Tackling Transitions of Care Together

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Healthcare systems continuously invest in resources and strategies to enhance and improve care transitions as a way of improving patient outcomes. According to Parry et al. (2021), transitions of care (TOC) is often defined as the time between moving a patient from one setting or level of care to another, for example from hospital to home or from the acute care to the outpatient setting. Undoubtedly, this period is critical in measuring the success of the health care system as well as attempts to improve the patient's experience. One such report estimates that Medicare's spending related to poor acute transitions of care is between $26-45 billion dollars annually and with the Medicare population estimated to reach 80M beneficiaries by 2040, this could rise to $88 billion dollars (Ouayogode, 2024). Although there is no standard practice model, a multidisciplinary approach is often seen as a hallmark of success for TOC interventions. The aim of this article is to describe a successful ambulatory case management approach to improving the TOC period while providing timely and convenient care for vulnerable patients at high risk of poor outcomes.

ChristianaCare's high-risk acute care (HRAC) ambulatory case management team was established in 2022 and is comprised of nurses, social workers, pharmacists, physicians, and care connectors. Unique to our program, the HRAC team receives real-time admission notifications through a robust admission, discharge, and transfer (ADT) dashboard and engages the patient and/or caregiver early — prior to discharge — to impact care immediately. Earlier outreach using a multidisciplinary team approach helps to establish continuity of care as well as assist case managers with building a successful, trusting, engaged relationship earlier in the TOC process (Rochester-Eyeguokan et al., 2016). The success of this outreach and intervention is dependent upon the inpatient/outpatient collaboration as well as the intentional efforts made by both parties to provide a seamless experience for the patient.

As able, the HRAC and inpatient case management team participate in weekly huddles to share clinical updates and patient progress for patients who fall into ChristianaCare's value- based arrangements, while developing comprehensive care plans collectively. After discharge from the acute care setting to home, the HRAC team manages patients for 30 days to ensure continuity of care and support. If discharged to a skilled nursing facility (SNF), a specialized team of experienced nurses manage those same patients in our valued-based contracts, throughout their SNF stay as well as 30 days beyond discharge until the patient moves into one of our longitudinal/disease management programs. TOC outreach involves a high-touch, high-quality, multimodal approach to care. The team utilizes a texting platform to engage the patient between scheduled outreach calls. Texting programs help to identify concerns early thus deploying specific, targeted interventions to help empower self-management action planning with the patient (Leconte et al., 2019).

Patients who have transitioned to a SNF are managed by a post-acute care (PAC) team. The PAC team engages the facility staff, at both ChristianaCare and unaffiliated SNFs, during weekly huddles with the goal to support discharge planning efforts. SNFs have been categorized as a platinum, gold, or silver participating facility based on a high-performing partnership. The level of partnership and the criteria which has been used to determine the status is shared with patients and their caregivers to assist with informed decision-making. Additionally, the criteria are shared with the SNFs so that visibility is present, and a partnership is established to assist the SNF with achieving a higher status pending established criteria is met. Research suggests that having a preferred network of SNFs results in lower resource use and

better-quality performance (Zwart et al, 2021)). While there are many factors influencing the high-performing partner criteria, having a timely post-facility follow-up process in place is one of them.

Patients with Medicare transitioning from a SNF to home have an approximately 1 in 4 chance of readmission at 30 days (Ouayogode,2024), many of which are both costly and avoidable. Timely follow-up to care is instrumental in decreasing the likelihood of a readmission, but access barriers often exist. Patients may have social or economic barriers, such as transportation challenges, therefore preventing a successful post-discharge follow-up. In order to address this concern, a pilot program was developed to have an emergency medical technician (EMT) visit Medicare patients discharged from a SNF to home if they were unable to see a primary care provider (PCP) within 3-5 business days of discharge. During the visit, the EMT completes a patient questionnaire, and then connects the patient with an appointed geriatrician virtually. The geriatrician will then provide care during the TOC period or until the patient can resume their regularly scheduled follow-up and has returned to their baseline health status. Patients who do not meet pilot criteria are managed by our PAC nurses for 30 days at which time they are then transitioned to our longitudinal/disease management team. The PAC team assists patients to secure early post-acute follow-up care with the PCP by taking advantage of the access to the clinicians' schedule, utilizing the after-hours clinic, and exploring telehealth options while assisting with care gap closure for those social or economic barriers by coordinating efforts with our licensed clinical social workers.

In closing, successful transitions are intentional, adaptable, comprehensive, and measurable. A successful transition is dependent upon the healthcare team working in tandem to create a seamless experience for patients and families. Ensuring high-quality exchange of information, joint decision-making, and accountability creates strong care coordination. Patient, family, and/or caregiver involvement is instrumental in preventing poor coordination, miscommunication, stress, and caregiver burnout while also developing and maturing patient self-management action planning. Empowering patients with knowledge about their condition, required treatment, and self-care strategies will improve the likelihood of a successful transition. Adverse events decrease as the patient becomes more engaged in their care (Dieleman, et al., 2018) The importance of tackling transitions of care together cannot be overstated. ■

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