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The complete instructor materials include the following:

- Test bank
- PowerPoint slides for each chapter
- Instructor guides for each chapter (with answers for discussion questions and case studies)

This sample includes the PowerPoint slides and instructor guide for Chapter 3, “Transitions of Care and Post-Acute Care Services.”

If you adopt this text, you will be given access to the complete materials. To obtain access, e-mail your request to [hapbooks@ache.org](mailto:hapbooks@ache.org) and include the following information in your message:

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# **Chapter 3**

## **Transitions of Care and Post-Acute Care Services**

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# Learning Objectives

After completing this chapter, you should be able to

- define *transitions of care* between acute care, residential long-term care, and home and community-based long-term care settings within the US healthcare delivery system;
- define *care coordination services* and discuss their importance in transitions of care;
- discuss subacute and post-acute care and their roles in transitions of care;
- understand the impact of key healthcare policies and regulations on transitions of care;
- understand the role of technology and health information systems in the coordination of care during transitions; and
- examine future directions for transitions of care in healthcare delivery systems.

# What Are Care Transitions?

- **Care transitions** refer to the process of coordination and continuity of care for individuals as they move or transition from one setting of healthcare services to another.
- **Care coordination** is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of healthcare services.
- Transitions of care can apply to any individual regardless of age and health care status or disability.

# Healthcare Providers and Transitions of Care

- A variety of healthcare providers are involved in transitions of care. They include acute care providers (such as hospitals), ambulatory care services, home and community-based service providers, and long-term care or rehabilitation services.
- A hospital stay initiates a discharge planning process that includes transitions to the patient's home or another setting such as rehab with a long-term care provider.
- Discharge planning is an important component of transitions of care.

# Healthcare Providers and Transitions of Care: Acute Care Providers

- Acute care providers are hospitals and healthcare systems.
- Hospitals are where patient care starts, and they play a major role in transitions of care.
- Some hospitals have initiated early palliative care consultations to identify patients who may need hospice and end-of-life care services.
- **Acute Care for Elders (ACE) units**, another new form of inpatient care, specialize in geriatric care to reduce the risk of functional decline of a hospitalized older adult.

# Benefits of Collaboration Between Acute and Post-Acute Care Settings

- Collaboration is essential in a system where an individual being treated for one condition can move from an emergency room to a hospital to a rehabilitation facility and then to a nursing home if appropriate.
- Studies indicate support for the use of **transition coaches** (sometimes called *care navigators*) to deliver transitional care services for post-acute care patients and their family and caregivers.

# Historical Perspectives on Care Transitions

- Changes in payment systems have had a profound influence on the transition from acute to post-acute care.
- The shift to prospective payments created incentives for hospitals to decrease patient length of stay.
- Patients no longer stay in the hospital until they are completely well; they are discharged to a variety of post-acute settings such as rehabilitation hospitals, long-term care facilities, nursing homes, and skilled nursing facilities for recovery.
- Evidence of poor clinical outcomes and unnecessary spending of Medicare and Medicaid resources have prompted new thinking related to managing post-acute care services and care transitions.



# Research on Care Transitions

- Research has shown persistent problems related to the movement of patients across settings, resulting in high hospital readmission rates.
- Studies of discharge planning from the hospital to the community found that approximately one-third of re-admissions to the hospital might be avoided by instituting a more comprehensive system of transitional care from the hospital to the community.
- Research suggests that patients who receive post-acute care services following a major health episode see greater and more rapid clinical improvements compared to patients discharged to their homes without follow-up.

# Problems in Care Transitions Guidelines

- Poor transitions and lack of coordination increase the likelihood of service duplication, care fragmentation, care delays, and medication errors, along with other adverse outcomes.
- The American Geriatrics Association has recommended standards for care transitions, which include preparing and educating individuals and their caregivers, involving those individuals in the care transitions process, having a communications process between care levels, developing outcomes measures for each care level, and conducting research to improve transitional care outcomes.

# Community-Based Care Transitions Program

- This program puts community-based organizations in charge of identifying the needs of Medicare beneficiaries who are moving from the hospital to their homes and coordinating care to address those needs.
- It encourages partnerships between community-based organizations providing services to elders (such as Area Agencies on Aging, Aging and Disability Resource Centers, and Meals on Wheels organizations) with healthcare systems, long-term care communities, rehabilitation facilities, and other post-acute care providers.

# Accountable Care Organizations

- The ACA also introduced accountable care organizations (ACOs) as a type of integrated delivery model in which groups of providers and suppliers of healthcare and health-related services and others caring for Medicare beneficiaries voluntarily work together in one of four possible models to coordinate care under the traditional Medicare program.
- Some post-acute care providers are entering agreements with ACOs to establish and implement care protocols, processes for care coordination and transitions, and, in some cases, complete integration with acute care providers.

# Hospital Readmissions Reduction Program

- The ACA added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program.
- This program requires CMS to reduce payments to hospitals with excess readmissions from discharges occurring after October 1, 2012, for specific diagnoses.

# **CMS Bundled Payment Initiatives: Comprehensive Care for Joint Replacement Model**

- Under the conditions of the program, Medicare will pay hospitals a flat rate payment for certain joint replacement procedures and will allow patients to receive rehabilitative services in nursing homes after their procedure.
- Only nursing homes with a 3 star, or average, rating or above will be able to participate as post-acute care providers in this bundled payment program.

# PAMA of 2014

- PAMA required that CMS specify an all-cause, all-condition hospital readmission measure for nursing homes by October 1, 2015, and an all-condition risk-adjusted potentially preventable hospital readmission rate by October 1, 2016.
- As a result of this legislation, nursing homes will have uniform readmissions measures that they can use to measure their performance relative to their peers’.
- By 2017, this readmissions performance data will be publicly available on CMS’s Nursing Home Compare website.

# IMPACT Act of 2014

- The IMPACT Act requires post-acute care (PAC) providers to report standardized patient and resident assessment data, data on quality measures, and data on resource use and other measures, and for the data to be interoperable to allow for its exchange and comparison among PAC and other providers.
- Ultimately, this will lead to the creation of a prospective payment system that results in coordinated transitions of care, helping patients achieve their goals and have quality outcomes.



# Proposed Discharge Planning Rule

- In 2015, CMS released a proposed rule that would require healthcare providers to develop personalized, detailed discharge plans for patients within 24 hours of a readmission (including a system for post-discharge follow-up and medication reconciliation) and complete the plan before transitioning the individual to the community or another care setting.
- The proposed rule also includes planning for individuals with psychiatric or mental health diagnoses.

# **The Future of Care Transitions: Bundled Payments and Post-Acute Care Referrals**

- If bundled payment programs continue to grow, hospitals and healthcare systems may try to direct patients to certain post-acute providers that are known for quality outcomes where the potential for readmission is low.
- Employing effective readmission reduction strategies, such as having nurses or other transitions coaches follow up with patients after discharge, may be expensive and unaffordable for many institutions, particularly safety-net institutions.

# Care Transitions and End-of-Life Care

- The Advanced Illness Management program, an initiative started in 2010 by California-based Sutter Health, is an integrated service delivery model that advises individuals and their families on how to make transitions to hospice and end-of-life services while individuals still receive medical care in the community at home.

# Remote Monitoring Technologies

- Some post-acute care providers have adopted innovative technologies to lower the risk of hospital readmissions of their rehabilitation residents.
  - Such technologies may include telehealth and remote monitoring systems in a nursing home or in an individual's home.
- Organizations that have adopted these technologies have seen cost savings, more effective resource utilization, and reductions in their hospital readmissions rates.

# Supportive Social Services

Social services organizations such as Meals on Wheels have started to partner with healthcare providers to ensure adequate nutrition services at home for individuals recently discharged from the hospital to the community.

# Looking Ahead

- In the years ahead, policymakers will have to closely monitor the impact of the Affordable Care Act reforms, Medicare's proposed rules, and various demonstration programs on care transitions.
- They also must be prepared to amend policies as necessary to ensure that reforms exert effective controls on spending without compromising the delivery of appropriate, personalized post-acute services (Grabowski et al. 2012).

***Dimensions of Long-Term Care Management: An Introduction 2<sup>nd</sup> Edition***  
**Instructor Resources**

**Chapter 3**

**Transitions of Care and Post-Acute Care Services**

**Learning Objectives**

After completing this chapter, you should be able to

- discuss transitions of care between acute care, residential long-term care, and home and community-based long-term care settings within the United States healthcare delivery system;
- define care coordination services and discuss their importance in transitions of care;
- discuss subacute and post-acute care and their roles in transitions of care;
- understand the impact of key healthcare policies and regulations on transitions of care;
- understand the role of technology and health information systems in the coordination of care during transitions; and
- examine future directions for transitions of care in healthcare delivery systems.

**Summary**

This chapter examines the emerging trend of developing systematic processes to move patients from acute care into post-acute care settings and ensuring a coordinated level of care. Transition coaches and coordinators are key in working with patients, patients' families, and caregivers at the receiving post-acute settings. Through educating all of the stakeholders in a patient's plan of care, transfer to post-acute care results in better outcomes for the transferred patient and potentially lower costs for providers and insurers. The care transition process develops a care plan that encompasses the services of acute care, skilled nursing facility care, rehabilitation services and home care. Both

hospitals and post-acute care providers are supportive of this initiative, as it will be a cornerstone in supporting a bundled reimbursement system for issuing one payment to a healthcare system for an episode of care. Recent legislation supports streamlining the transition of care process through uniform data collection and utilizing uniform patient assessment tools.

### **For Discussion**

1. What are care transitions, and how are they related to care coordination?

**The term *care transitions* describes the interaction among the patient, the patient's family, and members of the healthcare team to provide the appropriate care as the patient moves from one healthcare provider to another. It is most effective when coordinated by a healthcare professional who is familiar with the capabilities of the range of post-acute services. Care coordination is an essential part of the transitions of care process. It involves planning, organizing activities, and sharing information across two or more providers of healthcare services to ensure safer and more effective care.**

2. Define *subacute care* and *post-acute care*, and describe the difference between the two types of services.

**Subacute care provides the highest acuity of services in the dimensions of post-acute care services. Subacute patients require specialized services and treatments (such as ventilator care or complex pharmacological administration) but no longer require or qualify for acute care. Post-acute care describes the range of care after hospitalization and includes transitional care units, skilled nursing facilities, nursing homes, inpatient rehabilitation centers, and home health agencies.**

3. What is discharge planning, why is it important, and what types of care settings can patients be discharged to? (Name and describe at least two types of settings.)

**Discharge planning is the process of planning and moving a person from one care setting to another care setting or back to the community. It is an important component of a transition of care. Patients who are discharged from the hospital**



**may be transferred to skilled nursing facilities, nursing homes, rehabilitation centers, or home with home health care.**

4. What are some benefits of collaboration between acute care and post-acute care settings in the care transitions process?

**Collaboration between acute care and post-acute care settings is essential for ensuring a smooth transition to post-acute care services such as those provided in rehabilitation centers or skilled nursing facilities. Failure to coordinate information between levels of care can impede patients' recovery at home or in a post-acute facility and, in some cases, put patients in danger of losing their ability to care for themselves. Accuracy of medical information such as medications, treatments needed, prior surgeries, medical history, and family support helps to ensure proper treatment and care for patients in the new setting.**

5. Describe the role of acute care and community-based settings for care transitions. What types of community service providers should be contacted to assist in an individual's care transitions, especially if the individual lives alone?

**Health reform legislation created the Community-Base Care Transitions program, which puts community-based organizations in charge of identifying the needs of Medicare beneficiaries who are moving from a hospital to their homes, as well as coordinating care to address those needs. It encourages partnerships between community-based organizations providing services to elders—such as Area Agencies on Aging, Aging and Disability Resource Centers, and Meals on Wheels organizations—with healthcare systems, long-term care communities, rehabilitation facilities, and other post-acute care providers.**

6. What are transitions coaches, and why are they important in the care transitions process?

**Transitions coaches specialize in assisting patients and residents in movements through the care transitions process. Their use has been linked to significant cost savings and improved quality outcomes.**

7. What are accountable care organizations, and how can they help the care transitions process and prevent hospital readmissions?

**Accountable care organizations (ACOs) are groups of providers and suppliers of healthcare and health-related services, along with others caring for Medicare beneficiaries, that voluntarily work together to coordinate care under the traditional Medicare program. Through establishing and implementing care protocols, ACOs develop processes for care coordination and transitions, and they integrate completely with acute care providers, which leads to better utilization of health resources and prevention of unnecessary rehospitalization.**

8. How can Medicare bundled payment programs help or hurt reimbursement for rehabilitation services in nursing homes?

**Under the Medicare bundled payment programs, hospitals and healthcare systems may try to direct patients to post-acute providers that are known for quality outcomes and low readmission rates. By funneling more persons to post-acute providers that achieve excellent results, hospitals will likely avoid penalties for excessive readmissions. Ethical dilemmas may emerge when a hospital or healthcare system attempts to limit competition through this type of referral system. The free choice of consumers to obtain post-acute care services, regardless of programmatic restrictions for reimbursement, is a key component of the US market-based healthcare and long-term care service delivery systems.**

9. What are PAMA and the IMPACT Act, and how can they help the care transitions process?

**Enacted in 2014, both the PAMA and IMPACT Act aim to improve measurement of hospital readmissions and standardizing measures for resident assessment, resource use, and quality data. The IMPACT Act expands data collection and reporting to all post-acute providers. These initiatives will eventually lead to a prospective payment system that promotes coordinated transitions of care that help patients achieve their goals and have quality outcomes.**

10. How can the proposed rules about discharge planning for Medicare patients in acute care settings, as well as involvement of caregivers in the care transitions process, benefit the Medicare beneficiary as well as the beneficiary's caregivers and loved ones?

**Medicare's proposed a rule would require healthcare providers to develop personalized, detailed discharge plans for individuals within 24 hours of admission (including a system for postdischarge follow-up and medication reconciliation) and complete the plan before transitioning the individual to the community or to another care setting. Research suggests that persons who receive post-acute care services following a major health episode see greater and more rapid clinical improvements compared to those who are discharged to their homes without follow-up. Involvement of caregivers in discharge planning, patient and family teaching, helps to improve continuity of care, prevent poor health outcomes among older adults, and reduce the likelihood of readmission to acute care.**

### **Case Study: The Case of Mrs. Flynn**

Mrs. Flynn, a 68-year-old widow living alone in her home, was admitted to Community Medical Center after she became dizzy and fell while shopping for groceries. She broke her ankle in the fall. When interviewed by the hospital social worker, Mrs. Flynn admitted that she had not been taking her blood pressure medication on a regular basis and that her chronic obstructive pulmonary disease gave her difficulties when she would try to walk her dog in her gated community.

After six days in the hospital for ankle surgery and a week in the hospital's subacute rehabilitation unit, Mrs. Flynn was discharged home under the care of a home health agency. She was directed to take eight medications, three of which were brand new for her. Mrs. Flynn set goals for herself to monitor her blood pressure and to be able to walk her dog daily. The goals of the hospital's care team were to control her high blood pressure and make sure that she could walk properly.

Once home, Mrs. Flynn's condition deteriorated quickly. The home health agency did not start its visits until five days after she had returned home. Mrs. Flynn's primary care physician was not informed that she had been hospitalized, and his practice's

electronic medical record system was not compatible with the system used by Community Medical Center. Mrs. Flynn's two daughters—who lived two hours away and did not have a close relationship—could not coordinate how to manage her care, and her son, her primary caregiver, had to leave town on an unexpected business trip. Mrs. Flynn thus lacked transportation to her follow-up appointments, and her dog could only be walked once every two days by a neighbor in her complex. Mrs. Flynn had heard that a local community agency for seniors could drive her to appointments and get her a home-delivered meal, but she did not know whom to contact about such an arrangement.

When Mrs. Flynn had returned home, she was given a list of her medications; soon, however, she was not sure which of the medications to continue taking. She also could not afford all the medications, and she had no way of having the prescriptions filled and the medications delivered. Mrs. Flynn had limited food in her home following her hospital stay, and her son was reluctant to shop for provisions because his mother had not given him money to pay for them.

Mrs. Flynn became even more confused when she received her medical bills. She had no way of knowing what costs would be covered by Medicare or by her supplemental retiree health insurance from her deceased husband's employer. She was also having trouble walking with the walker given to her by the hospital, and she was becoming increasingly depressed because she could not walk her dog as she had done before. Mrs. Flynn became lonely and isolated. She also became afraid to go outside for any reason, because she feared she would become dizzy and fall and end up back in the hospital.

### **Case Study Questions**

1. Does Mrs. Flynn's situation resemble a typical transition home for hospitalized older adults? How could better communication between hospital staff, her care providers, her primary care physician, and community-based agencies have helped? What types of services might have been contacted and utilized during the transition?

**This is an example of the a la carte method of providing healthcare and demonstrates an ineffective discharge planning process. Mrs. Flynn had no one to advocate for her posthospitalization experience. If a transition coach had been employed at the beginning of her hospitalization, then an assessment could have been made of her success of recovery after hospitalization.**

2. How could Mrs. Flynn's children have been included in her hospitalization and discharge planning process?

**A thorough interview with Mrs. Flynn and with any available family members would enable the transition coach to make an assessment of her home situation and arrange for services to be available when Mrs. Flynn finally returns home.**

3. What community-based agencies and organizations could have helped Mrs. Flynn with services during and after her transition back to the community?

**Home care for companion services, meals on wheels, pet walking services, and coordination through the division of aging from the city, county, or state department of health and humans services.**

4. Is Mrs. Flynn at risk for readmission to the hospital? Why or why not?

**Mrs. Flynn is at risk of readmission to the hospital for several reason: (1) she lives alone, (2) she has a history of falling due to inability to managed self-medication, (3) she has a remarkable medical history of COPD, which compromises her breathing, and hypertension, which makes her susceptible to stroke.**

### **Additional Teaching Resources and Suggested Readings**

Jencks, S. F., M. V. Williams, and E. A. Coleman. 2009. "Rehospitalizations Among Patients in the Medicare Fee-For-Service Program." *New England Journal of Medicine* 360 (14): 1418–28.

Luke, J.D. (2015) *Readmission Prevention: Solutions Across the Provider Continuum*. Chicago: Health Administration Press.