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Improving Care Transitions to Drive Patient Outcomes

The Triple Aim Meets the Four Pillars

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ABSTRACT

Purpose: The purpose of this article is to examine how case managers can support positive outcomes during care transitions by focusing on the goals of the Triple Aim (D. Berwick, T. Nolan, & J. Whittington, 2008) and Coleman's Four Pillars (E. Coleman, C. Parry, S. Chalmers, & S. Min, 2006). Case managers can play a pivotal role to ensure high-quality transitions by assessing patients and identifying those who are at high risk; coordinating care and services among providers and settings; reconciling medications; and facilitating education of patients and their support systems to improve self-management. These activities are congruent with an underlying value of case management as defined by the Code of Professional Conduct for Case Managers: "improving client [i.e., patient] health, wellness and autonomy through advocacy, communication, education, identification of service resources, and service facilitation" (Commission for Case Manager Certification [CCMC], Code, Rev. 2015).

Case Management Primary Practice Settings: Case managers across health or human services must assess for, identify, and understand the vulnerability of patients during care transitions and must adopt best practices to support successful care transitions. This includes case managers in acute care, primary care, rehabilitation, home health, community-based, and other settings.

Implications for Case Management Practice: Two frameworks that support care transitions are the Triple Aim of improving the individual's experience of care, advancing the health of populations, and reducing the costs of care (D. Berwick, T. Nolan, & J. Whittington, 2008), and Coleman's "Four Pillars" of care transition activities of medication management, patient-centered health records, follow-up visits with providers and specialists, and patient knowledge about red flags that indicate worsening conditions or drug reactions (E. Coleman, C. Parry, S. Chalmers, & S. Min, 2006). From a case management perspective, these approaches and their goals are interrelated. As an advocate for the individual and at the hub of the care team, the professional case manager engages in important activities such as facilitating communication across multiple providers and care settings, arranging "warm handoffs," undertaking medication reconciliation, and engaging in follow-up, particularly with high-risk patients. To support successful transitions of care, case managers must adopt best practices and advocate within their organizations for systematic approaches to care transitions to improve outcomes.

Key words: *care coordination, case management, case management process, case manager, certified case manager, code of professional conduct for case managers, commission for case manager certification, four pillars of care transition activities, patient outcomes, transitions of care, Triple Aim*

Across the spectrum of health and human services, two frameworks, the Triple Aim and Coleman's "Four Pillars" of care transition activities, seek to improve the quality of care delivery and patient outcomes. The Triple Aim targets the goals of elevating the individual's experience of care, advancing the health of populations, and reducing the cost of care (Berwick, Nolan, & Whittington, 2008). Coleman's Four Pillars span medication management, patient-centered health records, follow-up visits with providers and specialists, and patient knowledge about red flags that indicate worsening conditions or drug reactions (Coleman, Parry, Chalmers, & Min, 2006). Although separate, from a case management perspective, these approaches and goals are interrelated; in fact, the Triple Aim can be seen as driving the need for improving care transitions to achieve desired outcomes in patient health, population health, and cost of care. At the intersection of the two frameworks is the professional case manager whose role is integral in pursuing the Triple Aim (Tahan, Watson, & Sminkey, 2015) and in carrying out the activities of the Four Pillars to support patient education and empowerment. The case manager acts

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as both an advocate for the patient (the individual or "client" receiving case management services) and as the hub of a patient-centered transdisciplinary care team. The case manager facilitates better communication among all stakeholders (patients, their support system/family, and care providers) across multiple care settings, arranges "warm handoffs" from one setting to the next, and engages in patient education such as on medications, follow-up appointments, and other aspects of self-care. This has been well-known for years. As Carr (2007) observed more than a decade ago,

> In a culture that places a strong emphasis on patient safety, case managers can facilitate opportunities that ease care transitions whereby a change in venue is no longer perceived as a disruption in the flow of care but rather is viewed as a coordinated changeover where cautious and comprehensive communication sets the tone for the continued delivery of safe and effective healthcare (p. 1).

The point remains relevant today. Given the uniqueness of each case and care transition, it is essential for all case managers to become deeply familiar with best practices in care transitions and to put those theories into practice.

Despite an intense focus for more than 10 years on the Triple Aim goals and better care transitions, challenges remain because of the increasing fragmentation of the health care system. Radhakrishnan, Jones, Weems, Knight, and Rice (2018) observe that, even after a decade of attention and ongoing efforts to reduce fragmentation of care, Medicare patients with chronic diseases continue to experience high rehospitalization rates, at least 25% of which are considered preventable. To reduce costly, unnecessary hospital readmissions, emphasis must be placed on support during care transitions, including patient education and self-management (Boutwell & Hwu, 2009). This is a tangible way for case managers to move from theory into practice in support of better care transitions, while helping to address the multiple factors that complicate transitions and increase the risk of readmission (see Table 1).

At the intersection of the two frameworks is the professional case manager whose role is integral in pursuing the Triple Aim and in carrying out the activities of the Four Pillars to support patient education and empowerment.

One best practice is transitional case management, which offers extended posttransition follow-up lasting 30, 60, or 90 days or more (Kaiser Permanente Washington, 2018). Such programs can support higher risk patients through transitions, resulting in better patient outcomes and satisfaction as well as reductions in avoidable hospitalizations and emergency department visits. Although most postdischarge follow-up typically occurs within the first week, research has shown that the most vulnerable period for patients is 30 days after a transition, including 3–4 weeks after hospitalization (Dharmarajan et al., 2013). Furthermore, extended posttransition follow-up is increasingly important as patients are being discharged sooner, before they are fully recovered, and often with intravenous medications, wound care, surgical dressings, and new and/or multiple medications. For higher risk patients,

- telephonic check-ins over several weeks following a transition can help ensure that follow-up care and laboratory tests have been scheduled and completed;
- there are no new or worsening conditions;
- medications are being taken as prescribed; and
- the individual knows to be watchful for symptoms and side effects.

Deployment of case management and other resources to support transitions of care for multiple weeks is not without cost; however, a case can be made that the benefit to organizations of improved quality, better patient outcomes, and avoiding penalties for avoidable hospital readmissions could offset that cost. Therefore, professional case managers need to increase their awareness of transitions of care best practices and to advocate within their organizations for extended transition follow-up, particularly for high-risk patients.

Background

The need to improve quality and outcomes in transitions of care has been well documented for nearly

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two decades. Coleman et al. (2006), in a randomized trial conducted between 2002 and 2003, studied how patient-centered interventions among chronically ill older patients and their caregivers improved care transitions and reduced subsequent rehospitalizations. They found that with

> explicit attention to reconciling disparate medication regimens, and enhanced continuity across health care settings, the care transitions intervention appears to hold promise for addressing the serious quality deficiencies that occur during care transitions and may reduce the rate of subsequent hospital readmissions (Coleman et al., 2006, p. 1827).

Naylor and Keating (2008) subsequently found that high-quality transitional care is crucial for older adults with multiple chronic conditions and complex therapeutic regimens and who typically receive care from multiple care providers and move between care settings. Even frequent transitions within a hospital, such as from the emergency department to the intensive care unit and then to a general medical-surgical unit, can pose risks for older patients (Naylor & Keating, 2008). A serious risk is medication errors, which if not detected and addressed can lead to patient harm, including death, as well as increased costs for care and hospitalizations (Saedder et al., 2016). To help mitigate this risk, case managers can perform medication reconciliation and facilitate the timely sharing of information with the patient and support system/family and among the care team, preferably by updating the patient's electronic medical record (EMR; Case Management Body of Knowledge [CMBOK], 2012-2019).

In addition to the focus on care transitions, a call to action across health care for more than a decade has been to reduce avoidable hospital readmission. A study of Medicare claims by Jencks, Williams, and Coleman (2009) found that nearly 20% of Medicare beneficiaries discharged from a hospital were readmitted within 30 days, and 34% were readmitted within 90 days. Half of the patients who were readmitted to hospital within 30 days of discharge to the community showed no claims data evidence of having visited a physician's office for follow-up in the time between discharge and readmission (Jencks et al., 2009). These frequently cited statistics highlight the links between hospital readmission rates and unfavorable patient outcomes and rising costs of care. The Centers for Medicare & Medicaid Services (CMS) has increased its focus on hospital readmission rates. Starting in October 2012, CMS's Hospital Readmissions Reduction Program began reducing payments to hospitals that experience excess readmissions, as part of efforts to improve health care by linking payment to quality of care delivered (CMS, 2019). Since then, researchers have recorded evidence of incremental improvements in hospital readmission rates (Angraal et al., 2018); however, efforts continue across the health care continuum to reduce readmissions, particularly with better care transitions to bridge the gaps in a fragmented health care system.

TABLE 1
Factors That May Increase the Risk of Readmission

Diagnoses associated with a high rate of readmissions
Presence of comorbidities
Numerous medications prescribed
Prior readmissions
Psychosocial and emotional factors, including mental health, interpersonal, or family issues
Lack of a caregiver to provide support or assist with care
Older age of patient
Financial distress
Deficient environmental conditions
Limited health literacy

Note. From *"Transitions of Care: The Need for Collaboration Across the Entire Care Continuum,"* by The Joint Commission, 2013. Retrieved from https://www.jointcommission.org/assets/1/6/TOC_Hot_Topics.pdf

Care Transitions Remain at Risk

The reality is challenges to safe and effective care transitions remain because of the complexity of the health care system and a lack of clear definitions of who is responsible for patient handoffs from one care setting to the next (National Transitions of Care Coalition [NTOCC], 2008-2019). There may be complicating

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factors that, if not addressed, can disrupt transitions. Contributing factors include poor communication, incomplete transfer of information, inadequate education of patients and caregivers, limited access to essential services, and the absence of a "single point person to ensure continuity of care all contribute" (Naylor & Keating, 2008, p. 58). Poor health literacy also poses challenges for patients navigating the health care system, including care transitions (LeDoux & Mann, 2019). When there are language barriers, cognitive impairments, and/or difficulty engaging in conversations with care providers, patients often do not receive the information they need to engage in follow-up, self-care, and medication management.

Moreover, within specific patient populations, additional support and attention must be given to high-risk patients. They include elderly patients prescribed five or more medications (Caleres, Bondesson, Midlöv, & Modig, 2018), patients with neurological illnesses (Josephson, 2016), patients recovering from cardiac events (Barnason, Zimmerman, Nieveen, Schulz, & Young, 2012), and children with special care needs (Davis, Brown, Taylor, Epstein, & McPheeters, 2014). For example, Josephson (2016) states that for neurological patients, the period between discharge and the first outpatient appointment is "particularly vulnerable," and patients who do not know how or where to get information may overly use emergency department resources instead of contacting the appropriate clinical personnel (p. 183). In addition, neurological patients frequently have new or different medications following hospitalization, requiring medication reconciliation and patient education to reduce the risk of medication errors that, as Josephson (2016) observed, may occur in as many as half of patients. These same red flags can also be present among high-risk patients with other diagnoses, health conditions, and multiple comorbidities, attesting to the need for extended post-discharge follow-up to avoid unnecessary hospital readmissions and other adverse outcomes.

Case managers can play a pivotal role to ensure high-quality transitions by putting best practices into action: assessing patients and identifying those who are high risk; coordinating care and services among providers and settings; reconciling medications; and facilitating education of patients and their support systems to improve self-management (CMBOK, 2012-2019). These activities are congruent with an underlying value of case management as defined by the Code of Professional Conduct for Case Managers (the Code): "improving client [i.e., patient] health, wellness and autonomy through advocacy, communication, education, identification of service resources, and service facilitation" (Commission for Case Manager Certification [CCMC], Code, Rev. 2015, p. 3). Board-certified case managers are obligated to abide by the standards set by the Code, which makes them particularly well qualified to help ensure safe and successful care transitions and reduce readmission risks. The knowledge, skills, and competencies inherent in case management practice (see Table 2) further underscore the importance of the case management role in care transitions.

Case managers, care coordinators, and/or discharge planners work with physicians and other members of the team to plan and coordinate the transition from one care setting to the next. Case managers, discharge planners, and other staff then provide discharge instructions to patients and/or their family/support system and may also make follow-up appointments for patients (The Joint Commission, 2013). Overall, the professional case manager plays a vital role in improving care transitions by advocating for the individual, facilitating collaboration among care providers, and ensuring that communication is shared among all stakeholders and across care settings.

An important aspect of case management, and one of the Four Pillars of care transition activities, is

TABLE 2
Select Knowledge, Skills, and Competencies for Case Managers

Functional status assessment and risk scoring of clients
Medication management and reconciliation
Self-management skills building and health education
Negotiation with multiple specialists to develop a unique plan of care that considers all of a client's comorbidities
Implementation and modification of disease-specific guidelines
Education and coordination of care among informal caregivers and community organizations
Communication with care providers across settings and with clients/support systems

Note. From *"Primary Concerns* of *Transitions of Care,"* by Case Management Body of Knowledge, 2012-2019. Retrieved from https://www.cmbodyofknowledge.com/content/primary-concerns-transitions-care

medication management. As defined by Coleman et al. (2006), the objective is for the patient to be informed about medications prescribed. Some patients may be in control of their own medications; others may receive help from a caregiver who administers or assists with medication. The case manager who is performing the follow-up needs to ensure that the correct medications are being taken and in the right doses.

During hospitalization, caregivers should discuss with the patient the importance of knowing and understanding their medications. Prior to discharge, medication reconciliation is undertaken as part of confirming the discharge summary. Such steps help avoid errors that can occur when new medications are prescribed in the hospital and/or the dosage of a medication is changed. Once at home, the patient may not remember the instructions and may be taking the "old" medication instead of the "new" one or may be taking both. One recommendation is for patients to bring all their medications with them to their follow-up visit with their doctor. When current medications and doses are compared with the hospital record and the physician's orders, errors can be avoided. Furthermore, during postdischarge calls with case managers performing follow-up, patients can ask questions about the medication regimen and/or side effects.

A particular challenge in care transitions is ensuring that timely referrals for follow-up care are in place. The difficulty often encountered is when a patient is treated across networks (Radhakrishnan et al., 2018), such as a hospital in one network to a primary care provider in another network.

An example is "Mr. Jones," a 68-year-old man who was a Medicare beneficiary with a managed plan of care for his Medicare benefits. This managed plan of care required him to be treated "in-network" in order to be fully covered. However, when Mr. Jones was severely injured in an automobile accident, he was taken to the nearest Level 1 trauma center where he underwent emergency surgery. But the trauma center was not "in-network" under his managed care plan. His primary care doctor was in another network; moreover, Mr. Jones was recently reassigned to a different provider and was not established with that primary care physician as yet. As Mr. Jones was ready to be discharged, requests for follow-up appointments with the primary care provider could not be made electronically because the out-of-network trauma center and the nearest in-network hospital were on different platforms. When the case manager at the trauma center reached out by phone and e-mail to the primary care provider to request a follow-up appointment for Mr. Jones, the response was that there were no openings for 3 weeks. Mr. Jones, however, needed to be seen within a week to 10 days.

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This illustrates a common frustration with referrals, whether across networks or from a primary care provider to a specialist, particularly when separate networks become like silos that reduce visibility across the patient's care continuum (Kressel, 2016). Limited connections across the fragmented health care system can impair communication and undermine the process of ensuring timely referrals. This is a concrete example of where knowing best practices does not suffice; persistence and resourcefulness are essential for closing the gap and supporting care transitions.

To advocate for Mr. Jones, the case manager tried to facilitate peer-to-peer outreach from the trauma center hospitalist to the primary care physician. Finally, the trauma center case manager engaged with an appointment coordinator at the in-network hospital to arrange for outpatient care and also identified in-community resources to assist Mr. Jones as he recovered at home. Practical experience among case managers working in acute care attests to the fact that there is no one solution for managing care transitions across networks; cases and their particular challenges are unique. In some instances, referrals require continued requests across networks. In others, an insurance company case manager may approve continued treatment at the out-of-network hospital, particularly if there is a shortage of beds in nearby in-network hospitals.

Case managers draw on their expertise in advocacy, care coordination, communication, collaboration, and working on interdisciplinary or transdisciplinary teams to advocate for individuals and to facilitate warm handoffs from one setting to another to the best of their ability. In addition, there are many resources available (see Table 3) to help case managers understand the challenges and improve management of care transitions. For example, case managers must help ensure that information such as discharge summaries, new medication regimens, and follow-up care is transmitted to and received by the patient and the next care provider. This information should go beyond a specific episode of care to also address

TABLE 3
Transition of Care Resources

Resources exist to support professional case managers in guiding patients through care transitions. They include:

- American Case Management Society's Transitions of Care Standards (Transitions of Care Standards, 2019)
- Commission for Case Manager Certification's Case Management Body of Knowledge (CMBOK, 2012-2019)
- The Joint Commission's Transitions of Care Portal (The Joint Commission, 2013)
- National Transitions of Care Coalition (NTOCC, 2019)

the patient's long-term goals, for example, that a patient transitioning from a hospital to an inpatient rehabilitation facility ultimately expects to return to the community rather than a skilled nursing facility (CMBOK, 2012-2019). A complete picture of the patient's condition, treatment received, next stage of care, and long-term goals helps ensure that patients receive appropriate, timely, and coordinated care across as they transition across the continuum.

In-Network Transition Care Planning

Referrals and follow-up can be more readily facilitated when providers are within the same network and have access to the EMR. In addition, follow-up laboratory testing and other diagnostics may be performed before discharge so that the most recent updates can be sent to the primary care physician before the first follow-up visit. An example of an in-network integrated approach is Kaiser Permanente Washington's Care Transitions Program for individuals who are Kaiser health plan members and who receive treatment in the Kaiser network of urgent care, emergency departments, and hospitals. When a patient discharges from the hospital, that individual receives a postdischarge phone call from a nurse who reviews medication knowledge, the care plan, follow-up appointments, and knowledge of symptoms and other red flags that indicate the need to reach out for help (Kaiser Permanente Washington, 2018).

When patients are informed and then reminded about what to expect during recuperation—that is, what symptoms might be considered normal and which may indicate a problem—they know when to reach out to the primary care physician, call a 24-hr nurse line, or go to the emergency department. An example is "Mr. Smith" who underwent a scheduled surgical procedure for knee replacement. He experienced no complications during or immediately after surgery and was discharged to his home. Within a few days, however, Mr. Smith began experiencing shortness of breath, which surprised him because these symptoms did not appear to him to be associated with his knee replacement. But Mr. Smith had been alerted to report any changes in his health. He contacted his primary care practice and spoke to a nurse who advised him to go immediately to the emergency department, where it was discovered that Mr. Smith had developed a pulmonary embolism, a surgical complication that is not uncommon among elderly patients who have limited mobility. Without education and support for self-management, Mr. Smith could have been at risk for a severe health episode.

The Kaiser Permanente Care Transitions Program also provides for extended follow-up for high-risk patients enrolled in transition management. Telephonic follow-ups may extend for 2 or 3 months, based on the patient's risk (Kaiser Permanente Washington, 2018). After 1 year, improvements in transition management at Kaiser Permanente Washington reduced non-Medicare admissions and hospital days by 3.5% and 7.6%, respectively (Kaiser Permanente Business, n.d.) The ongoing goal is for further improvement, for example, in 2019, 80% of all targeted members with an inpatient hospital stay are expected to receive a postdischarge phone call within 7 days of being discharged from the hospital; 90% of Medicare members with an inpatient hospital stay are to have a completed medication reconciliation within 30 days of being discharged from the hospital (Kaiser Permanente Washington, 2018).

An example of transition management was the case of "Mrs. Green," who was hospitalized after suffering a significant stroke that required surgical repair to her heart. As she recovered in the hospital, Mrs. Green experienced slurred speech, but she had no other lasting effects requiring inpatient rehabilitation. Mrs. Green was discharged to her home to receive outpatient physical therapy. But there were risks for Mrs. Green, including a lack of referrals for follow-up care, new medications, and multiple comorbidities, which could have compromised her ability to remain at home where she also took care of her brother who had disabilities. Therefore, Mrs. Green was enrolled in transition management and received telephonic support for 3 months to ensure that referrals were in place. The case manager followed up on Mrs. Green's adherence to her medication regime, ongoing physical therapy appointments and home exercise regime, and her progress in gaining strength to care for herself and her brother. In addition, the case manager confirmed that she was being seen by her primary care doctor and a cardiologist, who shared information about her progress, changes in medications, and other pertinent case details.

Mrs. Green's case is an example of taking a systematic approach to ensure safe care transitions by addressing over time any barriers that impede the patient's goals. Because of the extended postdischarge

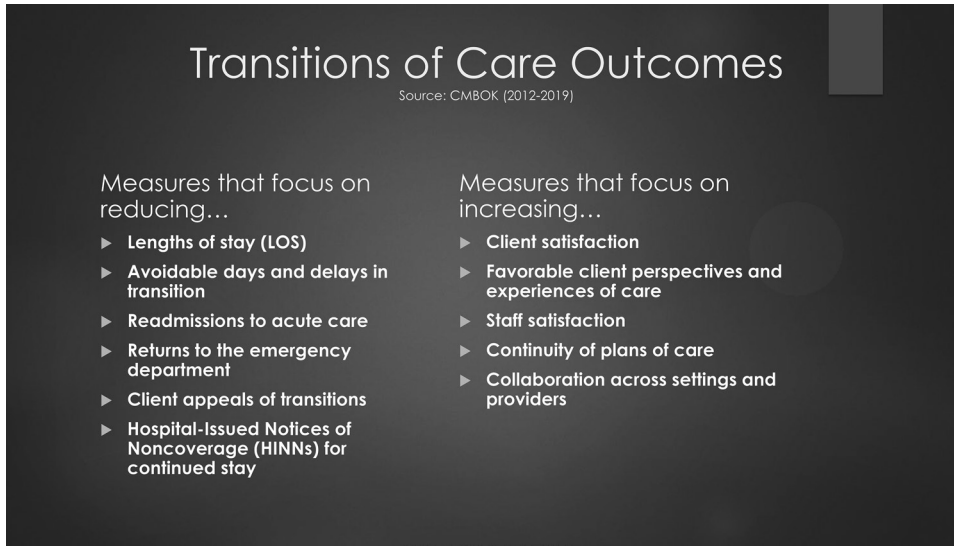

FIGURE 1
Transitions of care outcomes. From *"Primary Concerns of Transitions of Care,"* by Case Management Body of Knowledge, 2012-2019. Retrieved from https://www.cmbodyofknowledge.com/content/primary-concerns-transitions-care.

transition care management, Mrs. Green did not decline in health, nor did she require any emergency department visit or unscheduled hospitalizations. Thus, she achieved outcomes that reflect the measures of successful care transitions (see Figure 1).

Advocacy Across the Care Continuum

As a collaborative process of assessing, planning, implementing, coordinating, monitoring, and evaluating options to meet the individual's health and human service needs (CCMC, 2019), case management is increasingly recognized for its value across the care continuum. Through advocacy, communication, and resource management (CCMC, 2019), case managers promote quality and cost-effective interventions and outcomes, as well as a patient-centered transdisciplinary approach by the care team. With the patient involved in and at the center of care delivery, care transitions can become safer and more seamless. Such positive outcomes support the Triple Aim of improving patient health, improving population health, and reducing health care costs, as well as the Four Pillars to improve transitions of care and reduce hospital readmissions. As these best practices are put into action, the benefits are realized by patients and other consumers, as well as by providers, across the care continuum.

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Instructions:

- Read the article. The test for this CE activity can only be taken online at www.nursingcenter.com/ce/PCM. Tests can no longer be mailed or faxed.
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Disclosure Statement:

The authors and planners have disclosed that they have no financial relationship related to this article.

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