

# Transitional Care Management: Five Steps to Fewer Readmissions, Improved Quality, and Lower Cost

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Transitional [care management](#), managing patient transitions from one level of care to the next, is an important part of healthcare [outcomes improvement](#). The National Association of Clinical Nurse Specialists defines [transitional care](#) as “care involved when a patient/client leaves one care setting...and moves to another.” Care settings include hospitals, nursing homes, assisted living facilities, skilled nursing facilities, and the home environment.

The practice of transitional care management aims to identify and overcome barriers to successful transitions and prevent gaps in care; the goal is to improve the patient experience while saving health systems the cost of avoidable [readmissions](#). Care managers are integral to achieving successful transitions of care and preventing unnecessary readmissions.

This article outlines a pragmatic, five-step framework for delivering successful transitional care to avoid unnecessary admissions and associated cost.

## Reducing Readmission Rates and Lowering Costs

Under the [Hospital Readmission Reduction Program](#) (HRRP)—which the [Affordable Care Act](#) established in 2012—organizations are penalized financially for unacceptably high readmission rates among Medicare

and Medicaid patients. According to estimates from the [Medicare Payment Advisory Commission](#), 12 percent of readmissions are avoidable, and Medicare could save \$1 billion by preventing just 10 percent of avoidable readmissions. Such policies and reports make reducing readmissions through transitional care management vital as both a quality measure and a cost-management strategy.

After five years of the HRRP, [data](#) suggests readmission rates are falling. Before 2012, [Health and Human Services](#) reported an all-cause 30-day readmission rate among Medicare beneficiaries of around 19 percent. By 2013, this rate was down to around 17 percent, indicating an estimated 150,000 fewer hospital readmissions (and avoidance of associated cost) between January 2012 and December 2013.

The [Institute for Healthcare Improvement](#) (IHI) estimates that a structured and comprehensive transitional care management program can help health systems reduce avoidable readmissions. And because hospitalizations make up a significant portion of annual U.S. healthcare spending—almost one-third of the total \$2 trillion, of which the IHI observes, “a substantial fraction” is often avoidable readmissions—decreasing readmissions through transitional care management is a priority in today’s healthcare environment.

## Transitional Care Management at Work

[Sun Health](#), a non-profit community-based organization in Arizona, implemented an intensive transitional care management program in 2011. The anticipated outcomes were reduced readmissions and a decrease in medical cost, which the program achieved after nine months. As an additional, unanticipated benefit, the program showed positive qualitative outcomes: patients were not only satisfied with the care management program, they also reported that their confidence level regarding self-care improved as well. Fostering independence and self-advocacy are key elements of any care management program.

## Successful Transitional Care Management in Five Steps

Successful transitional care management is rooted in five essential steps, resulting in better outcomes at a lower cost. A care manager oversees the transition plan and ensures that each member of the patient’s care team (patient, primary care provider [PCP], specialist, pharmacist, social worker, family caregiver, and any others who will participate in the care plan) are included in carrying out the care plan.

### Step 1: Start Discharge at the Time of Admission

When a care manager learns that a patient is readmitted, they contact the case manager at the hospital or skilled nursing facility. This initial contact lays the groundwork for a successful discharge that lowers risk of readmission. The care manager should ask the case manager several questions:

- What's the care plan?
- What's the expected length of hospitalization?
- What kind of care will the patient need when they go home?
- Does the patient need to be discharged to a facility other than home, such as a skilled nursing facility or a rehabilitation facility?
- How will the case manager communicate the discharge plan to the patient, family, or caregiver?

Communication about discharge between the transitional care manager and hospital or facility case manager is particularly critical. As hospital stays become shorter in duration, care is best coordinated when the community or transitional care manager collaborates on discharge plans with the facility care manager immediately upon admission. The care manager, as part of discharge planning, will communicate with the PCP and facility care manager to coordinate visiting nurses, or other community agencies, for immediate home health assistance. Timely communication is essential to preventing a readmission.

For example, if a patient is discharged on a Friday, the visiting nurse agency may not get to the home for an assessment until the following Monday or Tuesday. This is an avoidable gap in care that would leave the patient without care for up to four days, increasing risk for readmission. The care manager must ensure agencies are aware of the discharge and schedule timely visits prior to discharge.

A follow-up call to the patient within two days of discharge is important to assess the patient's condition and understanding of prescriptions, and to educate them on signs and symptoms that should prompt a call to their PCP.

## Step 2: Ensure Medication Education, Access, Reconciliation, and Adherence

When a person is hospitalized, either due to a chronic or a new acute condition, it is likely that the patient will receive a new prescription or a change in medication. The transitional care manager must cover the following key points regarding medication:

- **Education:** The care manager works with the care team to teach the patient or caregiver about all medications—what they're for and how (i.e., with or without food) and when to take them. This includes an understanding of the risks of missed doses and what to do if they miss a dose. Education should be completed prior to discharge.
- **Access:** Access to medication includes both the ability to get to the pharmacy to pick up prescriptions and the ability to pay for them. Prompt pick-up is particularly important with certain medications; with antibiotics, for example, a delay or interruption may cause an infection to return. Before patients are discharged, the care manager verifies with the patient or caregiver that they

can access and afford their medications, or connects them with resources to help (such as elder services or a social worker from the PCP practice or from the discharging facility).

- **Reconciliation:** The care manager can collaborate with the facility or practice pharmacist, if there is one available, on medication reconciliation. The pharmacist can play a vital role in obtaining an accurate medication list (inclusive of new prescriptions, over-the-counter medications, and pre-existing medications) for the patient's follow-up visit with the PCP. Ideally, this reconciliation should be done at the time of, or immediately after, discharge. The reconciliation should be communicated to the PCP prior to the follow-up visit (scheduled within seven to 10 days of discharge).
- **Adherence:** Care managers can help patients and caregivers understand the importance of adhering to the medication plan. How likely is the patient to take the medication as prescribed? Is there a literacy or understanding issue that might prevent them from taking the full course of medication or taking it every day at same time?

### Step 3: Arrange Follow-Up Appointments

Upon discharge, the care manager makes sure the patient has a follow-up appointment with their PCP seven to 10 days after discharge. Patients should not skip the PCP follow-up, even if they have plans to see a specialist. The PCP is the continuum-of-care point person, meaning they need stay informed of all other care to avoid prescription contraindications, conflicting clinical plans, confusing or contradicting patient instructions, and other adverse events. Likewise, the care team pharmacist or care manager must conduct a medication reconciliation to obtain a current list of prescriptions, including any new medications given in the hospital or upon discharge. This medication list should be given to the PCP before the follow-up appointment.

### Step 4: Arrange Home Healthcare

The care manager determines what type of help the patient needs at home and whether they have someone to help. This is critical for anyone in weakened state (e.g., elderly patients). After discharge, patients may need help with cooking, dressing, and other daily tasks, as well as someone to check in with them and make sure they're adhering to their medication and follow-up care plans, and that their home is safe (e.g., handrails where needed and no slippery rugs or clutter to trip on) and all needed durable medical equipment has been ordered (e.g., walkers and commodes). Visiting nurse agencies, elder services, therapy, and/or social work interventions are all examples of services that must be in place prior to discharge.

### Step 5: Have Patients Teach Back the Transitional Care Plan

The final, indispensable step in the transitional care management framework is having the patient and caregiver teach back the care plan. This is how the care manager confirms that they've successfully

educated the patient on their discharge plans, diagnosis, medication, and when to call their PCP. It confirms the patient's understanding of the follow-up appointment with the PCP. The care manager gives the patient a number to call with any questions (e.g., the ED or case manager at the hospital or skilled nursing facility).

## Transitional Care Management Is Critical in Today's Healthcare Environment

Readmissions are preventable in many cases. This five-step transitional care management framework can serve as a guide for transitional care managers. Each step is intended to improve outcomes, mitigate cost, and to prevent [gaps in care](#).<sup>11</sup>

### About the Author



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KimSu Marder joined Health Catalyst in September 2015 as Care Manager Lead. Prior to coming to Health Catalyst, she worked for Tufts Health Plan as Care Management Relationship Manager. KimSu has a degree in Education from Lesley University, a degree in Nursing from Regis College, and is currently working on a Psychiatric Nurse Practitioner MSN at Regis College.



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