Care Across Settings: Challenges, Successes, and Opportunities

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I. Introduction: Framing the Issue

Meet Mrs. Davis.[1]

Mrs. Davis just turned 79. She is a retired schoolteacher who has lived alone since her late husband passed away four years ago. Mrs. Davis isn't wealthy, getting by on Social Security and a pension, but considers herself rich in spirit. She still lives in her own home; she tries to get out for a walk when the weather is nice; she volunteers at her church; and she delights in the regular company of her grandchildren, who live with her daughter just 10 miles away.

But, Mrs. Davis's health is declining. Several years ago, she had her thyroid removed because of a growth. She suffers from heart disease and glaucoma. Last spring she fell at the grocery store and broke her hip, for which she was hospitalized. All told last year, Mrs. Davis tallied three hospital admissions and 19 outpatient visits, spent six weeks in sub-acute care in two nursing homes, received five months of home care from two home health agencies, and received 22 prescriptions for eight medications.

Mrs. Davis's chronic conditions and hospitalizations have made life difficult for her. She is confused by her care instructions and sometimes forgets to take her medications as prescribed. She's discouraged by the seemingly conflicting advice she gets from her three different specialists. Her daughter comes by often to sort through her medications and try to make sense of her doctors' instructions, but she's got her own family to raise and career to manage.

Last year, Medicare spent nearly $50,000 on care for Mrs. Davis. Thankfully, she suffered no actual medical errors—at least none that she or her family knows about. But her care was poorly coordinated, inefficient, and in some instances unsafe. Records were misplaced. Her physicians weren't talking to each other. Her heart doctor was not aware that her orthopedist was prescribing a medicine that increased her blood pressure. That this lack of communication did not lead to a calamitous result is a matter of sheer luck. The doctors and nurses she saw took very good care of her during visits—one nurse in particular remembers her grandchildren's names and always asks about them—but once she left their offices, she was on her own.

Mrs. Davis receives care that can be very good at certain points, but is sporadic, confusing, and fragmented, and thus of poor overall quality. And she's not atypical. Millions of Americans receive care just like hers.

Every day in the United States, millions of dedicated workers, many of them highly trained and intricately familiar with the latest technologies, work very hard to deliver health care. They do a relatively good job of dispensing medical care services. In the decade since the Institute of Medicine identified quality deficiencies in the U.S. health care system,[2, 3] numerous quality improvement initiatives have sought to improve the safety and quality of U.S. health care. Examples of successful health care quality improvements include the provision of certain medications at appropriate times (e.g., aspirin at arrival at a hospital for

heart attack) and initiatives to reduce the incidence of certain healthcare-associated infections (e.g., in intensive care units).[4, 5] As a result of these, our system has improved, albeit at an unacceptably slow rate, in a fragmented manner and not equally across racial, ethnic, and other groups.[6, 7]

Many of the initiatives that have improved care have done so by focusing on points at which care is delivered (e.g., acute care hospitals, nursing homes). Yet the ultimate goal of a health care delivery system should be to improve overall health. By that measure, our system is far less successful. Measures of outcomes that actually matter to patients, such as life expectancy, continue to lag in comparison both with other industrialized nations and with the high standard we set for ourselves.

While focusing on care delivery in a particular setting improves care in that one area, it ignores others. The end result is that even successful quality improvement interventions have focused attention on the location of care rather than on the patient receiving that care. But people—especially the elderly and those with chronic conditions—don't need care just in one setting. So, Mrs. Davis benefits from care of higher quality while hospitalized but still suffers from relatively poorer quality of care once she goes home.

"Health care is only as good as its weakest link," says Robert Graham, MD, Program Director of the Aligning Forces for Quality (AF4Q) National Program Office. "If care is excellent quality in one setting and poor in another, then the overall experience is poor—and that's unacceptable."

Ideally, health care should be of equally high quality across settings, including within an acute care hospital, in an emergency department, at the doctor's office or similar ambulatory setting, in the home, and in nursing homes. And, just as importantly, care should be of high quality through transitions, when a person moves from one setting to another. In short, Americans don't just need better care; we need better care across settings.

AF4Q, the Robert Wood Johnson Foundation's (RWJF) signature effort to lift the overall quality of health care in targeted communities, has turned its attention to improving the quality of care across settings. Among its many activities, AF4Q is working with its 16 community alliances across the nations to define problems related to care transitions and care across settings, design interventions, and measure and improve the quality of care. Some communities have succeeded; others have stumbled and have had to regroup. But all are engaging in the important task of improving care such that the patient receiving care, rather than the setting in which that care is provided, is what matters most.

Improving Care Across Settings: Areas of Special Need

Care that is not coordinated across settings is redundant, expensive, and unsafe. When care is poorly coordinated, each health care interaction is an opportunity for something to go wrong. Especially for patients with chronic health care needs, poorly coordinated care often leads to medical errors, higher costs, and unnecessary suffering.

Care across settings is problematic under the following conditions:

- **The "handoff."** The handoff, or transition, is the period in which a patient moves from one setting to another (e.g., from a hospital to a nursing home).[8] Lapses in care, miscommunication of information between clinicians, and medication mix-ups are all possible side effects of handoffs that are not well coordinated. Handoffs account for an estimated 35 percent of The Joint Commission's sentinel events.[9] In response, The Joint Commission created a National Patient Safety Goal to implement a standardized approach to handoff communications.[10]

- **Follow-up care.** Many patients do not receive timely follow-up with their primary source of care after being discharged from the hospital.[11] Examples of such problems fall under "bad handoffs," including what medications patients should take upon discharge—those they were given in the hospital or those they had been prescribed before being hospitalized—what they should eat or avoid eating (and when), or when to return to visit the clinician. Nearly one in five patients discharged from the hospital to home experience an adverse event within three weeks, and two-thirds of them are due to adverse drug events.[12]

- **Ongoing care for patients with multiple chronic conditions.** Coordinating the treatment or management of multiple conditions presents a serious challenge because clinicians often are not aware of how each other is treating an individual patient. Today, the average Medicare patient sees two primary care physicians and five specialists a year,[13] and patients with multiple chronic conditions may see up to 16 physicians a year.[14] These numbers add up. In 2000, 125 million people in the United States were living with at least one chronic illness—a number that is expected to grow to 157 million by 2020; and the number of patients with multiple chronic conditions is expected to reach 81 million by 2020.[15]

- **Care when something goes wrong.** Ideally, when processes are working and the patient responds to treatment as expected, health care can resemble a well-oiled machine. However, introduce one glitch—e.g., a medical complication, an unanticipated staffing shortage, a transcription error in the medical record—and the entire process can break down. This is especially true with acute or emergent care (e.g., stroke), when time is of the essence, patients don't always respond to treatment right away, and opportunities for communication breakdowns are high.

When breakdowns occur in providing care across settings, patients suffer.

Incomplete or inaccurate transfer of information, poor communication, and a lack of appropriate follow-up care can lead to medication errors, preventable hospital readmissions, and unnecessary emergency department visits.

These breakdowns also are costly. The cost to Medicare of preventable hospital readmissions is estimated to be more than $15 billion a year.[16] For the one-fifth of patients who have another preventable admission within six months, the costs skyrocket to $729 million, or $7,400 per readmission.[17]

Measuring Breakdowns in Care

There are numerous measures to gauge the quality of care across settings. The most common are hospital readmissions (a second admission to a hospital after discharge, usually within 30 days, for treatment of the same or a related health problem) and preventable admissions or emergency department visits (admissions or visits that could be avoidable if the health problem were treated in a proactive, preventive approach). Another approach is to ask patients directly—to gauge their experience with care by routinely asking them to rate how well their care has been coordinated, explained to them, and tailored to meet their goals and preferences.

There is substantial room for improvement. Nearly 20 percent of Medicare patients are readmitted to the hospital within 30 days, and three-quarters of those readmissions are potentially preventable.[18] For congestive heart failure (CHF) alone, that figure rises to 24.5 percent for Medicare patients, at an annual cost to the federal government of up to $17 billion a year.[19] Nearly 20 percent of patients admitted to the hospital with a preventable admission had at least one preventable readmission within six months.[20] The United States consistently ranks behind other industrialized countries in the frequency of emergency department use for conditions that could have been treated with appropriate primary care.[21]

Yet care across settings is not a lost cause. Models for managing transitions exist, and some communities are bringing stakeholders together in a collaborative environment to improve care across settings.

II. Challenges in Improving Care Across Settings

The goal of every clinician who sees a patient is to provide the best possible treatment, care, or health care intervention for that patient. No clinician wants to do anything other than his or her best work for the patient. Yet, safety and quality problems occur at a disturbingly high rate. Why?

The simple answer is that our health care system isn't really a system at all. It is an assemblage of parts—of physicians' offices, hospitals, labs, nursing homes, and other components—that together comprise a series of care experiences for the patient. No one is coordinating these parts. "Care across settings suffers because it's nobody's job to manage it," says Jane Brock, MD, MSPH, chief medical director of the Colorado Foundation for Medical Care. "We shoehorn management of chronic disease into a system that is much more appropriate for treatment of acute conditions."

Thus, problems are likely to occur because of the following related issues:

- **Culture.** Each health care organization (e.g., a hospital or a physician's office) has its own distinct culture. Organizational culture is "how we do things around here." It includes a wide range of social phenomena, from the way employees dress to how much employees are involved in decision making, all of which help to define an organization's character and norms.[22, 23]Culture is a big influence on how employees approach their work and how they work with others both within the organization and outside the organization. Issues affecting culture include number of employees, labor-management relations, and religious affiliation. While all health care organizations have the same goal in mind—treating the patient—they take different steps to get there and have different "feels" about them. Unfortunately, some cultures don't work well with others.

- **Relationships.** Many organizations tend to function well as closed units, but interactions with other organizations that have different cultures (even subtly different ones) can create problems. Issues related to organizational culture can be overcome when strong relationships exist between or among multiple clinicians or provider organizations. The relationships among attending physicians, residents, and nurses within a hospital unit; between clinical

providers from a unit and the discharge team; or between nurses at a skilled nursing facility and a primary care provider all can mean the difference between a successful care experience and an unsuccessful one.

- **Leadership.** Organizations, even those with disparate cultures, can develop relationships and overcome cultural barriers if guided by strong leaders. Leadership is an often discussed but also often overlooked aspect of health care. Succeeding organizations maintain their strong position only with strong guidance, and failing organizations can achieve a turnaround only with equally strong guidance. This is important because organizations have to work together to achieve high-quality care across settings, and very often the impetus to work together successfully (especially in instances in which culture is a potential barrier) must come directly from an organization's or group of organization's senior leaders.

- **Communication.** Communication underlies every health care transaction. The ability of clinical providers to communicate with each other regardless of where they work or circumstances in which they work is of paramount importance. This is because clinicians must tell each other what they know about the unique condition of each patient as he or she interacts with various points of the health care system.

Data collection and transmission is at the heart of many of these issues. A significant amount of relevant health care information, such as diagnoses, lab results, vital signs, and prescriptions can be reduced to numeric data elements. Yet the U.S. health care system is notoriously poor at standardizing the collection and transmission of important health data across settings. It is important to note that electronic systems such as electronic health records (EHRs) can enhance this communication, but successful inter-clinician communication does not demand their use. Yet even when all relevant health care providers do use EHRs, it is likely that multiple EHRs are in use (e.g., a hospital uses one system while a nursing home has another), so the EHRs cannot "talk" to each other. Thus, data can be collected and transmitted within closed systems but not across settings.

Our system also struggles with identifying proper roles for stakeholders. Many communities have multiple entities that could be equipped to supervise care transitions, such as clinicians, payers, employer alliances, or even inter-stakeholder alliances. Care across settings ideally should be a partnership among various stakeholders; and while one or a small group of organizations can lead it, it requires the participation of and buy-in from all community stakeholders.

Yet while the problem of lack of responsibility is persistent in almost every community, local market dynamics must dictate how to meet the challenge. Different market dynamics play out in a variety of ways, including:

- **Dominant players.** In some markets, a single hospital system dictates the local health care culture. In others, it's a large health plan. In still others, a few large employers dominate. In many communities, a dominant stakeholder often controls the local agenda and is in natural position to set strategic priorities for the entire community. Significantly, dominant stakeholders often are able to exercise outsized control of financial resources. No matter who the dominant stakeholder is, that entity often is the natural leader to take charge. This, however, is not an excuse for inaction by non-dominant entities. Natural leaders can be led under certain circumstances if powerful voices from other stakeholder groups arise.

- **Turf issues.** Physicians and nurses may not agree on whose "job" it is to work directly with patients. Case managers from hospitals and health plans may get their signals crossed. Hospitals and health plans, fresh off of contentious reimbursement negotiations, compete for direct communication with patients. In establishing a care-across-settings program, it's important to acknowledge and directly confront issues of turf so no stakeholder feels overlooked.

- **Resource commitment.** Care transitions programs cost money. In many communities, the desire to get along elicits verbal assent—but these promises are rarely accompanied by the commitment of resources, financial or otherwise. But a promise of "support" is meaningless unless stakeholders commit funding to ensure a program's success. In any care-across-settings program, it's essential to elicit actual financial contributions from all stakeholders, especially providers and plans.

Ultimately, care suffers across settings because nobody is in charge of it, systems aren't in place to manage it, and, because of the prevailing health care reimbursement system built on a fee-for-service model, nobody pays for it.

III. Doing Something About It: Action Steps for Communities

The Patient Protection and Affordable Care Act of 2010 calls for progressive reduction in Medicare payments to hospitals beginning in fiscal year 2013 based on high rates of 30-day readmissions for Medicare beneficiaries.[24] Incentive payments are

available if care across settings is improved. This is one example of both an impetus and an opportunity for a care across settings initiative because readmissions are affected by factors that occur in multiple settings.

Accordingly, most communities in the United States would benefit from an initiative to improve care across settings. But that doesn't mean they should start one immediately if no work has been done yet. Care-across- initiatives take time and careful planning. "There are relatively easy steps to take to improve care across settings, but even these require a well thought-out plan," Graham says.

Graham encourages the following steps when considering an initiative:

- **Solicit stakeholder buy-in.** Convene stakeholders, including hospitals, physician practices, skilled nursing facilities, home health agencies, health plans, purchasers, and consumers, for a discussion about goal setting. Make the case for why care across settings is an issue and identify potential solutions. Ideally, this should occur under the auspices of a neutral third party.

- **Secure solid financial commitments from stakeholders.** In many communities, support is easy to assemble—until it's time to contribute money. But asking stakeholders to contribute even a small amount of money to a nascent program is the true test of commitment.

- **Measure, measure, measure.** Data is a key element. In any care-across-settings initiative, rigorously analyze local numbers to understand where opportunities for improvement lie—and be confident in your data source before committing to a program.

- **Start small.** Identify goals that can be accomplished. The total elimination of hospital readmissions, while a worthy goal, is too broad to accomplish with one initiative. Instead, pick a smaller goal, such as reducing readmissions for a certain condition by a certain percentage, and work rigorously toward achieving it. It can be difficult for some communities even to start an initiative at all, so starting small may be appropriate.

- **Dream big.** Set numeric targets that are difficult to achieve. Even though a community should set attainable goals, its achievement shouldn't be easy. It's okay to fail to meet the target in the first year if your community has a plan in place to meet those targets in years two and three.

Existing Models

Graham also advises that communities use existing models when possible to create their own initiatives. "No community needs to create an initiative from scratch," he said. "Much of the hard work, in analyzing issues and testing assumptions, has already been done." He advised that existing models can be tailored to individual communities to fit local needs. Good models include (but are not limited to) the following:

- **SBAR.** Short for "Situation-Background-Assessment-Recommendation," this technique provides a framework for communication between members of the health care team about a patient's condition. SBAR is an easy-to-remember, concrete mechanism for framing any conversation that requires a clinician's immediate attention. The original SBAR tool, modeled after U.S. Navy communications procedures and developed by Kaiser Permanente of Colorado, consists of two documents, guidelines and a worksheet. The tool has been implemented widely in a variety of health care settings.[25]

- **The STAAR Initiative.** In 2009, the Institute for Healthcare Improvement launched the STate Action on Avoidable Rehospitalizations (STAAR) initiative, a multi-state, multi-stakeholder approach that aims to reduce readmissions by working across organizational boundaries and by engaging various stakeholders, including payers, patients and families, and caregivers at multiple care sites. The two-part strategy for reducing readmissions focuses on improving care transitions by cultivating a cross-continuum learning collaborative and engaging state-level leadership to eliminate systemic barriers to change. Participating states are Massachusetts, Michigan, Ohio, and Washington State,[26] but models developed under STAAR can be used in other communities.

- **Project BOOST.** This initiative, led by the Society of Hospital Medicine, focuses specifically on care transitions. Project BOOST (which stands for Better Outcomes for Older adults through Safe Transitions) seeks to identify high-risk patients on admissions and target risk-specific interventions, reduce 30-day readmission rates and length of stay, improve patient satisfaction and patient experience of care scores, and improve the flow of information between providers. The program offers a significant number of resources (such as toolkits) and mentoring opportunities for new participants.[27]

- **Guided Care.** Guided Care, which integrates a chronic care-trained registered nurse into a primary care practice,[28] is conceived as a comprehensive care program that incorporates evidence-based processes and patient preferences to attempt to improve outcomes for patients 65 years or older with chronic conditions and complex health-care needs. In one study, Guided Care was shown to improve self-reported quality of chronic health care for multi-morbid older patients.[29]

IV. Case Studies: Improving Care Across Settings in AF4Q Communities

AF4Q communities are connecting their quality improvement efforts to improve care across settings. Alliances are working to design care delivery systems that focus on the continuity of care, avoid unnecessary risks in quality and safety, and promote coordination among clinicians.

Cincinnati: Reducing Readmissions and Integrating Care

Cincinnati is home to several hospitals and physician groups that eagerly compete with each other for market share, but it has found its clinicians need to work together to coordinate care.

Like many communities, Cincinnati's clinicians have been concerned about reducing hospital readmissions. So Cincinnati's AF4Q Alliance, the Health Improvement Collaborative of Greater Cincinnati, partnered with the local hospital association, the Greater Cincinnati Health Council, to lead an effort to reduce CHF readmissions under a program called Accountable Care Transformation, or ACT.

ACT consists of 19 hospitals and health systems, creating a "learning community" to reduce readmissions by 10 percent by adopting five best practices. These "T5" best practices are:

1. Upon admission implement a risk assessment tool with a focus on heart failure to identify patients who are at high risk of readmission considering social factors.

2. Use the teach-back method during the hospital stay from admission to discharge during key clinical interventions.

3. Provide real-time handover communications.

4. Address timely physician follow-up (appointment to occur within five to seven days of discharge)

5. Follow up with the patient or primary care giver (or emergency contact) within 48 to 72 hours of discharge via telephone or home visit.

Barbara Tobias, MD, professor of family and community medicine at the University of Cincinnati Academic Health Center and medical director of the Health Collaborative, said the ACT rests on two core principles: collaboration and transparency. "Our efforts all have to be regional because patients cross the bridge [from one community within the Cincinnati region to another] all the time. They're not bound by our hospital structures, so we can't be either," Tobias said. "We're a competitive environment, but we have to share data and talk to each other."

The T5 practices were created from a variety of sources including Project BOOST, the STAAR Initiative, and the Institute for Healthcare Improvement. Tobias will acknowledge that its implementation hasn't been smooth. "We're not getting data back in real time, and that slows us down," she said. (This "data lag" also has hampered Cincinnati's ability to track dollars saved and number of readmissions reduced; however, self-reported data from hospitals participating in the ACT indicate a downward trend in readmissions.) "But regardless of whether we meet our goal, the journey and the process has been so helpful and has improved care for patients in our communities."

There is other activity in Cincinnati as well. Encouraged by AF4Q and the Beacon Community Program, Cincinnati primary care providers are piloting the patient-centered medical home (PCMH), with several goals, including reducing hospital readmissions for CHF, reducing ED visits, and improving patients' overall experience of care. This work is being done with infrastructure established by AF4Q and enhanced by Beacon.

Currently, 19 primary care practices representing approximately 70 physicians are undergoing full transformation into PCMHs according to standards from the National Committee for Quality Assurance, a quality and accreditation organization that has published PCMH guidelines.[30] The Health Collaborative also is indirectly supporting the conversion of dozens of other practices into PCMHs; by the end of 2012, it is anticipated that nearly 100 PCMH practices will be operating in the region, and Cincinnati is forming a multi-payer claims database that will enable the community to evaluate its PCMH efforts regarding utilization and other measures. The PCMH model—which involves using electronically generated and maintained data to coordinate care with a primary care physician in active charge—comports with the care-across-settings goal of

improving the overall care experience, said Ronda Christopher, director of practice transformation and quality improvement at the Health Collaborative.

Through Cincinnati's Beacon initiative, the Health Collaborative is using emergency department/inpatient alert technology to access and evaluate utilization information for diabetic patients in these PCMH practices, according to Gina Carney, project manager for the Health Collaborative. The pilot, still in a formative phase, has made the case among providers for increased communication and collaboration across settings, Carney said.

As with the ACT, there are challenges with PCMH implementation in Cincinnati. The biggest: electronic health records do not fully support the work, despite the adoption of meaningful use standards. But getting physicians on board, which often can be a major obstacle, has not been a problem. "I have never seen a group of physicians work so hard and so tenaciously on anything in my life," Christopher said. "The PCMH can create some challenging politics, and they can sometimes be unpleasant—but everybody keeps coming back to the table."

Humboldt County: Care in the Hospital, and Help Outside of It

Humboldt County is a remote, largely rural area in Northern California. Its idyllic setting—among the redwoods and along the Pacific coast—belie a community suffering from severe economic challenges, homelessness, substance abuse, and mental illness. Hospital readmissions and overstays have proven to be problem for the county's dominant hospital system, St. Joseph Health.

An examination of the nature of readmissions led to an inescapable conclusion: The hospital was being used as a homeless shelter. "We had a lot of people staying in the hospital for a long time, even when their medical condition didn't warrant an acute care setting," said Laura McEwen, former project director of Aligning Forces Humboldt. These typically were patients with CHF and a history of substance abuse or mental illness; skilled nursing facilities couldn't take them because they wouldn't mix with frail elderly. "They had no place to be discharged to, and the hospital was the place that couldn't say no," McEwen said.

So the Humboldt region looked to Care Transitions, a program developed by Eric A. Coleman, MD, MPH, a nationally recognized expert in care across settings.[31] Care Transitions features four pillars: medication self-management, primary care and specialist follow-up, use of a dynamic patient-centered record (i.e., a personal health record, or PHR), and knowledge of red flags to look for when a condition is worsening. "It's really an empowerment model—so that after care is provided to a patient, the patient understands that care rather than just being told, 'Off you go,'" McEwen said.

St. Joseph Hospital developed its Care Transitions program in 2007, working with nursing students from Humboldt State University in Arcata, initially enrolling 77 patients. The program grew the next year to nearly 300 patients with additional funding and the hospital's hiring of a full-time coordinator, Sharon Hunter, RN. Under Hunter's direction, the hospital pulls daily reports on CHF and chronic obstructive pulmonary disorder admissions. "We're developing the relationship at the outset, when the patient is admitted to the hospital, rather than at discharge," Hunter said.

Humboldt's Care Transitions has made patient involvement its centerpiece. Patient education and coaching, supplying transitional housing for those who need it, and multiple home visits are vital to the program's success. Success is measured by lower readmissions—down from 15.34 percent for CHF at the start of the program to an average of 11 percent today—and lower costs. The latter are harder to measure because of the opacity of health care costs and spending, but Melissa R. Jones, JD, project director of Aligning Forces Humboldt, estimates that Care Transitions has saved more than $2 million in avoidable hospital stays.

The program has had to overcome obstacles. Most significantly, Humboldt State University, which had been supplying nursing students to staff the program, has closed its nursing school—so St. Joseph had to secure funding to hire a full-time replacement. But that presented an opportunity for dedicated staff. "We couldn't just say, 'Oh, there's a challenge, let's just stop.' We had to keep going forward. This was too important," McEwen said.

South Central Pennsylvania: Clarifying Handoffs

The handoff has always been one of the most challenging aspects of care because of so many opportunities for things to go wrong. Underlying the handoff issue is a communications challenge: Clinicians must tell each other exactly about the situation of each patient in clear and concise language. In South Central Pennsylvania, clinicians are using a modified version of the SBAR method to improve handoffs between hospitals and skilled nursing facilities.

SBAR, short for "Situation-Background-Assessment-Recommendation," is a framework for communication among members of the health care team about a patient's condition. It recognizes that nurses and physicians often communicate in different

ways. Nurses are taught to report in narrative form, providing all details known about the patient. Physicians are taught to communicate using brief "bullet points" that provide key information to the listener. SBAR standardizes this communication so all parties know all relevant information about patients at handoffs.

The South Central Pennsylvania alliance of AF4Q modified SBAR by adding a fifth dimension: "teach back." Teach back is the concept of asking recipients of information to repeat information they have just learned in their own words to demonstrate their understanding of the information.[32] This "SBART" approach requires nurses and physicians to communicate with each other in a structured environment, ensuring valuable information isn't lost or misunderstood.

This structured communication led local clinicians to confront several underlying but incorrect assumptions, according to Samantha Obeck, AF4Q's South Central Pennsylvania Nurses Council leader. "When a patient in a nursing home had a change in condition, the nurse was required to inform the primary care physician," Obeck said. "But a lot of times, the doctor just assumed, 'If the nurse is calling me, it's because she can't handle the situation,' so the physicians were ordering the patient to be sent to the ED—when that's not what the patient needed at all. We realized that physicians and nurses often are working off a different set of underlying assumptions."

The community started by piloting a project—still ongoing—with four hospitals, each with a nursing home partner, standardizing a written discharge instructions form. A follow-up call was required with every form. That's where the physician-nurse communication issues became apparent. "This is in many ways a nurse-empowerment tool," said Chris Amy, AF4Q's project director for South Central Pennsylvania.

Although the project is still in its infancy, it's already showing some results. The community has seen an average reduction in ED visits and preventable hospitalizations of 11 to 33 percent, baseline year compared with 2012.

The biggest barriers were cultural. Nurses were shy at first to speak up to doctors. Physicians resisted the teach-back component of SBART. But individual successes demonstrated the program's value. "We had one case in which everyone acknowledge we prevented a readmission," Obeck said. "A nurse told a doctor about a nursing home resident with altered mental status, explained that this happened over the course of three days. The patient wasn't febrile, was suffering more incontinence than usual, but his vitals were normal. The physician said, okay, this sounds like a urinary tract infection, why don't we send him to the ED? And the nurse said—and this took gumption—the nurse said we can do the urinalysis right here. The provider said ok, and analyzed the results and started the patient with oral antibiotics right there in the nursing home. The patient was never admitted. That was a real 'aha' moment for everyone."

VI. Conclusion: Meeting the Challenges Ahead

While these case studies indicate that communities can work on care across settings, the results cannot be duplicated without adaptation to the community's unique context. Each community has its own history, standards, and stakeholder perspective to consider. "Complex problems like improving care transitions can rarely be solved with simple solutions," Coleman said.

Yet while each community is unique and therefore care-across-settings programs must be tailored to each, there are threads of commonality. Breakdowns in care transitions and readmissions are rife in many communities. AF4Q Alliances and other communities can apply aspects of what has been proven to work elsewhere—such as SBAR or STAAR—and apply them to their own communities, adapting them for their own environment and learning from the examples of others.

Mrs. Davis's case is illustrative. She sees multiple clinicians in multiple settings for multiple conditions. In some instances, her clinicians know her name and individual circumstances and take very good care of her. In other instances, she's just one more patient.

When the Institute of Medicine identified quality deficiencies in the U.S. health care system,[33, 34] it set forth six domains of quality care: that high-quality care should be safe, timely, effective, efficient, equitable, and patient-centered. Of these domains, the latter—patient-centeredness—is perhaps the hardest to measure and ultimately achieve. But it is arguably the most important because patient-centeredness encompasses the other five domains and remains the reason for the endeavor in the first place.

The challenge, then, is to put Mrs. Davis at the center of her care, rather than simply the recipient, to make sure she receives care that is of equally high quality in and across all settings of care.

How? We can start by recognizing the "systemness" of the U.S. health care system. "Health care grew up in our country as a cottage industry, as a series of vaguely connected parts—but that has to end," AF4Q's Graham says. "What happens at the doctor's office affects what happens in the hospital, and what happens in the hospital affects what happens in the nursing home, and so on."

In other words, clinicians must put aside parochial interests and work together on behalf of patients. This is, of course, a tall order because most clinicians assume they are already doing their best for their patients—and they usually are. But clinicians need to acknowledge they can affect care for the patient in novel ways. Further, clinicians are likely to find new financial incentives, such as those called for in the Affordable Care Act or those enabled by accountable care organizations, to reduce readmissions and otherwise improve care across settings.

The experiences of the AF4Q communities that are undertaking care-across-settings initiatives show that it is possible to coordinate care. They also demonstrate that many challenges exist and that what works in one community will not necessarily work in another. While care across settings remains a challenge for AF4Q communities and for the health care field at large, it is critically important because it strives toward the goal of getting the right care to the right person at the right time, every time.

[1] This example is based on a presentation by Boult C. *Care Across Settings: Moving to Action*. Presentation to Aligning Forces for Quality National Meeting, 10 Nov 2011.

[2] Institute of Medicine (IOM). *To Err is Human: Building a Safer Health System*. Washington, DC: National Academy Press, 2000.

[3] IOM. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press, 2001.

[4] Pronovost PJ, Goeschel CA, Colantuoni E, et al. Sustaining reductions in catheter related bloodstream infections in Michigan intensive care units: observational study. *BMJ*, 340:c309, 2010.

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