’t know who to call with their concerns, and that they don’t know how to pursue their own care after returning to what they considered home. My second thought was embarrassment and alarm.

By consensus, our patients are clearly not asking and answering at last, in a clear and methodological fashion, but also published in a scientific journal so that clinicians can learn from our peers in a format and language we accept. Project ACHIEVE: Achieving Patient-Centered Care and Optimized Health in Care Transitions by evaluating the value of evidence — a 5-year, $15 million study funded by the Patient-Centered Outcomes Research Institute (PCORI) — rigorously evaluated care transition strategies to understand what matters most to patients and caregivers (Ann Fam Med 2018;16:225–231). Their results were derived from focus groups and interviews with 248 patients and family caregivers.

So what do our patients (as well as our families and ourselves) tell us is important about transitions in their own words? Patients and caregivers in the ACHIEVE study emphasized three desired outcomes of care transition services:

1. To feel cared for and cared about by medical providers.
2. To have unambiguous accountability from the health care system.
3. To feel prepared and capable of implementing care plans.

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The major concern that arises after reading the ACHIEVE study is that we now support two parallel avenues for patient care during care transitions. One course is dictated by the prevailing payment structure: check the boxes in the guidelines for payment, and consider the job done. The other is to understand why our patients are crying out and to meet their needs, even if doing so deviates from actions that promise the most reimbursement.

I feel we should respond to the needs of our patients — and the demands of the payment system should answer them as well. If not, we need to advocate for changes in the measures now being used. To do so means creating a coalition with our patients to begin to “measure what matters” as we move forward in these tumultuous times. An alliance with patients, families and caregivers is so natural a kinship for us and our Hippocratic Oath that it scarcely requires my elaboration.

So, VBP can, and should, support through its measures what is important to patients and families. If not, clinicians should continue to perform the type of care to “ACHIEVE” the type of quality that patients and family anticipate.

More From JAMDA

Two papers in the April, hospital-themed issue of JAMDA focus on the nature of transitions between hospital and post-acute care and highlight the important role of communication and physician presence:

• An editorial by Dale et al proposes geriatric-specific standards for bi-directional information transfer between nursing homes and acute care hospitals, with focus on functional and cognitive status, medications, advance care planning, and key contact information.

• A research study by Kobewka et al underscores the importance of physician presence in long-term care. It suggests that same-day physician access could prevent almost one in six hospitalizations.

services and provider behaviors associated with achieving the excellence we seek:

1. Use empathetic language and gestures. (What we say and the body language we present are acutely seen and felt.)
2. Anticipate the patient’s needs to support self-care at home. (The social determinants of health are demonstratively crucial.)
3. Use collaborative discharge planning. (All members of the discharge-planning team should join in one discharge plan, rather offering multiple, sometimes contradictory and unrealistic conversations and plans.)
4. Provide actionable information. (That is, provide realistic next steps.)
5. Provide uninterrupted care with minimal hand-offs. (Communicate to the clinicians at the next site of care what needs to be done, what the patient’s goals of care are, and who should be contacted for questions.)

The Foundation for Post-Acute and Long-Term Care Medicine, past chair of the Society’s Transitions of Care Commit-tee, and previous editor of this column.

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