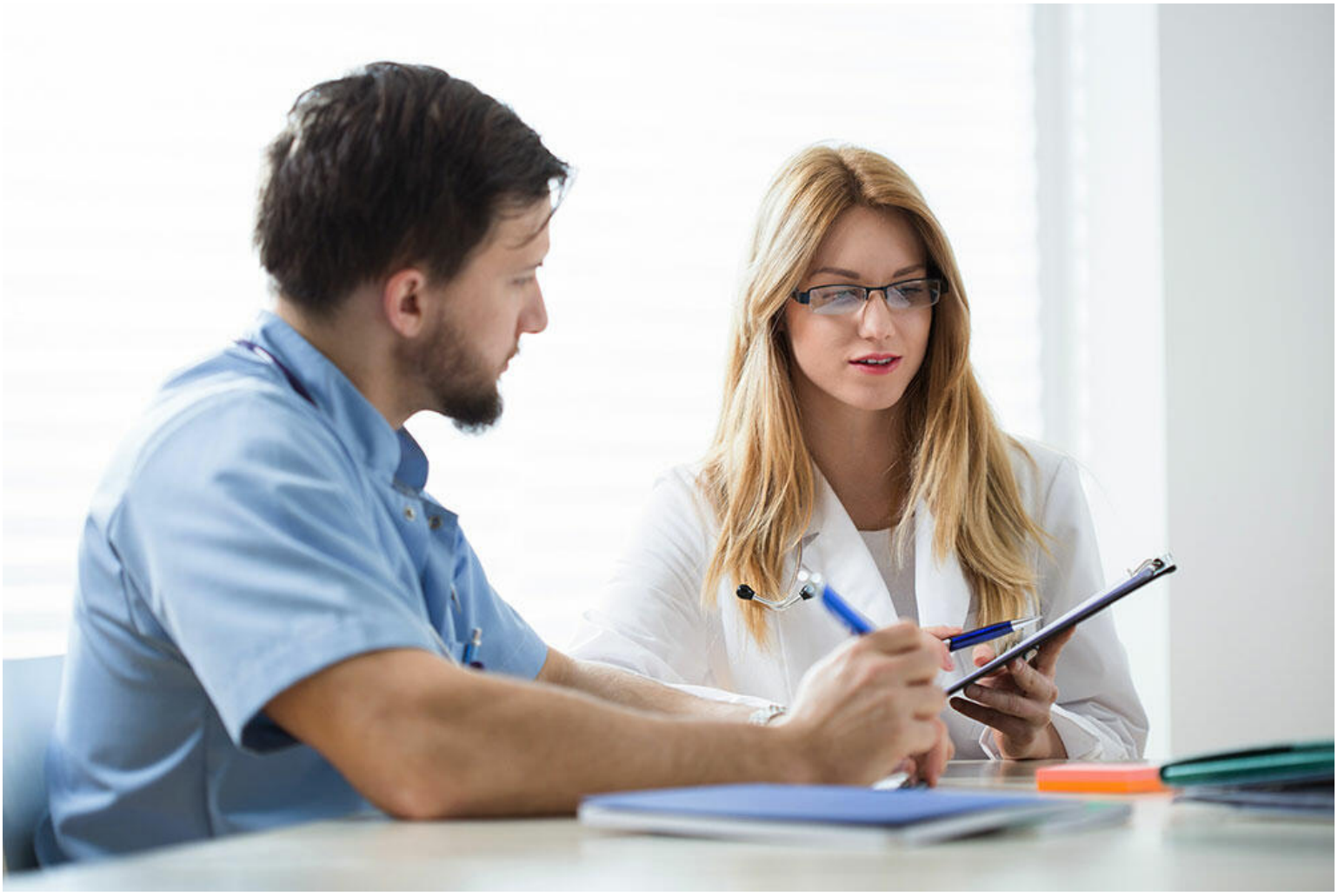
Practical Approaches to Enhance Care Transitions into the Community



As seen in Becker's Hospital Review.

Enhancing care transitions requires involvement from all members of the care team. From the provider to the patient, practical approaches to advancing communication and data are key for improving outcomes and quality of care. Health education, community-based organizations (CBOs), soft handoffs, nurse case managers, and shared action plans can all enrich care transitions and lead to improvements throughout the care continuum. By focusing on data and analytics and finding gaps in transitions of care (TOC), problems can be identified and an effective improvement plan can be implemented.

Focusing on Soft Handoffs

Care transitions occur at every level of care. From hospital to physician, skilled nursing facility (SNF) to home health, and even behavioral and wellness care providers, the transfer of information is critical in enhancing these transitions. Soft handoffs are at the core of TOC improvement and every stage of transition must be accompanied by information that is both accurate, timely, and actionable.

Development of standardized health reports that accompany the patient through these transitions will ensure that current health statuses, medications, and treatment plan data are transferred accurately and efficiently within the appropriate format. This information should mimic a shared action plan and serve as a communication platform between TOC facilities, physicians, and home health providers, the patient and family caregivers. Transparency of data is essential for maintaining consistency of care and improving both efficiency and accuracy of patient data. It should extend through all areas of the care continuum and include a patient-centered perspective to promote engagement and a self-management approach to support the patient care goals.

Care Management Teams

New goals of improving care transitions center on care management teams to monitor TOC and work toward improving patient/provider communication. Nurse case managers play a critical role in the communication process, serving as the information and coordination hub between the patient and an interdisciplinary care team that may include primary care, home health, pharmacists, and licensed clinical social workers. This holistic approach to care is extremely valuable for patients with chronic or complex health issues, and has been shown to improve patient outcomes and decrease readmission rates significantly.

Providing a nurse case management system as part of a care coordination team effort will help ensure that the correct data accompanies the patient and can assist them in navigating through the care continuum. Continued focus on a patient-centered approach to care management will improve the care transitions from each facility and enhance the continuation of care to the home environment. Nurse care managers oversee each stage of TOC, proving a continual link between the patient and provider.

The Importance of Community-based Organizations

Community-based organizations (CBOs) are another important aspect of TOC. CBOs are often underutilized, despite their value in reaching out to extended areas of population health management. These organizations offer significant value in community health outreach and can provide continuing care and education services in a non-traditional setting. These settings typically involve a high level of trust and draw a large number of the population, improving ongoing care success and standing as a resource for care referrals to local providers.

Enhancing these organizations through ongoing development and education teams allows care transitions to flow from provider facilities to the community to the patient and back. By providing the tools to enable CBOs, patients will find the resources they need to manage care and improve outcomes overall.

Reimbursement Models

Over the last several years, CMS has made available CPT codes to incentivize health providers in offering Transitional Care Management (TCM) and Care Coordination (CC) services. Some hospital systems and post-acute care providers have started utilizing these codes to bill for TOC services. However, many other TOC providers are either unaware of their availability (resulting in revenue leakage), or do not understand how to implement them as a part of their portfolio of services.

Data Sharing, Analytics, and Workflow

One resource that cannot be overlooked is the management of data and the use of this information to inform decisions and change. There are four main areas of data development that affect TOC outcomes.

- Inclusion of Social Determinants Of Health: There is increasing clinical evidence to show the importance of social determinants of health to overall health outcomes. A patient's personal motivation, education level, economic status, resources and support structure is an integral component in developing a personalized care plan and drive meaningful behavioral change.
- An Outcome Matrix: This creates a system of patient care analysis and provides the data needed for bonus or incentive programs that require evidence of patient care improvement.
- Analytics and Reporting: Timely and accurate information enhance health outcomes and care delivery efficiency. Data on positive TOC, lowered readmissions, and improved patient outcomes provide the information needed to meet these incentive requirements. Commercial payers are offering shared savings programs for enhanced care management, including TOC, which models ACA guidelines for improved patient outcomes, quality, and value-based incentives.
- Workflow: Streamlining workflow from one setting to the other with the right analytics and data that can be repeatable is important for improving TOC. Defining successful workflows from the hospital to different care settings can help utilize existing EHRs and tools that are already in place.

