


## Transition care management reduces costs

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Today, many payers are focused on utilization management (UM) to evaluate the appropriateness, medical need, and efficiency of various healthcare services for patients based on established payer criteria. However, that broad category of proactive healthcare case management often does not properly address an emerging area that significantly impacts healthcare costs – transition care management.

Transition care management addresses the gap in care that can occur when patients migrate between different levels of care, such as a patient's transfer from critical care to a step-down unit or from one care setting to another. This patient hand-off is often riddled with communication breakdowns between disparate departments or organizations that lead to substandard patient outcomes, increased readmissions and higher healthcare costs.

Ideally, communications between departments or healthcare organizations are seamlessly disseminated, documented, and managed whenever patients are transferred between levels of care. However, the fragmented nature of our healthcare system presents a challenge in realizing that vision. Deploying effective information technology tools to support that communication and to provide access to up-to-date individualized care plans, as well as patient and benefit plan information, is key to ensuring consistent, high quality patient care.

### Crossing the Divide

While transition care management is commonplace within provider networks, the lack of insurer involvement reduces the total potential for improved quality and decreased costs. In other words, if payers aren't aware of the provider's care plan, or which services were rendered, until they receive a claim for reimbursement, then they cannot provide the real-time guidance and coordination of care that could have optimized patient care, experience, and outcomes.

Furthermore, many hospitals aren't efficient at executing or following up on transitions, which may be related to a lack of financial incentive to do so. For example, a facility may discharge a patient to a home health agency, but often fails to relay vital information to the agency when unable to reach them via telephone. Additionally, a hospital's lack of follow-up wouldn't uncover instances where the home health agency failed to act on its referral, or when the patient ultimately refused home health services, both of which would negatively impact patient outcomes and long-term costs.

When patients fall between the cracks during these transition times, the potential for increased healthcare costs soar because recently discharged patients often require rehospitalization or emergency care, or they may even end up in the wrong setting for the level of care required. Thus, by effectively managing bidirectional communications from one care level to another, providers and payers can substantially reduce expenses, particularly for patients with catastrophic injuries.

Paramount to the communication effort is the need for providers, payers, and patients to be aligned as a patient transitions from one care setting to another, be it intensive care to medical-surgical, or medical to outpatient services or rehabilitation. However, more frequently than not, these groups fail to coordinate patient transitions because they lack a vehicle, or platform, that allows them to easily communicate and exchange information.

By adopting a transition care planning approach and establishing a health information exchange (HIE) platform from which to interact with providers and patients, payers will be able to track patients' treatments every step of the way to ensure that the designated care continues without the disruptions that could potentially lead to inferior outcomes and unnecessary costs.

Although transition planning, communication, and documentation can be completed manually, an electronic platform with configurable interventions allows multiple users to collaborate simultaneously, thereby increasing efficiencies and savings. Additionally, users could access a host of data, including patient benefit details and in-network vs. out-of-network listings. By proactively reviewing benefit details when preparing the care management plan, healthcare stakeholders reduce the risk of patient reimbursement disputes or bureaucratic challenges when patients attempt to obtain needed services. Furthermore, a satisfactory patient experience strongly correlates with an improvement in payers' customer retention and recruitment efforts.

Transition care planning also enables plans to overcome the challenge of lack of access to care plans and clinical data. Currently, they extrapolate and craft medical management decisions from claims data, which, by definition, are acquired post-treatment. However, transition care planning would provide payers with access to data before a patient is transferred, enabling them to deliver vital information to providers that could impact clinical decision-making and deliver greater cost savings to all stakeholders.

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## Flexibility is Key

The integration of transition care planning makes sense for all health plans, but it is especially beneficial for staff-model HMOs, or organizations that assume risk or that are part of an integrated health system. Given that benefit plans vary from market to market, it is critical that payers implement technology applications that can be easily configured to address local and regional business needs.

The right transition care planning system will enable payers to address specificities based on whether their contracts call for diagnosis related group (DRG) codes, per diem, or capitation reimbursement. They also can customize the system to reflect the payer's relationships with various groups, or any other account-specific parameters. For example, if a third party administrator's (TPA) client indicates that their employees should only be referred to specific inpatient or skilled nursing facilities, the TPA can electronically post that information on its system. This data sharing allows providers to alert patients that a given facility is out-of-network and possibly suggest a more cost-effective, in-network facility.

Additionally, successful systems should be compatible with clinical decision support and other care management tools that facilitate communications between payers and providers. For instance, the patient may have an established medical home and the system can empower this model of care co-ordination by involving the medical home in the care transition process; thus, providing an opportunity for review and approval of the transition plan.

The ultimate goal of transition care planning management is to effectively move patients to a lower level of care and, ultimately, self-care. By automating communications and workflow processes necessary to help providers collaborate and meet patients' healthcare needs at different points across the continuum of care, all healthcare stakeholders will benefit from increased efficiencies, decreased healthcare costs and improved patient outcomes.

*Sathya Rangaswamy is the founder, CEO and chief technology officer of ZeOmega, a leading provider of health care management software products, consulting and outsourcing services.*



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