TRANSITIONS OF CARE

The following lessons learned and related considerations pertain to managing transitions of care between various levels of care: clinic visits or emergency room to inpatient services, as well as discharge and cross-setting care management processes under evaluation as hospitals adapt to the new environment.

The relationships and partnerships between acute care and post-acute care providers are key to ensuring the successful transition of patients to their home communities, including skilled nursing facilities, rehabilitation hospitals, long-term care hospitals, home or hospice. Thoughtful care management will allow patients to be transitioned from each level of care and supported on their journey to recovery. Specifically, this section focuses on transitions of care along the full continuum of care and complements the earlier section of this document on Ancillary and Support Services.

As background, we note that during the COVID-19 emergency, the experience in effectively utilizing post-acute care settings has been mixed. Some settings have struggled to respond to the crisis, most notably nursing homes. In contrast, as an example, long-term care hospitals have played an important role in treating ventilator and other highly-acute patients — especially in pandemic hot spots. As such, when considering relationships with community partners and opportunities to collaborate during this and future public health emergencies, it is useful for each hospital or health system to communicate with partners across the local continuum of care to compare COVID-19 lessons learned thus far. By identifying relative strengths and deficits, such exchanges can provide a baseline for future collaboration to improve the discharge process for COVID-19 and other target populations.

Likewise, the pandemic has illuminated the advantages of having provider offices, community health clinics, home care services, prehospitalization services (ambulances), community services, public health offerings and other parts of the care continuum coordinated with hospitals and health systems. Consider partnerships and collaboratives established through memorandums of understanding to evaluate the best use of all licensed beds and other clinical resources within a community/region. Throughout the public emergency, regulations have been made more flexible through emergency use authorizations. State and local regulatory agencies should be engaged so they understand the advantages of such partnerships and collaboratives.

INITIAL LESSONS LEARNED RELATED TO TRANSITIONING PATIENTS DURING THE COVID-19 PANDEMIC

- Some settings of care – most notably, many nursing homes – lack the infection control, personnel and physical plant required to effectively prevent and mitigate the spread of infectious diseases such as COVID-19. Receiving entities must be adequately staffed and trained to provide the necessary care for recovering COVID-19 patients. Larger organizations could offer educational training and on-site support to potential partner/skilled nursing facilities to ensure vulnerable patients receive appropriate follow-up and thus are less likely to be readmitted to the referring hospital.

- Some nursing homes – especially those affiliated with or already in a partnership with a hospital or health system – have effectively contributed to their local pandemic response. Of note, hospitals participating in alternative payment models, such as ACOs or bundled payments, that involve direct partnership with area nursing homes appear to be best positioned to collaborate during this pandemic and may provide a model for other communities to emulate. Some key elements of these relationships include existing channels of communication and protocols for joint case management, as well as standardized discharge processes and forms.

- Likewise, provider practices and community health centers that are part of these alternative payment models with hospitals also are well equipped to coordinate and partner with hospitals and health systems for the same reason.
- Some nursing homes tested all residents for COVID-19, which resulted in a burst of patients transferred to a local hospital and created capacity and resource challenges for the hospital. Plans to avoid repeating this action should be undertaken now.
- Other nursing homes temporarily evacuated all patients to an area hospital. While a portion of these patients met hospital admission criteria, most generally did not and therefore required hospital custodial care that is not reimbursed by Medicare. Plans to avoid repeating this action should be undertaken now.
- Care managers can play an effective role in outreach to patients prior to their visit (clinic, outpatient and inpatient) to provide guidance and set expectations.
- Communication with families of patients being discharged home also is key to ensure that they understand the care plan and can assist with care coordination and ongoing protocols for recovery.
- Telehealth is playing a critical role in mitigating community spread by reducing contact across health personnel, patients and the community. During the COVID-19 pandemic, policymakers have significantly extended the use of telehealth across post-acute care settings; but in certain cases, requirements for some in-person care were maintained, such as in home health settings. The ability to follow up and evaluate remotely should be available and supported through the use of telehealth at post-acute facilities and for homebound patients.
- Protocols for hospital-to-nursing home transfers of COVID-19 patients varied from state to state, with some standards set at a level that greatly delayed – and in too many cases, prevented – discharges back to a nursing home. Most commonly, this issue was caused by the requirement that a patient must have multiple negative COVID-19 tests prior to being admitted by the originating or other nursing home. Testing delays and inconsistent nursing home and post-acute care admission criteria for prior-COVID-19 positive and COVID-19 suspected patients exacerbated this problem. Plans to establish and standardize patient flow protocols should be undertaken now.
- Many hospitals reported sharing their supply of PPE with key post-acute care partners to facilitate safe patient transitions to a new setting. However, PPE shortages were a chronic challenge for many post-acute care providers.
- Additional resources and flexibilities provided by policymakers were key to enabling hospitals and post-acute care providers to make timely adaptations to existing transfer processes, care delivery protocols and the physical plant. These adaptations facilitated additional and faster hospital discharges by expanding space for COVID-19 positive and suspected cases, including new isolation spaces, and also reduced patient contact with clinical personnel and their communities. The volume and ongoing issuance of these new authorizations presented challenges for providers. Certain patients transitioning from a hospital to a post-acute care setting are encountering access to care challenges due to a shortage of key personnel, such as respiratory therapists needed to treat ventilator patients and behavioral health providers needed during home health visits.
- The mental health status of patients must be monitored both before and after discharge, providing appropriate recommendations for support services as needed; new partnerships with behavioral health care providers are needed to ensure continuity of care and to work toward better care coordination and efficiency.

- Some safety protocols caused discharge delays and reduced efficiency, including those prohibiting clinical personnel from local hospital partners from entering the referring care location to assist with discharges and related case management.
- The lack of interoperable EMRs across the local continuum of care slowed some patient discharges from hospitals to external post-acute care providers.
- Special needs populations, such as the homeless, prisoners and shelter residents, have certain unique transitions of care challenges; address these specifically within any protocols and plans.

IMPORTANT ELEMENTS FOR HOSPITAL DISCHARGES AND CROSS-SETTING COLLABORATION

COMMUNITY PLANNING

- Work with state and local emergency planners to identify:
  - Alternative sources for custodial care provided by hospitals for nursing home and other non-hospital patients, to allow hospitals to focus on patients needing inpatient-level care.
  - Identify the particular personnel that were uniquely needed during a pandemic, yet were in short supply, and to the extent possible, create surge staffing models and personnel supply plans.
- Create an ongoing system for dialogue with local health departments, other acute care hospitals, post-acute care and other key partners in your area to:
  - Address COVID-19 lessons learned related to transitions of care to prepare for future waves of COVID-19 and other viruses.
  - Standardize communitywide communications and care protocols.
  - Incorporate best practices from existing partnerships to improve care through joint case management, communications and problem solving.
  - Identify strategies to minimize movement of patients and clinical personnel across settings, with a focus on treating vulnerable patients in their originating setting when feasible.
- Support efforts to maintain the effective telehealth tools that were newly implemented during this pandemic.
- When planning for future PPE needs, in addition to using state guidelines and practices, consider collaborating with providers across the continuum of care on inventory levels and materials management practices.

KEY COMPETENCIES

- Establish a reliable system for communicating with key community partners during and after a hospital discharge, such as:
  - Primary care doctors and practices;
  - Post-acute care providers;
  - Durable medical equipment (DME) providers;

  - Social service agencies; and
  - Other services needed by patients transitioning to home.
- Develop discharge protocols that facilitate timely and patient-centered transfers and that focus on conveying priority information in a streamlined format.
- Address capacity for remote patient follow-up and other care, when clinically feasible.
- Ensure adequate access to the DME needed to provide safe care at any site.
- Consider incorporating support tools and artificial intelligence to augment case management decisions related to selecting the post-hospital site of care and related factors.
- Provide access to reliable and timely guidance on emerging waivers and other relief from payers.