Getting Your Care Transitions Right

No matter how well you believe your organization is performing with its care transitions, there is always room for improvement. A single mishandled care transition is one too many.

For an industry in the business of safely moving many of its primary customers from one setting to another, you would think health care would do better with care transitions. Yet despite the importance of care transitions to patients' quality of care, quality of life and outcomes, many health care organizations still struggle with care transition coordination.

The financial impact to health care organizations of poorly coordinated care transitions – potentially leading to procedure complications, medication errors, infections, falls and other negative outcomes – can be substantial. For example, nearly one in five Medicare patients discharged from a hospital – approximately 2.6 million seniors – are readmitted within 30 days, at an annual cost of more than $26 billion, according to CMS. More than 2,500 general hospitals nationally, 83% of 3,100+ hospitals evaluated in CMS' Hospital Readmission Reduction Program, were financially penalized in late 2019 due to readmissions.

Improving your facility's care transitions means getting all members of your care team – from providers to patients – involved in the effort. Here are four suggested areas of focus to potentially enrich your transitions and improve the care continuum. Start by looking at improving your care-related data to help deliver better outcomes and quality of care. More broadly, pay attention to the quality of your case management teams, soft handoffs and community-based organizations (CBOs).

Improving Decision-Making

Data management and analysis should be the foundation of care coordination, as it informs decision-making and opportunities for change and improvement. These four areas within data management systems primarily affect care coordination outcomes:

1. **Social determinants of health** – Increased clinical evidence shows the importance of social determinants of health to overall health outcomes, which is why they should be tracked. Identifying and tracking patients' personal motivations, education levels, economic status, resources and support structures can be integral for developing personalized care plans and driving meaningful behavioral changes.
2. **An outcomes matrix** – Establishing and maintaining an outcomes matrix creates a system of patient care analysis and provides the data needed for bonuses or incentive programs requiring evidence of patient care improvement.
3. **Analytics and reporting** – Maintaining timely and accurate data can enhance health outcomes and care delivery efficiency. Data on positive care coordination activities, lowered readmissions, and improved patient outcomes provide the information needed to meet payers' incentive requirements.
4. **Workflow analysis** – Streamlining workflow from one setting to another, with the right analytics and data which can be repeatable, is important for improving care quality. Defining successful workflows from the hospital to different care settings, along with how information will be tracked, analyzed and shared, is important.

Strengthening Case Management Teams

Over the past decade, there's been increased emphasis on improving care transitions using case management teams to monitor transitions and enhance patient/provider communication. Nurse case managers typically play a critical role in the communication process, serving as the information and coordination hub between patients and an interdisciplinary care team which may include primary care, home health services, pharmacists and licensed clinical social workers. This holistic approach to care is 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-based case management system as part of your care coordination protocol will help ensure that the correct data accompanies each patient and assists them in navigating through the care continuum. Focusing on a patient-centered approach to care management can improve care transitions from one facility to another, including care within a home environment. Nurse case managers oversee each stage of care transition, providing a continual link between patients and providers.

Standardizing Soft Handoffs

Care transitions occur at every level of care. From hospitals to physicians, skilled nursing facilities (SNFs) to home health care, and even from behavioral health to wellness care providers, transferring patient information is critical for enhancing these transitions. Soft handoffs like these are at the core of care transition improvement. Each stage of transition must be accompanied by information which is accurate, timely and actionable.

Developing standardized health reports to accompany patients 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 facilities, physicians and home health providers, as well as with patients and their caregivers. Data transparency is essential for maintaining consistency of care and improving the efficiency and accuracy of patient data. It should extend through all areas of the care continuum and include a patient-centered perspective, to promote patient engagement, and a self-management approach to support patient care goals.

Relying on Community-Based Organizations

Community-based organizations (CBOs) are a vital link in care transition. CBOs are often underutilized, despite their value in reaching out to extended areas to support 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. CBO settings typically engender a high level of trust among patients and draw a large segment of the local population. Because of this status, CBOs are vital for providing ongoing care success and acting as a resource for care referrals to local providers.

Enhancing CBO relationships through ongoing development and education teams allows care transitions to flow from provider facilities to the community to the patient and back. By providing CBOs with the information and tools they need to succeed, patients will more effectively find the resources they need to manage their care and improve their outcomes.

An Ongoing Effort

No matter how well you believe your organization is performing with its care transitions, there is always room for improvement. A single mishandled care transition is one too many. By diligently monitoring your care transition quality and empowering staff to make necessary improvements, you increase the likelihood of achieving care transition excellence and minimizing the negative financial impact of suboptimal transitions.

