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Should We Keep Spackling the Cracks Across the Health Care Continuum or Build a New Path Forward With Safer Transitions of Care?

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My mother at 83 can outwalk me in both speed and distance. She is in great physical shape because she takes long walks every day, come rain or shine. At the beginning of the pandemic, fearing exposure to illness, she dutifully set a timer and walked laps back and forth in her living room to maintain her routine. She is a role model for healthy aging.

Just a few years earlier, however, my mother's sneaker got caught on an uneven crack in the sidewalk, causing her to fall on the unforgivingly hard pavement. The fall resulted in a broken arm with severe bruises and lacerations on her face. The worst aspect for me was seeing her confidence damaged by the accident. It took many months, but thankfully she recovered fully and can, once again, cheerfully outwalk me.

The fall was the result of systems defects, a series of avoidable or mitigable moments. First, there was the tree planted too close to the sidewalk whose roots impinged on the concrete and lifted it, causing the errant crack. There were the municipal workers who routinely trimmed the grass and pruned foliage along the public path, yet they were not trained to look for these problems and report them. There were countless town residents that walked that same stretch of sidewalk daily who never reported the large crack. There was no sign, no warning. And sadly, trees continue to be planted and allowed to grow into the sidewalk path, setting the stage for future falls.

Transitions in care are rife with hazard, the dangerous cracks in health care delivery that are very much like the ones in my mother's sidewalk. An example of an entirely mitigatable harm stems from polypharmacy. It could be the result of a person who is treated by different clinicians or in different health care settings when the information is incompletely shared or not communicated at all. The results can be catastrophic, resulting in harms and death that disproportionately impact vulnerable older adults.[1] The underlying system issues range from a lack of shared electronic medical records to the patient's prescriptions being filled by different pharmacies, creating information gaps in the medication reconciliation. There is also the prescribing of new medication with no system wide process for discontinuation of the old medication and no guaranteed notice to the pharmacy, patient and/or family caregiver, or other treating clinicians that the old course of treatment has ended. This one example, and countless more, serve as strong justification for continued research and implementation efforts to address transitions of care.

The Patient-Centered Outcomes Research Institute (PCORI) is to be commended for advancing the science of safety in its $132 million research investment to address transitions of care. These 30 funded studies represent a new and nuanced body of knowledge and learnings about what works and—equally important—what does not. PCORI's investment has made important inroads in many domains such as patient-centered outcomes measures, implementation science, statistical approaches to measure complex interventions,

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research methodologies that foster patient and stakeholder engagement, engagement strategies that support sustainability, and contextual factors that foster success in addressing transitions of care. These findings must be taken up by researchers, health care professionals and health system leaders today.

Notable in the work of PCORI is the structural inclusion and codesign with patients and families, the recipients of care, providing important insights into the study design and questions being asked, reviewing patient-facing resources and processes of care, engaging in the analysis and interpretation of findings, and partnering in dissemination efforts. It is the element of codesign with those being served by health care that offers the possibility of addressing underlying issues of ageism and racism, by advancing diversity, equity and inclusion.

The John A. Hartford Foundation, where I serve as senior program officer, has long recognized the importance of addressing transitions of care and engaging patients and families in solutions. Established in 1929, the Foundation has invested > $600 million since the 1980s to improve the care of older adults. These efforts included decades of funding to the leading innovators addressing transitions of care, including Eric Coleman who developed and widely scaled the Care Transitions Intervention,[2] Mary Naylor who leads the Transitional Care Model,[3] and Mark Williams who led the Society for Hospital Medicine's initiative known as BOOST (Better Outcomes for Older adults through Safe Transitions),[4] approaches that all demonstrated significant improvements in cost and quality outcomes.

The Foundation made investments in this area over decades and continues today through many new and important efforts to address the cracks in health care delivery, some addressing setting specific needs like nursing home care,[5] others addressing the continuity of information across settings[6] or access to information in the electronic medical record by family caregivers,[7] and models of care targeting high-risk and high-volume events that are known to cause disproportionate harms to older adults by improving surgical outcomes[8] and emergency department care.[9] Our efforts, like PCORI's work, include patient engagement as a fundamental principle. The Foundation supports many groups, such as Patient and Family Centered Care Partners, Diverse Elders Coalition, and Community Catalyst, and our grants may include the participation of PCORI ambassadors, people with special training to help share their experiences and perspectives as patients in the codesign process. Their insights strengthen our work.

As we all address the many problems that cause preventable harms during transitions of care, we also need to rid health care of the underlying and pervasive cracks along the path. One such national movement, Age-Friendly Health Systems, led by the Institute for Healthcare Improvement in partnership with the American Hospital Association and the Catholic Health Association, is focused on creating higher reliability across all settings of care. The work is based on common elements of the most rigorously tested models of care for older adults, those most at risk for poor transitions. In 2016, a convening of the leading innovators that designed and tested these models of care, along with health system leaders and patients and families, led to the development of the 4Ms framework. The 4Ms framework represents the essential elements of care, each with a strong evidence-base, to be reliably implemented in all care settings at each interaction. The 4Ms are What Matters (to the older adult), Medication (which includes deprescribing medications that commonly interfere with What Matters, Mentation and Mobility), Mentation (delirium, dementia and depression) and Mobility (including plans for safe mobility every day). There are evidence-based assessments and actions that accompany the set of 4Ms with significant positive cost and quality outcomes reported across sites.[10,11]

What makes Age-Friendly Health Systems of note is that it transforms the delivery of care reliably and consistently across settings and providers of care. If we think about prevention of polypharmacy, for example, imagine the impact if all clinicians in every setting were attending to medications in the same way and not prescribing medications known to cause falls and delirium or interfere with mobility and what matters. We would not need to keep addressing the problems because we could prevent them.

I attended a virtual site visit for one of the health systems implementing Age-Friendly Health Systems recently. This was a small safety net health system. They shared a story at the beginning of the call about a woman admitted to the hospital and expected to be transferred to hospice. She was near death. The hospital had implemented the 4Ms framework, which included a "hard stop" daily medication reconciliation looking for specific problematic drugs and polypharmacy. The woman had been admitted to a number of hospitals recently and, each time, they egregiously increased her dosage of Seroquel. The team reported that it was immediately picked up and addressed thanks to their recent implementation of Age-Friendly Health Systems. The dying woman went home doing better 2 days later. That is the power of getting it right.

Transitions in care are in dire need of intervention and a choice to be made. Do we continue to spackle the cracks as we find them, or do we seek to build a new path designed to address the fundamental system defects? I say both strategies are necessary if we are to protect people today and build a safer health care delivery system for the future.

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