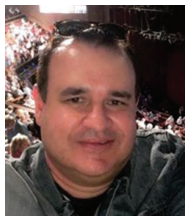


Preventing hospital readmissions: A transitions of care coordination framework

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Abstract Hospital readmissions (HRAs) have attracted significant worldwide interest because of the high associated costs. In the United States, HRAs have additional financial and legislative connotations, including monetary penalties to facilities across the nation. The transitions of care programmes are one of the most innovative hospital management initiatives in the current century to combat HRAs during the first month of discharge, increase customer satisfaction and facilitate a quicker and safer patient recovery in the community. Researchers around the world have been studying the implementation of similar programmes to tackle the problem. However, multiple studies have produced distinctive, controversial and conflicting outcomes following partial initiatives. The need for a customisable standard model is evident. This study discusses the scholarly justifications and international experiences for reducing HRAs and attempts to fill this gap proposing a transitions of care coordination framework (TCCF). The conceptual framework promotes the consolidation and standardisation of a series of organisational, financial and managerial initiatives and represents the first step towards the development, implementation and evaluation of transitions of care programmes in multiplayer health systems. The TCCF

summarises important general strategies for the design of a transitional health programme and the barriers and challenges that anticipate its implementation. Additional investigation will facilitate the identification of and validate the necessary strategies, tools, metrics, processes and procedures to operationalise the concept.

KEYWORDS: transitions of care, discharge process, care coordination, readmissions, customer satisfaction, post-acute care

INTRODUCTION

US hospitals are striving to stay financially viable. One of the primary reasons for this is the high rate of uninsured and underinsured populations, estimated at nearly 30 million.¹ Other causes include patient readmissions, account denials, hospital-wide flow² and the overutilisation of services. Preventing sickness is ideal. In practice, however, the prevention model is still incipient in a free market economy where healthcare is a growing business with one of the highest expenditures in the world.³ For almost a century, the system has been exceedingly curative and rehabilitative, but its financial engine consists of loss prevention programmes aimed directly at patient care.

In the process of care provision, facilities are subject to financial impacts from different sources. At admission, high priority is given to placing patients in the right admission status and avoiding losses owing to service denials. It is also critical to succeed in the health recovery process while preventing inappropriate stays and discharge delays. Upon discharge it is essential to place patients at the appropriate level of care (LC) to consolidate the desired outcomes. As the three processes are all interrelated, any deficiency may lead to hospital readmissions (HRAs).

Overview

At the beginning of the 21st century, scholars discovered the case of substantial HRAs with specific medical conditions within 30 days after discharge that were associated with high expenditures.⁴ HRAs then became a visible problem for the financial stability of the US healthcare system, affecting all stakeholders.

During 2003 and 2004, more than 2.3 million patients were readmitted within one month of discharge. Joynt and Jha⁵ estimated that these HRAs would represent a preventable loss of \$17bn annually.

Readmissions that follow hospitalisation are very costly to the system and often preventable.⁶ Consequently, the 2009 Health Reform introduced a section that modified the Social Security Act in an attempt to lower costs in the Medicare programme. The reform promoted the creation of the Hospital Readmission Reduction Program (HRRP), which imposes penalties on acute care facilities for high percentages of HRAs occurring within one month of patients' discharges.⁷

In the initial stages of coping with the HRAs, a multitude of factors associated with inappropriate stays were identified, which led to the improvement of care delivery. The prevention of losses and the reduction of HRAs followed. It is not possible, however, to control some of these factors. Masip⁸ found a statistically significant relationship between patient age and the average hospital length of stay (HLOS) with a predictor model that explained 87 per cent of the variability of HLOS as patients aged. While ageing is a natural process that science cannot halt or reverse yet, care coordination appears to be a potential solution to the bottlenecks in the clinical care and discharge processes for the ageing populations and the prevalence of unnecessary HRAs.

This paper proposes a transitions of care coordination framework (TCCF) to shrink the inappropriate HRAs. The term 'transitions of care' is defined by the Centers for Medicare & Medicaid Services (CMS) as the movement of a patient

from one setting of care to another.⁹ The TCCF addresses the most common causes of HRAs nationwide but encourages the identification of local circumstances and idiosyncrasies during the implementation and evaluation of the programme. The TCCF builds on the commonalities with current management, financial and organisational targets (Table 1):

BACKGROUND

To comply with the HRRP, the Centers for Medicare and Medicaid Services (CMS) established measures, formulas and benchmarks for placing readmission penalties and determining recoupment. The sanctions have been affecting the hospitals at fault in the present decade despite receiving additional revenues from billing patients with two different stays for other conditions during the same 30-day time frame.¹⁰ CMS started reducing payments to inpatient facilities in 2012 and progressively increased the penalties.¹¹

In 2012, CMS performed a comprehensive assessment and found that the national average of HRAs continued at 16 per cent.¹² During the fiscal year 2014, 2,225 hospitals were penalised under the HRRP. CMS estimated that more than 2,500 facilities would be fined in 2015, accounting for around half a million dollars.¹³ Overall, the HRRP showed promising results by reducing the early readmission rate in less than 12 months in more than half of the facilities.¹⁴

Table1: TCCF's Primary Targets

Targets	Facilitate patient transitioning from acute care to home or subacute care
	Increase HVBH-HCAHPS scores
	Identify the community-specific causes of readmission
	Facilitate patient recovery
	Integrate inpatient and outpatient services
	Decrease the average HLOS
	Lessen the duplication of services and resources

Medicare Readmissions

Along with the positive reduction of HRAs, there are also controversial findings in the literature. Fonarow¹⁵ argued that the HRRP increased mortality among patients with heart failure in the inpatient setting and unintended harm to patients with pneumonia. In the case of heart failure readmissions, more than 75 per cent of the hospitalisations had etiologies that were different from the initial acute cardiac diagnosis, which contributed to the overall reduction of HRAs after addressing the concomitant comorbidities.¹⁶

While the HRRP was aimed at generating financial incentives to transitioning Medicare patients back home and generating early outpatient care, CMS did not provide any tested guidelines, known outcomes or consequences of such initiatives.¹⁷ This void motivated the creation of care coordination models, and hospitals started designing transition programmes according to their financial and quality goals. Nonetheless, the implementation of the TCCF is still a novice initiative. Connecting multiple players remains a challenge, and while efforts to improve the models and minimise HRAs have dramatically increased in the recent decade, the financial outcomes and implications of the programmes are still unknown.¹⁸

Medicaid readmissions

Trudnak et al.¹⁹ found that Medicaid has also experienced similar trends with HRAs that are costly to the system. Medicaid readmissions accounted for almost 10 per cent of all admissions, costing the system more than USD \$75m per state, equivalent to 12.5 per cent of all hospitalisations for this payer. Mental illness, ailments and complications of pregnancy, labour and delivery accounted for 31 per cent of all HRAs.

States now have policies in place to stop payment for HRAs. These policies implicate non-payment sanctions for

patients readmitted during the first 48 hours post discharge regardless of the diagnosis and within one month of discharge for the same condition under treatment during the first previous hospitalisation. Shau, Shenvi, Easley, Smith and Guild²⁰ found an increase in HRAs within three months of discharge after total joint surgery in Medicaid patients.

Readmissions in other developed countries

In Norway, more than half of patients diagnosed with stroke without HRAs during the first year were readmitted within five years. Patients readmitted within the first 12 months had many risk factors for repetitive HRAs during the same five-year time frame. It is unknown, however, whether these patients were previously readmitted elsewhere.²¹

In other developed countries, HRAs are also a major problem that has necessitated the implementation of similar health programmes. In New Zealand, around 40 per cent of frail senior individuals were readmitted within the first three months of discharge with high levels of comorbidities, polypharmacy, functional issues and acute medical conditions. Despite the use of the Community Rehabilitation, Enablement and Support Team, high readmission rates were reported in spite of the outpatient interventions, and the failures were attributed to new acute health conditions requiring inpatient readmission. Only 25 per cent of the patients had a diagnosis different from that at the initial admission. Yet the majority of patients returned home after the HRAs.²²

In Singapore, Nurjono et al.²³ found that while the cost objectives of controlling and reducing HRAs through the Fidelity transitional care model were consistent with global initiatives, the study findings emphasised the commitment to training and engagement of all stakeholders, including the local providers, as a primordial insight for the success of the programme. The National

University Health System in Singapore developed the model for individuals with complex needs and targeted elderly individuals with complex cases and high utilisation of resources. In Australia, Finlayson et al.²⁴ found a reduction in unplanned HRAs in the first three months when multidisciplinary transitional interventions were in place.

Brown and Menec²⁵ performed a review of the literature on transitions of care programmes for the elderly and compiled worldwide characteristics of prior investigations intended to describe TCCF initiatives. All of these programmes follow different populations and derive from distinctive health systems. They also target specific health conditions, readmission criteria, plan structures and transitional interventions. And although the concept is growing worldwide, findings have been conflictive, presumably for want of a standardised conceptual framework that incorporates other components such as the organisation, management and funding of the models.

The emerging documentation of the impact of quicker patient recovery in the community is also adding up definitive justification to implement transitional programmes. The general objective is to keep patients out of the system for more than 30 days.²⁶ All these studies serve as guidance for constructing a TCCF, particularly for those hospitals that may have previously implemented it to cope with HRAs, albeit without a solid conceptual framework.

TRANSITIONS OF CARE CONCEPTUAL FRAMEWORK

Complex healthcare systems that have multiple layers and players and service fragmentation can benefit from the implementation of care coordination models to support and strengthen partnerships among providers and important participants. In the traditional hospital model, inpatient

case managers play an essential role in the assessment of the patients' post-discharge needs and in moving patients to the next LC or back to their prior home settings.^{27,28} Yet the potential for miscommunication during the transfer of patients' responsibility between facilities increases when transitioning processes are absent. Also, successful transitions may result in effective patient education about diagnoses, treatments and outpatient follow-ups.^{29–31}

Transitional nurses expand on the classic case management role by bridging important players and effectively communicating vital information to caregivers and outpatient providers. Transitional care coordination personnel navigate the whole discharge planning process, which continues after the service placement at the next LC. While the identification of any barriers in the post-acute care may also prevent unnecessary HRAs, working conjointly with the post-discharge players may facilitate recovery and increase patient satisfaction.³² Figure 1

illustrates the primary strategies and outcomes of the TCCF.

Challenges and barriers

Before the implementation, the transitions of care programme (TCP) may already have visible and hidden organisational barriers. Community hospitals that serve low-income populations face challenging patients who are low or non-compliant with their discharge instructions and treatments. Patients may not understand the importance of following up with their physicians in a timely fashion and the significance of treatment compliance after discharge. Plans for monitoring patients in their home settings may produce misinterpretations, misconceptions and rejections too.³³ In a retrospective study patients with tuberculosis adhered to treatment when they understood their condition.³⁴

Community demographics play an important role too. In states without the

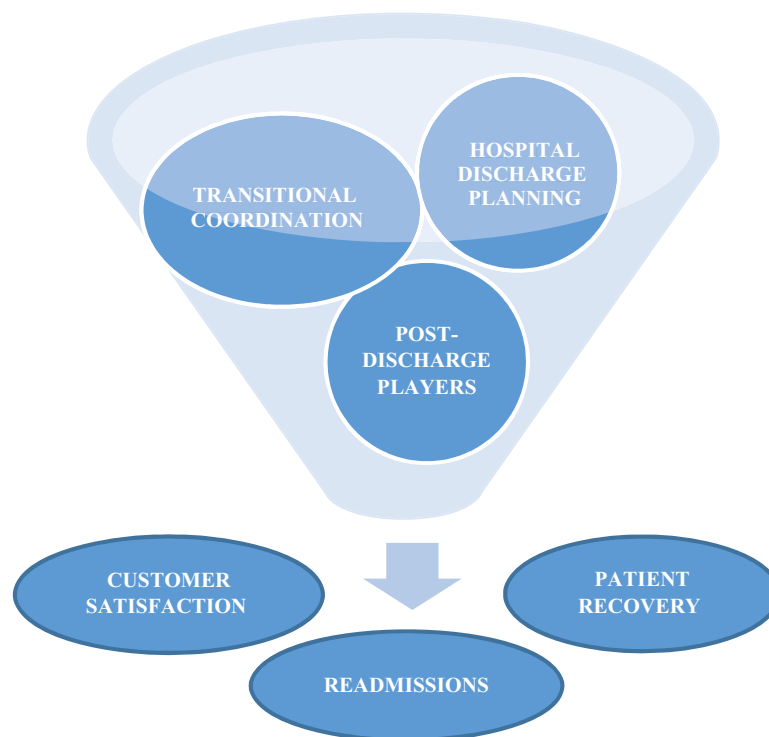


Figure 1: TCCF for customer satisfaction, patient recovery and readmission prevention

Medicaid expansion, hospitals face longer stays of uninsured patients with complex barriers for placement and outpatient services.³⁵ Medicines like low-salt diets to prevent congestive heart failure exacerbations are prohibitively out of these patients' budgets.³⁶

Cultural and ethnicity issues are also factors. Families, for instance, are often reluctant to place their relatives under hospice in an attempt to prolong the lives of their loved ones, thus generating multiple visits to the emergency room during the year and during the same 30-day period. Furthermore, an increasing number of these individuals with multiple comorbidities end up expiring while receiving critical care and before families agree with hospice services. It is not uncommon to observe patients passing before the hospice consultation takes place.³⁷

Physicians' buy-in is vital because some of the programme strategies are oriented towards the development and use of preferred provider networks. Physicians usually operate with external trustworthy providers, and patients might resist a network that excludes their favourite agencies and facilities. The relationship between facilities and physicians may lead to other unknown internal ramifications and uncertainties as transitional concepts are still developing in the country.³⁸

Resistance to innovation may be useful when hospital management makes assessments to identify the sources and rationales of the multiple factors causing negative results.³⁹ Since the TCP is a hospital-wide initiative, an administrator with the appropriate funding maneuverability should oversee the programme while delegating the operations to the corresponding programme managers, preferably the department heads in charge of the discharge planning process. The success of the programme requires collaboration among the administrators, all nursing departments, the medical staff, the information technology department, the senior leadership and the registration and case management teams.

Important general programme strategies

For programme effectiveness, hospital leaders need to captivate all stakeholders and promote the vision that these types of health programmes will bring about positive outcomes for the communities and the organisations.⁴⁰ Consequently, the introduction of ongoing educational programmes helps create awareness and motivate patients to enrol.⁴¹ Business development and marketing departments carry out these initiatives inside and outside the organisations.

The community's backgrounds play an important role in determining the right approaches.⁴² The strengthening of cultural and ethnic competencies in the workforce may enhance the chances of effective communication with patients and families to prevent stereotypical judgments and misdiagnosis while providing the appropriate care. Educating and working closely with patients may eliminate these barriers, boost recovery and the prevention of complications or exacerbations.⁴³

Specific hospital and community drivers of Medicare readmissions may be the result of miscalculations in the programme that would merit adjustments. While that happens, combating the most common reasons for HRAs will require adopting important strategies. Communities behave differently depending on many factors. Demographic assessments could identify disparities as well as gather specific readmission data.⁴⁴

The implementation of the TCP may entail the use of additional human, physical and technical resources. The programme may require the hiring of additional full-time registered nurses before the implementation phases for immersion in the development and coordination of the programme in its early stages. In the majority of health organisations, department directors and managers participate in the construction of health programmes. In other cases, external firms design and develop the health programmes and support their

implementation as well as the respective evaluation programmes. Regardless of the budgetary approach, facilities may face changes in the organisational structure with innovative processes and programmes that require the allocation of resources.⁴⁵

Filling patients' prescriptions before discharge is one of the important general strategies to avoid readmissions owing to non-compliance with medical treatments.⁴⁶ Increasing home agency referrals for medication management education and nursing care follow-up is imperative for patients going home, in view of the multicultural and language contexts of the communities.⁴⁷ Moreover, the primary expectation is that the programme coordinates physician appointments upon discharge and that all patients going home see their primary care physicians within a week.⁴⁸ Transitional nurses perform follow-up calls to query about these expectations after patients are back home.⁴⁹

The TCCF proposes a TCP with home services through home healthcare and hospice agencies. The outpatient services build upon the programme with outpatient pharmacies, practitioners and dialysis units as well as shelters, group homes, assisted living facilities, intermediate living facilities, transportation and other community services. The subacute inpatient care integrates the network with lower LC facilities such as skilled nursing facilities and long-term acute rehabilitation hospitals. And, finally, the other acute services complement the network with local and regional referent short-term acute facilities. The coordination of post-acute care within this context may as well benefit from continuous nursing monitoring and on-call services (Figure 2).

CONCLUSIONS AND RECOMMENDATIONS

Collaboration between scholars, clinical and policy leaders is the first step towards advancing evidence-based transitions of care

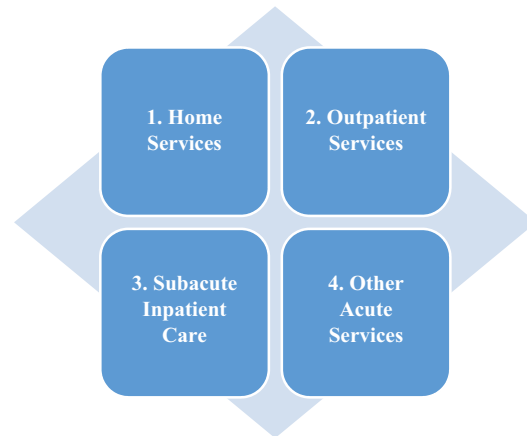


Figure 2: The TCP model

practices.⁵⁰ Engaging leadership, educating users and monitoring performance enhance programme effectiveness.^{51,52} In the United States, value-based programmes such as Medicare catalyse pioneering effective transitions of care initiatives.⁵³ The next step? Generating organisational, economic and financial strategies, processes, procedures, tools and metrics for the implementation and evaluation of the TCP in multiplayer systems. Besides, the operationalisation of the TCCF will demand economic evidence to quantify the costs of ineffective transitions versus the financial gains in decreasing HRAs and increasing hospital customer satisfaction.⁵⁴

The TCCF may reduce HRAs and HLOS as well as the ancillary healthcare costs in the provision of healthcare.⁵⁵ Patient loyalty to existing providers represents a challenge to the interprofessional transition of care models. The diverse cultural, educational, ethnic and socio-economic barriers that American hospitals are facing merit strong adaptation, competency and customisation. The conceptualisation of innovative applications of technology and social media linking patients and interdisciplinary healthcare providers also require further exploration.⁵⁶ As telehealth and virtual care venues continue to expand, additional research may elucidate the mechanisms to optimise coordination of care in these areas.⁵⁷

LEAD AUTHOR'S NOTE

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References

- (2019) 'Key facts about the uninsured population', *Medical Benefits*, Vol. 36, No. 3, pp. 8–9.
- Mayer, T., Jensen, K. (2018) 'Hardwiring hospital-wide flow to drive sustainable competitive performance', *Management in Healthcare*, Vol. 2, No. 4, pp. 373–387.
- OECD. (2019) 'Economic references', *OECD Health Statistics* (database). doi:10.1787/data-00548-en.
- Fonarow, G. C., Ziaian, B. (2019) 'Hospital readmission reduction program for heart failure: The spread of intended and unintended consequences', *Journal of the American College of Cardiology*, Vol. 73, No. 9, pp. 1013–1015.
- Joynt, K. E., Jha, A. K. (2013) 'A path forward on Medicare readmissions', *The New England Journal of Medicine*, Vol. 368, No. 13, p. 1175.
- Hoffman, J., Cronin, M. (2015) 'The true financial impact of hospital readmissions', *Healthcare Financial Management*, Vol. 69, No. 1, pp. 68–75.
- Glass, D., Lisk, C., Stensland, J. (2012) 'Refining the Hospital Readmission Reduction Program', Medicare Payment Advisory Commission, Washington, DC.
- Masip, J. (2019) 'The relationship between age & hospital length of stay: A quantitative correlational study', ProQuest Dissertations & Theses Global, available at: <https://search.proquest.com/docview/230555663?accountid=45853> (accessed 18th March, 2020).
- Agency for Healthcare Research and Quality. (2018) 'Transitions of care', Rockville, MD, available at: <https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure1.html> (accessed 18th March, 2020).
- Couch, K. (2011) 'Medicare: The fiscal challenge', *Journal of Policy Analysis and Management*, Vol. 30, No. 4, p. 927.
- Engle, C. (2013) 'Examining Medicare readmissions: Strategies to mitigate potential revenue hits', *Health Management Technology*, Vol. 34, p. 22+. Available from Academic OneFile.
- Ibid.*, ref. 5 above.
- Ibid.*, ref. 6 above.
- Brown, J. R., Sox, H. C., Goodman, D. C. (2014) 'Financial incentives to improve quality: Skating to the puck or avoiding the penalty box?', *JAMA*, Vol. 311, No. 10, pp. 1009–1010. doi:10.1001/jama.2014.421 (accessed 18th March, 2020).
- Fonarow, G. C. (2018) 'Unintended harm associated with the hospital readmission reduction program', *JAMA*, Vol. 320, No. 24, pp. 2539–2541. doi:10.1001/jama.2018.19325 (accessed 18th March, 2020).
- Blecker, S., Herrin, J., Li, L., Yu, H., Grady, J. G., Horwitz, L. I. (2019) 'Trends in hospital readmission of medicare-covered patients with heart failure', *Journal of the American College of Cardiology*, Vol. 73, No. 9, pp. 1004–1012.
- Ibid.*, ref. 4 above.
- Brock, J., Boutwell, A. E. (2013) 'How did we make transitions such a big deal?', *Generations*, Vol. 36, No. 4, pp. 35–43.
- Trudnak, T., Kelley, D., Zerzan, J., Griffith, K., Jiang, H. J., Fairbrother, G. L. (2014) 'Medicaid admissions and readmissions: Understanding the prevalence, payment, and most common diagnoses', *Health Affairs*, Vol. 33, No. 8, pp. 1337–1344.
- Shau, D., Shenvi, N., Easley, K., Smith, M., Guild, I. G. (2018) 'Medicaid is associated with increased readmission and resource utilization after primary total knee arthroplasty: A propensity score-matched analysis', *Arthroplasty Today*, Vol. 4, No. 3, pp. 354–358.
- Bjerkreim, A. T., Naess, H., Khanevski, A. N., Thomassen, L., Waje-Andreassen, U., Logallo, N. (2019) 'One-year versus five-year hospital readmission after ischemic stroke and TIA', *BMC Neurology*, Vol. 19, No. 1, p. 15.
- Heppenstall, C. P., Chiang, A., Hanger, H. C. (2018) 'Readmissions to hospital in a frail older cohort receiving a community-based transitional care service', *The New Zealand Medical Journal*, Vol. 131, No. 1484, pp. 38–45.
- Nurjono, M., Shrestha, P., Ang, I. Y. H., Shiraz, F., Yoong, J. S.-Y., Toh, S.-A. E. S., Vrijhoef, H. J. M. (2019) 'Implementation fidelity of a strategy to integrate service delivery: Learnings from a transitional care program for individuals with complex needs in Singapore', *BMC Health Services Research*, Vol. 19, No. 1, p. 177.
- Finlayson, K., Chang, A. M., Courtney, M. D., Edwards, H. E., Parker, A. W., Hamilton, K., Xuan Pham, T. D., O'Brien, J. (2018) 'Transitional care interventions reduce unplanned hospital readmissions in high-risk older adults', *BMC Health Services Research*, Vol. 18, No. 1, p. 956.
- Brown, C. L., Menec, V. (2018) 'Integrated care approaches used for transitions from hospital to community care: A scoping review', *Canadian Journal on Aging*, Vol. 37, No. 2, pp. 145–170. doi:10.1017/S0714980818000065 (accessed 18th March, 2020).
- Wolfe, L. M. (2012) 'Hospital readmissions: The need for a coordinated transitional care model: Analysis and synthesis of research on Medicare policy and interventions for the elderly (Order No. 3533633)', ProQuest Dissertations & Theses Full Text (1223343314), available at: <http://search.proquest.com/docview/1223343314?accountid=35812> (accessed 18th March, 2020).

27. McFolling, S. (2008) 'Data for healthcare improvement –Developing and applying avoidable delay tracking', *Collaborative Case Management*, Vol. 6, No. 2, pp. 3–12.
28. Steketee, G., Ross, A., Wachman, M. (2017) 'Health outcomes and costs of social work services: A systematic review', *American Journal of Public Health*, Vol. 107, pp. S256–S266.
29. Horwitz, L. I., Moriarty, J. P., Chen, C., Fogerty, R. L., Brewster, U. C., Kanade, S., Ziaecian, B., Jenq, G. Y., Krumholz, H. M. (2013) 'Quality of discharge practices and patient understanding at an academic medical center', *JAMA Internal Medicine*, Vol. 173, No. 18, pp. 1715–1722.
30. Philibert, I., Barach, P. (2012) 'The European HANDOVER project: A multi-nation program to improve transitions at the primary care—inpatient interface', *BMJ Quality & Safety*, Vol. 21, pp. i1–i6.
31. Reyes, B., Ouslander, J. G. (2019) 'Care transitions programs for older adults—a worldwide need', *European Geriatric Medicine*, Vol. 10, No. 3, pp. 387–393.
32. Ehrlich, C., Kendall, E., John, W. S. (2013) 'How does care coordination provided by registered nurses “fit” within the organizational processes and professional relationships in the general practice context?', *Collegian*, Vol. 20, No. 3, pp. 127–135. doi:10.1016/j.colegn.2012.04.006 (accessed 18th March, 2020).
33. Arbaje, A. I., Wolf, J. L., Yu, Q., Powel, N. R., Anderson, G. F., Boulton, C. (2008) 'Post-discharge environmental and socioeconomic factors and the likelihood of early hospital readmission among community-dwelling Medicare beneficiaries', *Gerontologist*, Vol. 48, pp. 495–504.
34. Aziz, K., Hisam, A., Azam, N., Pervaiz, F., Mehmood, H. (2019) 'Knowledge of disease and adherence to anti-tuberculosis treatment—a cross-sectional study in Rawalpindi district', *Pakistan Armed Forces Medical Journal*, Vol. 69, pp. S267–S272.
35. Mehta, V., Flores, J., Thompson, R. W., Nathan, C.-A. (2017) 'Primary payer status, individual patient characteristics, and hospital-level factors affecting the length of stay and total cost of hospitalization in total laryngectomy', *Head & Neck Surgery*, Vol. 39, No. 2, pp. 311–319. doi:10.1002/hed.24585 (accessed 18th March, 2020).
36. *Ibid.*, ref. 5 above.
37. Waite, K., Rhule, J., Bush, D., Meisenberg, B. (2017) 'End-of-life care patterns at a community hospital: the rest of the story', *American Journal of Hospice & Palliative Medicine*, Vol. 34, No. 10, p. 977.
38. Anoushiravani, A. A., Nunley, R. M. (2017) 'Gainsharing strategies, physician champions, getting physician buy-in', *The Journal of Arthroplasty*, Vol. 32, No. 6, pp. 1723–1727. doi:10.1016/j.arth.2017.02.011 (accessed 18th March, 2020).
39. Alecsioiu, O. (2017) 'Resistance to organizational change; literature review. Analele Universitatii “Constantin Brancusi” Din Targu Jiu', *Serie Litere Si Stiinte Sociale*, No. 4, pp. 16–20.
40. Cordasco, K. M., Frayne, S. M., Kansagara, D., Zulman, D. M., Asch, S. M., Burke, R. E., Post, E. P., Fihn, S. D., Klobucar, T., Meyer, L. J., Kirsh, S. R., Atkins, D. (2019) 'Coordinating care across VA providers and settings: Policy and research recommendations from VA's State of the Art Conference', *Journal of General Internal Medicine*, Vol. 34, No. 1, pp. 11–17.
41. *Ibid.*, ref. 23 above.
42. *Ibid.*, ref. 33 above.
43. Hickling, F. W. (2012) 'Understanding patients in multicultural settings: A personal reflection on ethnicity and culture in clinical practice', *Ethnicity & Health*, Vol. 17, No. 1/2, pp. 203–216. doi:10.1080/1357858.2012.655266 (accessed 18th March, 2020).
44. Aswani, M. S., Kilgore, M. L., Becker, D. J., Redden, D. T., Sen, B., Blackburn, J. (2018) 'Differential impact of hospital and community factors on medicare readmission penalties', *Health Services Research*, Vol. 53, No. 6, pp. 4416–4436. doi:10.1111/1475-6773.13030 (accessed 18th March, 2020).
45. Fink, A. (2015) 'Evaluation Fundamentals: Insights into Program Effectiveness, Quality, and Value', SAGE, Thousand Oaks, CA.
46. Ni, W., Colayco, D., Hashimoto, J., Komoto, K., Gowda, C., Wearda, B., McCombs, J. (2018) 'Reduction of healthcare costs through a transitions-of-care program', *American Journal of Health-System Pharmacy*, Vol. 75, No. 10, pp. 613–621.
47. Karliner, L. S., Auerbach, A., Nápoles, A., Schillinger, D., Nickleach, D., Pérez-Stable, E. J. (2012) 'Language barriers and understanding of hospital discharge instructions', *Medical Care*, Vol. 50, No. 4, p. 283.
48. *Ibid.*, ref. 19 above.
49. Kind, A. J. H., Jensen, L., Barczy, S., Bridges, A., Kordahl, R., Smith, M. A., Asthana, S. (2012) 'Low-cost transitional care with nurse managers making mostly phone contact with patients cut rehospitalization at a VA hospital', *Health Affairs*, Vol. 31, No. 12, pp. 2659–2668.
50. *Ibid.*, ref. 40 above.
51. *Ibid.*
52. Haugen, H. A., Woodside, J. R. (2010) 'Beyond Implementation: A Prescription for Lasting EMR Adoption', Magnusson Skor, Denver, CO.
53. *Ibid.*, ref. 40 above.
54. *Ibid.*, ref. 30 above.
55. Kripalani, S., Chen, G., Ciampa, P., Theobald, C., Cao, A., McBride, M., Dittus, R. S., Speroff, T. (2019) 'A transition care coordinator model reduces hospital readmissions and costs', *Contemporary Clinical Trials*, Vol. 81, pp. 55–61.
56. *Ibid.*, ref. 30 above.
57. *Ibid.*, ref. 40 above.