



Care Transitions: A Primer on Managing Post-Acute Patient Placement

The end-to-end patient journey is increasingly under scrutiny for inefficiencies and gaps in care that can negatively impact patient outcomes, lower customer satisfaction, and increase costs of care. Subsequently, health care delivery systems are now challenged to meet the needs of patients both during the acute phase of care and when transitioning from one health care setting to another. Given these market dynamics, providers must turn their attention toward facilitating more effective care transitions and seek ways to improve levels of patient engagement and management. This can be challenging; however, given limited patient transition data and lack of expert consensus on defining best practices and quality across facilities. Nonetheless, steps can be taken to improve care transition management, thereby increasing quality of care and reducing overall costs.

The Financial Realities Behind Care Transitions

Care transitions can make a significant impact on a health facility's bottom line and patient outcomes – both positive and negative. Hospital readmissions within 30 days after discharge are estimated to account for more than \$17 billion in avoidable Medicare expenditures. As a result, changes under the Affordable Care Act include penalties for facilities experience high readmission rates within 30 days of discharge for certain conditions. While certain discharge intervention programs have been shown to avoid readmissions, the most effective of these interventions are complex, which can deter implementation.

Looking beyond readmissions, suboptimal care transitions from the hospital to other care settings have been estimated to cost up to \$44 billion per year. Costs associated with poor transitions include medication errors, complications from procedures, infections, and falls. New payment models – such as bundled payments and shared savings programs for Accountable Care Organizations – create financial incentives for providers to coordinate transitions and provide care in less intensive settings.

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Coordinated, optimized care transitions are difficult and costly, especially for the most medically complex patients. Nonetheless, the current health care environment demands that providers address current gaps in care, inclusive of those inherent in care transitions.

Current Variability in the Management of Care Transitions

It is estimated that 20 percent of patients are admitted to post-acute care after being discharged from the hospital (roughly 8 million patients annually). The greatest contributing factor to the more than 70 percent Medicare spending variation among post-acute care settings is the variation in the services offered in each setting.

When patients require rehabilitation or additional services after a hospital stay, there is often a lack of coordinated, formalized discharge planning in getting that patient to a skilled nursing facility, home health agency, inpatient rehabilitation facility, or long-term acute care hospital. Where a patient transitions can have a significant impact on outcomes, but discharge placement is often a choice based on convenience, familiarity, or the hospital discharge planner's or other clinician's preferences.

Unfortunately, post-acute care is often disjointed and disconnected from the rest of the health care system, which can result in poor coordination of care, higher than normal readmission rates, and suboptimal patient outcomes. Prior to reimbursement changes driven by the Affordable Care Act, hospitals and other providers had little incentive to direct patients to the highest quality, most appropriate post-acute care facility. Recent regulatory changes, however, now put those providers at risk for managing patients for defined

periods of time post-discharge. Now, hospitals have a financial incentive to track and manage patients following the acute episode. There is more importance in paying close attention to the downstream care network and understanding how to efficiently transition patients to and through that network – a complex undertaking that requires significant expertise and resource dedication to achieve optimal outcomes.

Care Transitions: Implementing Best Practices

Best practices in care transitions are based on identifying and leveraging effective programs that focus on smooth transitions from one level of care to the next. Though there is a general lack of research on transitions from the hospital to settings other than the home, certain guard rails are in place to help guide practitioners, including:

- **Comprehensive discharge planning:** Throughout the acute stay and with increasing effort as the discharge date approaches, transition personnel should evaluate and address a range of patient characteristics, including but not limited to: financial resources, psychosocial situation, short- and long-term recovery prognosis and care needs, and patient/family requests.

- **Open and timely communication channels:**

Discharge planners should act as a hub for patient care communications between physicians, nurses, facilities, payers, and caregivers. Essential documentation and information sharing on a per patient basis should include: diagnoses, test and procedure results, pending tests, medication lists, rationale for medication changes, advance directives, caregiver status contact information [for the discharging physician, and a recommended follow-up care plan.

• **Medication tracking:** Discharge planning must include the reconciliation of medications at each transition (for example, to inpatient, outpatient, or post-acute care). The discharge process must also work to ensure the accuracy of medication lists and dosages, immediately flag contraindications, and consider financial barriers to filling prescriptions for certain patients.

• **Patient/caregiver education:** Educational efforts toward the patient and caregiver should be timely and focus on major diagnoses, medication changes, time of follow-up appointments, self-care, warning signs, and what to do if problems arise.

• **End-to-end follow up:** Proactively tracking and communicating with patients is a key factor in the discharge planning process. Regularly scheduled touchpoints, whether in-person or telephonically, can be a critical step in smooth care transitions, improved patient satisfaction, and enhanced clinical outcomes. The discharge process should include mechanisms for patient engagement and follow up throughout the care journey, including post-discharge.

Implementing these best practices can create a strong foundation for high-quality, cost-saving care transitions. Hospitals, ACOs and other providers are increasingly investing in partner organizations with formalized care transition programs to improve value in optimizing transitions and the placement process.

Evaluating Care Transition Partners

Improving care transitions allows hospitals, ACOs and other providers to improve quality, save money, and enhance the patient experience. One way to improve care transitions is by partnering with entities that have the focus and expertise, but selection of a partner should always include

a comprehensive review of historical cost, quality, market data, and interviews with senior leaders and key clinical staff. During the evaluation process, potential partners should be able to produce data on their ability to:

- Reduce readmissions
- Increase hospital capacity
- Create efficiencies
- Build effective networks of post-acute providers
- Lower the cost of care, and
- Improve health outcomes

In addition, potential partners should be evaluated on both their past track record and their future potential in achieving innovation in care transition management, as these attributes are key in the emerging health delivery system. In summary, figuring out which option is best for the provider system, payer, patient, and caregiver is a necessary but difficult task, but it is still each health system's responsibility in ensuring positive outcomes.

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