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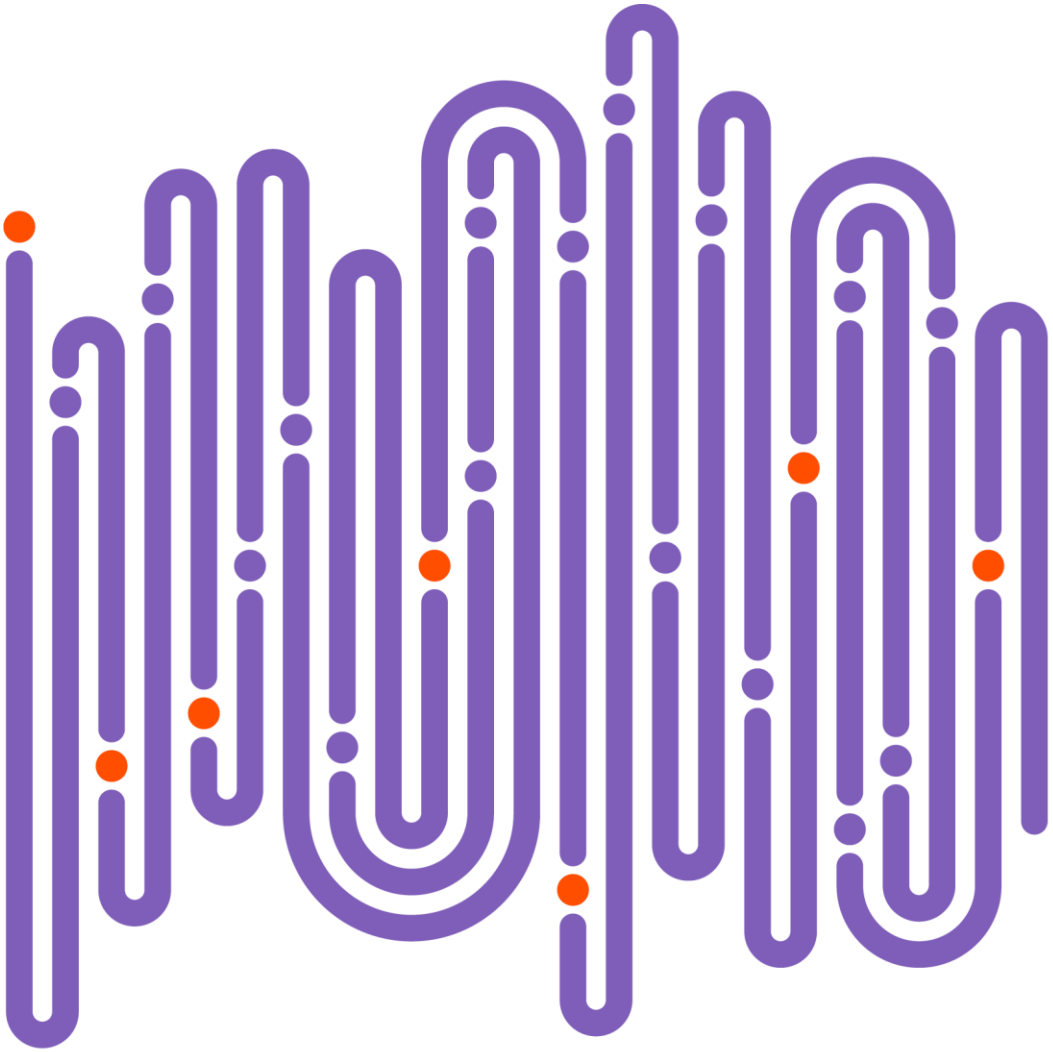
Patient Transitions to Post-acute Care Collaborative Guidebook

The case for change, assessments, and action steps for improvement

November 2021



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Key results

Collaborative participants avoided 1,826 hospital readmissions and saved $26,289,503 in post-acute discharge readmission costs overall*. Additionally, on average, readmissions coming from discharges to skilled nursing facilities (SNFs) were reduced by 22% and the 30-day inpatient readmissions coming from home health discharges achieved an average reduction of 9.8% from baseline to remeasure. These results were accomplished through these change levers:

- Optimizing post-acute care network management
- Formalizing care team roles & responsibilities
- Enhancing patient and family engagement & experience
- Proactively planning for post-acute care
- Maximizing technology for communication and information transfer

Specifics on activating these change levers, a current state assessment, and action steps to maximize impact are included in this document.

Case for change

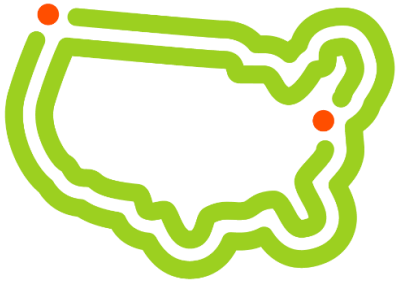
Overview

In 2015, more than 40% of Medicare beneficiaries received post-acute care after a hospital discharge, which cost Medicare more than $60 billion[1]. “In Medicare, most of the variation, the IOM committee said, was due to spending in post-acute services such as nursing facilities, home health care and long-term-care hospitals. The panel found that if variations among those providers were eliminated, the overall variation between different parts of the country would drop by 73 percent”[2].

The Patient Transitions to Post-acute Care Collaborative enabled 27 participating hospitals and health care organizations to collectively work on proactively mitigating the risk of readmissions, effectively educating patients and leveraging technology for robust communication and coordination between care settings.

Figure 1. Patient Transition Statistics

$26 Billion spent on poor transitions of acute are Medicare patients per year[1]



Nearly 23% of SNF patients are readmitted to the hospital within 30 Days, on average[3]

80% of serious medical errors involve miscommunication during hand-off between providers[4]

Project method

Significant opportunity for improvement was demonstrated by activating the change levers and related approaches that make up the collaborative framework for this project:

Collaborative Framework

Change Levers	Approaches
Optimize post-acute care network management	• Develop post-acute care (PAC) network strategy shaped around balancing competition and collaboration in the same market[10,11] • Prioritize and maintain engagement with preferred providers • Hold preferred provider meetings/gather partners together to discuss and review performance results, process outcomes, progress tracking, quality improvement and financial opportunities [7,8]
Formalize care team roles & responsibilities	• Implement a multidisciplinary care team dedicated to management of total episode of care[5] • Establish case management role(s) to serve as critical coordination points • Provide staff orientation and education on care transition communication pathways and discharge protocols[6] • Design a post-acute provider program to manage care outside of the hospital and coordinate with acute & post-acute care resources
Enhance patient and family engagement & experience	• Develop dynamic care management plan with patient and family involvement • Create specific touchpoints throughout care continuum to assess for risk of care path deviation[6] • Create a comprehensive list of PAC sites and providers to help patients understand placement options and compare sites quality performance ratings[9] • Create comprehensive and intelligible discharge instructions[6]
Proactive PAC planning	• Perform patient identification and risk stratification for patients at risk for poor transitions, readmissions, and at risk in the new setting[5] • Establish care team meetings to discuss high risk patients • Employ proactive assessments early to identify appropriate PAC disposition[7] • Evaluate, map and document precertification processes and requirements[12] • Conduct post-hospital follow-up calls within 48-72 by RN or case managers[13]
Maximize technology for communication and information transfer	• Establish bi-directional communication pathways, standardized handoff forms and data sharing opportunities between key individuals at PAC partners and multidisciplinary team [6,8] • Assure system of health information exchange (HIE) between hospital and PAC • Embed discharge summary module/form into EHR, ensure PAC providers have access to portal[14] • Streamline referrals, create referral manager system[7]

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Assessment

This checklist can be used to assess your current ability to use the change levers effectively.

Collaborative Patient Transitions Change Levers

Change Levers	Approaches
Optimize post-acute care network management	☐ Create standardized education program for providers on optimizing care management in PAC setting ☐ Evaluate PAC protocols (diabetes, sepsis, HF, etc.) ☐ Establish touch points and meetings with PAC partner sites on a monthly and quarterly cadence ☐ Implement pre and post surveys to identify current workflows and knowledge gaps
Formalize care team roles & responsibilities	☐ Educate across the system on regulatory requirements, transition standards, expectations, patient/family experience ☐ Enhanced Care Program (ECP) involves 3 interventions[17]: ○ A team of nurse practitioners participating in the care of SNF patients ○ A pharmacist driven medication reconciliation at the time of transfer educational in-services for SNF nursing staff ○ Educational in-services for SNF nursing staff
Enhance patient and family engagement & experience	☐ Develop a primary care at home strategy ☐ Implement self-management patient education pathway throughout continuum ☐ Recruit patient and family advisors to develop transition process and education, support, and communication for patients ☐ Dedicate discharge nurse to review goals for care and transition setting options with patient ☐ Dedicate hospital pharmacist to provide discharge medication education ☐ Schedule PCP appointments at discharge ☐ Confirm transportation to PCP appointments or provide information on arranging transportation
Proactive PAC planning	☐ Utilize adequate tools to address social determinants of health ☐ Assign patients with >4 admissions/year and complex care needs to transitional care social worker ☐ Assess self-management abilities (activities of daily living (ADL), patient's decision-making ability and willingness to participate in care planning) ☐ Establish daily readmission huddles, SNF/Home care liaison, provider link between acute care/SNF, ACO navigator, etc. ☐ Make clear to all relevant staff, particularly those contacting insurers to obtain appropriate authorization and precertification for admission
Maximize technology for communication and information transfer	☐ Ensure data and access include: ○ Utilization data (ED/ Hospital) ○ Ambulatory transitional care managers must be able to find discharge plans ○ Able to identify ACO patients in the EHR (identifier) ○ Acute care needs to be able to find documentation from ambulatory ☐ Share the care management plan through secure data exchanges to create a paperless system of care planning across the care continuum

Action steps

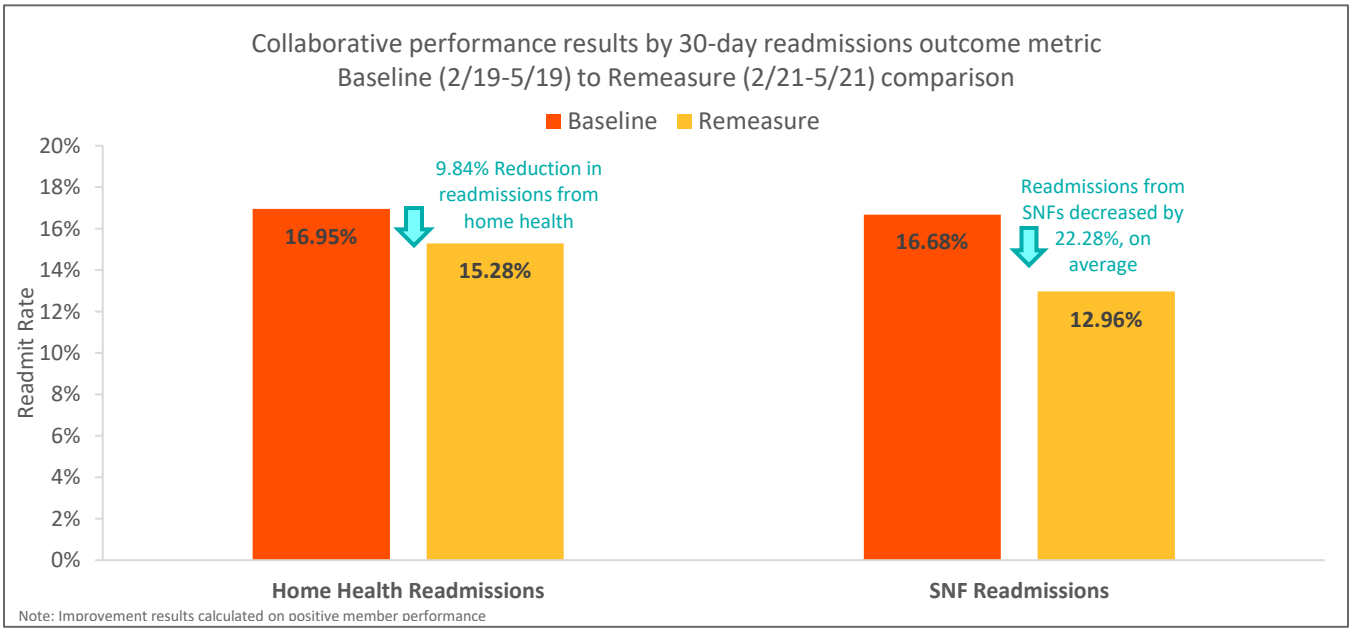
Using the areas identified in the assessment above, these action steps and call to action questions can be used to improve your effectiveness in successfully using the patient transitions change levers.

☐	Do we currently have a post-acute care strategy?
☐	How frequently are we meeting with preferred providers and what performance results are being reviewed and tracked?
☐	Have we developed a high-risk transitions of care assessment? Do we assess social determinant of health needs?
☐	Are we currently utilizing a bi-directional communication platform to transfer information and medical records to and from PAC providers?
☐	What type of transitional care education program do we provide to our acute, PAC and partner staff?

Collaborative results

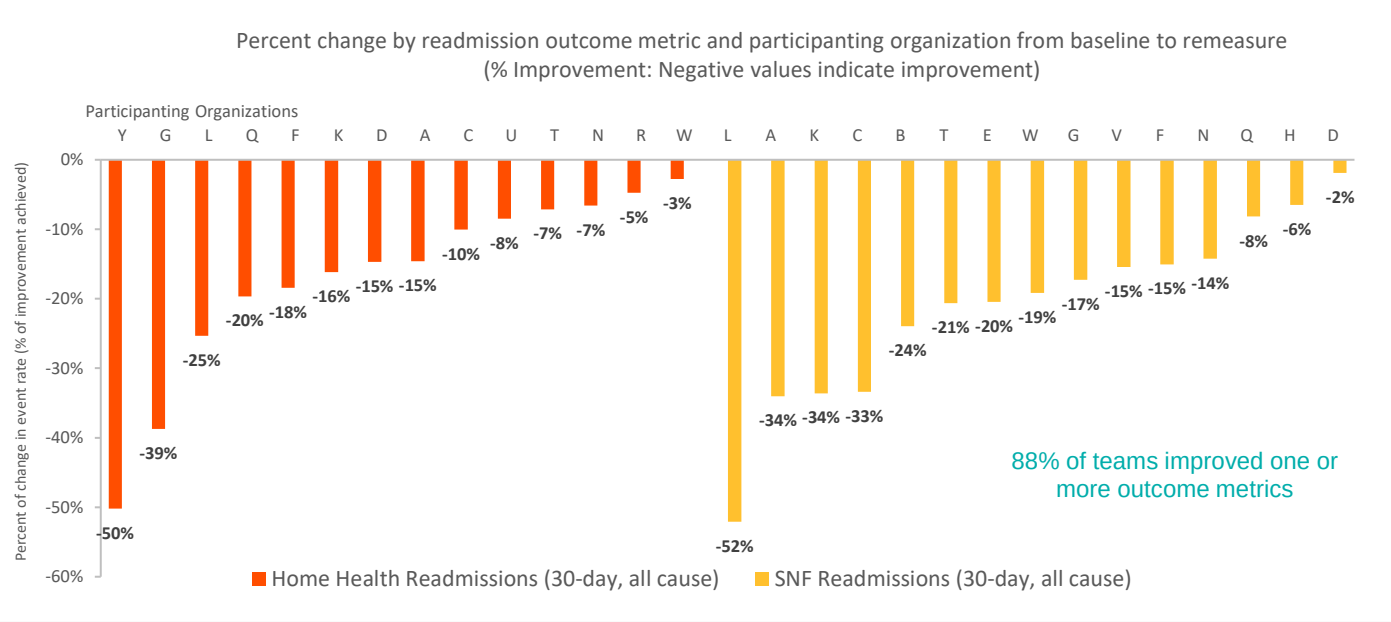
By using the Collaborative Framework as a guide for applying the change levers, the collaborative group avoided 1,826 hospital readmissions and saved $26,289,503 in post-acute discharge readmission costs overall*. Collaborative performance results Indicate, on average, readmissions coming from discharges to skilled nursing facilities (SNFs) were reduced by 22% and the 30-day inpatient readmissions coming from home health discharges achieved an average reduction of 9.8% from baseline to remeasure (Figure 1). Overall, 88% of organizations saw improvement in one of the three post-acute care related readmission outcome metrics. Organization-level improvement varied greatly between both participants and outcome metrics due to the focus of the organization's project and post-acute care partner(s) (Figure 2).

Figure 1



Source: Romstad-Hanser, Amber. Patient Transitions Collaborative Knowledge Transfer. October 14,2021. Link to online recording Accessed October 27,2021.

Figure 2



Source: Romstad-Hanser, Amber. Patient Transitions Collaborative Knowledge Transfer. October 14,2021. Link to online recording Accessed October 27,2021.

Additional resources

Solution	Network Membership Resource	Fee Based Service
Topic project page	✓	
Knowledge Transfer webinar recording and slides	✓	
Archived topic-specific case study	✓	
Related communities: Readmissions	✓	
Supportive materials used in collaborative link	✓	
Clinical Data Base (CDB) Users COPD report builders (included in CDB access). CDB information is available here		✓
Advisory Services (specific to topic) for personalized consulting		✓

Operational Data Base (ODB) to support improvement initiatives		✓
Clinical Practice Solutions Center data solutions for medical practice health		✓
Clinical Team Insights to optimize the clinical workforce		✓
Procedural Analytics to connect procedural and supply data		✓
Accreditation consulting		✓

References

1. Werner, R.M., Coe, N.B., Qi, M, Konetzka, R.T. Patient Outcomes After Hospital Discharge to Home With Home Health Care vs to a Skilled Nursing Facility. JAMA Intern Med. DOI:10.1001/jamainternmed.2018.7998
2. IOM Finds Differences In Regional Health Spending Are Linked To Post-Hospital Care And Provider Prices. Kaiser Health News. https://khn.org/news/iom-report-on-geographic-variations-in-health-care-spending/
3. Burke RE, Whitfield EA, Hittle D, et al. Hospital Readmission From Post-Acute Care Facilities: Risk Factors, Timing, and Outcomes. J Am Med Dir Assoc. 2016;17(3):249-255. doi:10.1016/j.jamda.2015.11.005
4. Improving patient handoff safety. Wolters Kluwer. https://www.wolterskluwer.com/en/expert-insights/improving-patient-handoff-safety
5. American Case Management Association. Transitions of Care (TOC) Standards. https://transitionsofcare.org/
6. Sevin C, Evdokimoff M, Sobolewski S, Taylor J, Rutherford P, Coleman EA. How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations. Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at www.IHI.org
7. American Hospital Association (AHA). Transitions of Care. October 2020. https://www.aha.org/system/files/media/file/2020/07/aha-covid19-pathways-transition-care.pdf
8. Ipekdjian, Michael. Effective Transitions of Care After Discharge Process. October 24, 2019. https://www.managedhealthcareexecutive.com/view/effective-transitions-care-after-discharge-process
9. Rogut, Lynn. Difficult Decisions About Post-Acute Care and Why They Matter. Quality Institute United Hospital Fund. November 2018.
10. 3 Steps for ACOs to Build Effective Post-Acute Care Networks. July 31, 2019. MHE Staff. https://www.managedhealthcareexecutive.com/view/3-steps-acos-build-effective-post-acute-care-networks
11. https://www.hfma.org/topics/hfm/2018/may/60603.html
12. https://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-20-2015/No3-Sept-2015/Continuity-of-Care-Transitional-Care-Model.html#Cowan
13. Hirschman, K., Shaid, E., McCauley, K., Pauly, M., Naylor, M., (September 30, 2015) "Continuity of Care: The Transitional Care Model" OJIN: The Online Journal of Issues in Nursing Vol. 20, No. 3, Manuscript 1.
14. https://www.ajmc.com/view/drivers-of-health-information-exchange-use-during-postacute-care-transitions

*Emerging Practices: include practices assessed through field-based summaries or evaluations in progress that show some evidence of effectiveness and at least plausible evidence of reach, feasibility, sustainability, and transferability https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3864707/