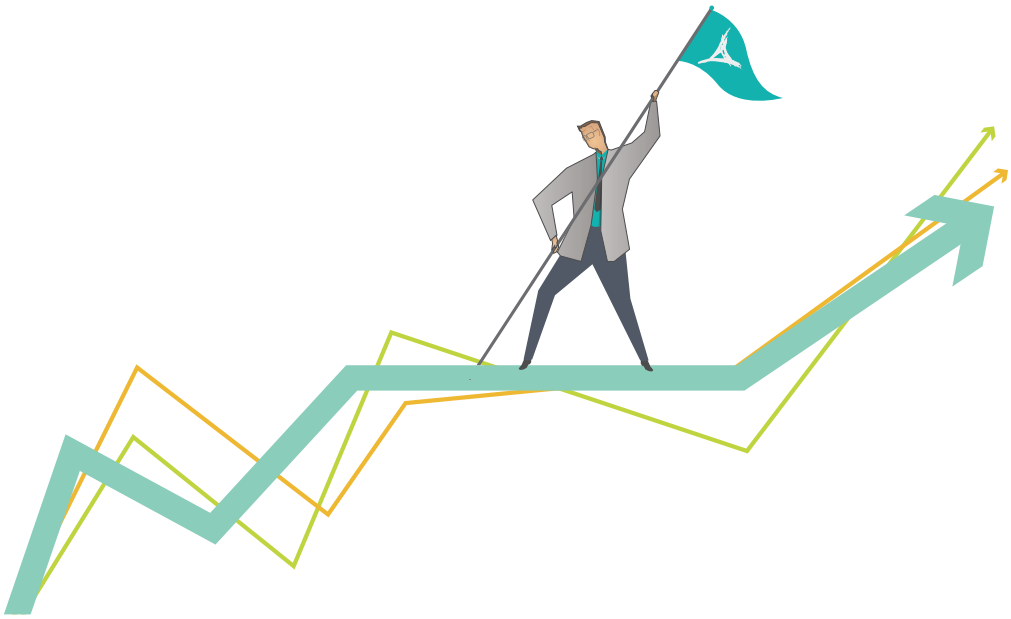

Who's Minding the Gap Between Acute- and Post-Acute Care In the Quest For the Triple Aim?

Effective strategies for delivering continuous quality during transitions of care

TwelveStone HEALTH PARTNERS™

Remember the old fee-for-service system when most acute-care hospitals paid little attention to what happened to patients after they were discharged?

New readmission penalties and changing payment methods, though, have led acute-care facilities to invest in integrating care by improving coordination and follow-up visits.

Hospitals are now using best practices for closing that transition gap upon discharge by setting up appointments and accounting for transportation and patients' other logistical needs.

The government's Triple Aim to achieve value-based care—to improve quality, reduce cost, and improve the patient experience—can't be addressed by hospitals alone. In conjunction with post-acute providers, hospitals can bridge the gap improving patient compliance and reducing readmission by

- Care coordination specifically by an APRN or RN to reduce noncompliance with medication and the care plan
- Communication between the hospital and primary care provider within one week of discharge
- Home visits within three days of discharge
- Telephone outreach and telehealth services

Instead of feeling as if they are teetering on a tight-rope, hospitals and post–acute care facilities can partner with companies whose focus and expertise is on coordinating the care continuum from the hospital to home or another interim care location. The result? A smooth transition of care to reduce readmissions and create happier and healthier patients with better outcomes.

With a trained transition team in place (something that most hospitals aren't staffed up to do), patients receive care coordination, packaged medications, correct home care and education before and after they leave the acute setting, and a care plan with communication that centers around the patient's needs so patients and their families are not responsible for figuring things out themselves.

A bad transition, on the other hand, upsets patients, which in turn is reflected on HEDIS scores that hospitals rely on—not to mention poorer patient health outcomes and costly readmissions.

Fast Fact

Comprehensive transitional care programs can reduce the number of patient readmissions to hospitals for the first 30 days after discharge—and up to an entire year.

Achieving the Triple Aim

It takes a collection of resources and services to ensure optimal communication and to coordinate care during the transition between facilities with different levels of acute care.

Programs delivering on the promise of the Triple Aim (the highest quality, cost-effective results, and improved patient outcomes) include

- Multidisciplinary services before and after the transition
- Multimodal services that address several gaps in care instead of a single issue, like medication reconciliation
- Ongoing services in all locations
- Multiple communication formats—written, oral, and technical—for patient instructions and education and for clinical protocols
- Long-term follow-up

Support for high-risk patients

Programs that focus on patients with the highest risk for readmission to acute care are most likely to be effective at achieving the Triple Aim. At the simplest level, that evaluation means assessing which patients need post-hospitalization care, and for the ones that do, what type of care, how much, and in what order.

Top factors that affect risk for readmission include age (older adults with cognitive or health issues are at higher risk), lack of social support, finances (money problems affect housing and nutrition), and transportation issues (such as access to food and medical care). Functional limitations such as lower levels of education and health literacy and cognitive impairment can affect how patients manage medical instructions and how compliant they are in their own care. The introduction of predictive analytics, leveraging social determinants of health, and delivering alerts that flag at risk patients can also support applying the right services to the right patient.

Of course, readmission to acute care isn't always preventable or unwarranted. Sometimes acute care is a necessary aspect of quality treatment. Even with optimal, targeted care, some patients may need more frequent acute care to manage their chronic conditions.

A post–acute-care partner is in a position can assess the risk factors and effectively address them in the transitional setting.

Mind the discharge gap with a patient-centered focus

Well before the day a patient leaves a facility, providers and clinicians can start building the bridge to the next stage of care by

- Assessing how a patient's physical, psychosocial, emotional, and financial status may affect the risk for readmission
- Talking with the patient, family, and caregivers about their preferences and helping resolve any conflicts
- Reaching a mutual decision from all stakeholders about the best time for discharge
- Defining a plan for post–acute care for the next 60 days that considers every setting of care and that accounts for palliative care
- Communicating the discharge plan with the patient's primary care provider—verbally if possible, or by e-mail or fax
- Staying in communication with the patient to ensure treatment compliance and addressing issues rapidly

On the day of discharge, a transition partner can go over medications with the patient and caregivers and discuss in easy-to-understand terms the discharge instructions and care plan going forward, such as follow-up appointments and home delivery of medical equipment. For example, for patients going to an after-care facility, a care coordinator can arrange services at a skilled nursing facility or hospice.

Since patient satisfaction surveys get sent to patients as long as six weeks after their discharge, having an after-care partner who shares your values and systems can keep your excellent, compassionate care fresh in your patients' minds.

Fast Fact

Weekend discharges increase a patient's risk for readmission due to reduced accessibility to pharmacy services and durable medical equipment.

The bonus to hospitals for expanding their reach into the post-acute experience is the power of the halo effect. The halo effect refers to how a person's satisfaction in one area can spread to other areas. When patients have positive feelings about a person, event, or reputation associated with your organization, for instance, they subconsciously tend to quickly judge everything about you more positively and help you achieve the tenets of the Triple Aim.

Mind the Communication Gap by Enhancing Relationships

High-performing hospitals distinguish themselves through communication efforts that

- Shape working relationships to increase collaboration across the care continuum, both within a facility and with outpatient providers
- Elicit successful communication
- Value and prioritize communication with case managers, primary care physicians, patients, as well as with families and caregivers
- Strive for timely transfer of critical information
- Include standardized hand-off procedures for all assessments, medications, equipment, and care plans
- Include timely transfer of information about diagnoses, procedures, complications, lab test results, and recommendations for specialty consultants

Other measures that help protect patient safety, boost satisfaction, and lower costs, include

- Employing transitional care nurses or nurse navigators
- Linking electronic medical records across the continuum of acute- to post-acute, to ambulatory care
- Handing over real-time communication, often including calls from one provider to another about high-risk patients
- Sharing expertise and data about readmissions and clinical and quality improvement expertise with other providers across the continuum of care

Pharmaceutical Consultants Help Close the Gap

Poor communication is the cause of half of all medication errors. That's why coordinating support pharmacy services is an important piece of post–acute care. Support services include a long-term care pharmacy, home infusion pharmacy, and specialty pharmacy.

Best-in-class partners should be expected to provide these pharmacy services, along with support in terms of education and communication.

- State-of-the-art technology: Electronic medication verification, automated medication substitution formularies, electronic medication ordering, first dose ER systems, online bill pay
- Formulary consultations
- Medication adherence support, including presorted, individual pocket-size packages that contain prescription pills, vitamins, and supplements. Labels show the prescribed dosage and the date and time to take the medicine.
- 24/7 access to a pharmacy technician and licensed pharmacist
- Management of prescription refills to avoid gaps in usage.

Helping Patients Take Ownership of Their Care

The goals of the Triple Aim can be met when a post–acute care facility partners with an experienced company such as TwelveStone.

Our care coordinators meet your patients on site at your facilities. We coordinate care that your patients will need as soon as they step out your door, and we show up to support your patients when the next level of care starts—to educate about home care or care in a post-acute facility. We help ensure that the care plans you as our partner have defined for patients are followed and that you are informed if and when the plans change.

Together, we can provide compassionate, comprehensive care that boosts patient experience, improves quality of care with medication support, education, and follow-ups, and reduces preventable costs from communication gaps and errors, prescription errors, or abandoned recovery efforts from lack of understanding, encouragement, or support. Working as a team makes achieving the Triple Aim more achievable.

For more information, visit or call.
www.12stonehealth.com
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