One Patient, Many Places: Managing Health Care Transitions, Part III: Financial Incentives and Getting Started

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This article is the last in a three-part series. Part I appeared in the September issue and Part II in the October issue of the Journal.

This article is the third in a three-part series. This series of articles addresses how health care organizations (ie, organized or integrated care systems or large provider groups that receive payment under either a capitated or fee-for-service basis) can improve the quality of transitions among care venues for patients with complex care needs. Part I provided an introduction and discussed strategies for ensuring accountability for patients in transition and facilitating the effective transfer of information. Part II focused on enhancing practitioners' skills and support systems and enabling patients and caregivers to play a more active role in their transitions. Part III will address the need to align financial and structural incentives to improve patient flow across care venues, and will recommend steps organizations can take to initiate a quality improvement strategy for transitional care.

FINANCIAL INCENTIVES AND STRUCTURAL ISSUES

Recommendations

Health care organizations (HCOs) should:

1. Ensure that financial incentives among providers are aligned to promote (1) high quality care transitions, and (2) the transmission of essential data elements to practitioners involved in a patient's care across different settings.
2. Structure their delivery systems to promote seamless transitions across care settings.
3. Review benefits coverage and limitations with patients and/or practitioners prior to a transfer, and explain to patients what they should expect at the next care setting(s).

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Statement of Problem

Payment mechanisms commonly lack incentives for assuring that optimal care coordination occurs across settings. Per-stay (or per-case) payment mechanisms can promote premature patient transfer without adequate focus on the patient's needs at the next setting. Yet reducing the length of stay in one setting may negatively influence care as well as costs in a subsequent setting. Furthermore, each additional care transition provides another opportunity for an adverse transition-related event or error to occur.

Structural barriers may also impede the provision of optimal care for patients in transition. For example, HCOs that attempt to create an affiliated or contracted continuum of care for a variety of acute and post-acute services often encounter differences among providers with respect to their mission, staffing, internal incentives, and professional cultures. These differences can contribute to poor communication, insufficient information transfer, and inadequate preparation of the patient and caregiver. Further, the continuum of care may be incomplete or lack the capability to care for certain subsets of patients, such as those who require ventilators, have antibiotic-resistant infections, or have moderate-to-advanced dementia. Finally, tensions may arise within HCOs between clinicians who desire to affiliate

or contract with high-quality facilities and the finance department, which desires to negotiate the lowest rates.

The manner in which services are structured also impacts the provision of care. For example, under one HCO, a patient with osteomyelitis may be treated at home and receive intravenous antibiotics three times daily from a visiting nurse. Under another HCO, the home health agency may not have the technical ability or requisite staffing to provide such frequent home visits, requiring that the patient be admitted to a skilled nursing facility (SNF). Although some degree of variation is inevitable, the HCO is responsible for adopting mechanisms to ensure that care is provided in the most appropriate setting and is of high quality. Also, the lack of a common medication formulary across settings heightens the risk for miscommunication and error as the medication regimen must be revised in each setting.[1-4]

Additionally, patients may not comprehend their benefits package and their resulting financial obligation, including how that obligation varies by care setting. For example, a common misconception among patients and caregivers is that their SNF benefit covers 100 days of care, irrespective of medical necessity. In addition, some patients may choose to receive care in settings that lack adequate staff and resources (eg, going directly home instead of to a SNF), potentially resulting in a lack of essential services and a greater risk for medication errors, fragmentation of care, and utilization of costly services.

Proposed Solutions

During negotiations with affiliated or contracted facilities and providers, HCOs can attempt to create financial incentives that support information transfer. Under a contracted relationship, HCOs can adopt a "pay for performance" approach, including specific language regarding the types of information that need to be transferred and the time frames within which the transfer must occur in order to receive payment. Audits can be conducted periodically to assess performance.

In addition, HCOs in capitated or fee-for-service settings can provide incentives to practitioners who meet predefined goals for quality indicators. Existing satisfaction tools that hospitals, SNFs, and home health care agencies currently use can be supplemented to include items related to transitional care, with incentive payments that reward specified patient ratings. In addition to using established measures of transitional care, managed care organizations (MCOs) can design their own approaches. For example, when the federally sponsored voluntary Hospital Consumer Assessment of Health Plans Survey® (HCAHPS) is implemented nationwide, hospitals will have the opportunity to supplement the standardized questions included in this patient satisfaction survey with additional items tailored to their quality priority areas.[5] Thus, providers could incorporate validated measures of care transition quality to enhance their survey.[6]

Health care organizations operating under capitated payment can pay practitioners to participate in extended advanced care planning visits with patients and their caregivers to formulate contingency plans in the event that at-risk patients become physically unable to perform daily functional tasks (ie, who would care for the patient, and where would that care occur?). Advanced planning for future transitions would allow patients and their caregivers to face these difficult decisions without the pressure that occurs in a time of crisis.

Organizations can also adopt innovative structural approaches to improve the quality of transitional care. For example, receiving care nurses or care managers can be encouraged to meet with patients and sending care teams prior to an impending transfer. In some cases, this initial visit might occur in the emergency department or ambulatory clinic. The purpose of this "pretransfer" visit would be to:

- Conduct an initial assessment, with particular attention to whether the receiving care team has the capability to meet the patient's needs after the transfer.
- Gather the essential data elements directly from the sending care team, thereby reducing the potential for errors.
- Update or modify the care plan with the patient to reflect his or her care goals in the next setting.
- Prepare the patient and caregiver for what to expect after the transfer, including how the care will be covered by the health plan and any associated copayments.
- Estimate the length of stay in the next setting.

Again, under capitated financing, the HCO could reimburse the receiving team for this visit, selectively contract

with those providers who are willing to offer such a service, or build such a requirement into the contract. These visits might best be targeted to particularly complex cases, as not all patients would benefit from this approach. The benefits to the receiving provider organizations include building and maintaining business relationships and improving quality. These pretransfer visits are commonly conducted by Programs for All-Inclusive Care of the Elderly (PACE) programs in the United States and by some agencies in Canada.[7]

GETTING STARTED

For HCOs that are just beginning to address the issue of improving care transitions for their patients, the solutions proposed thus far, taken as a whole, may seem daunting. This section suggests steps that HCOs can take to get started. One approach is to begin improvement efforts by selecting and focusing on only one patient population (eg, patients with specific conditions such as stroke, hip fracture, or dementia, or those who reside in particular settings such as nursing homes or assisted living facilities) and one particular type of transition (eg, transfer from the hospital to a SNF or from the hospital to home with home care). Once the patient population and type of transition have been identified, the episode of care should be defined. This definition could be based on time (eg, 30 days), resolution of an acute exacerbation, or completion of a particular type of transfer, such as return to independent living.

The next step is to gather preliminary data to quantify the extent of the challenge. Data collection does not need to be a lengthy process or require sophisticated statistical analysis. The data might include tracking whether the requisite information was transferred in a timely fashion, whether patient safety was compromised (ie, by medication errors or if the transfer occurred before the patient was medically stable), or what the rate of recidivism was within a defined time period. In addition to analyzing patterns of care, HCOs can also gauge the quality of care transitions from the perspective of their patients. Patients could be telephoned after returning home and asked about their transition experience. Alternatively, items related to care transitions could be added to standard post-hospital satisfaction questionnaires.

Once the data have been gathered and analyzed, they can be shared with clinicians and key stakeholders to assess potential short- and long-term solutions. Ideas for practice improvement can be generated from these discussions and supplemented with the approaches proposed in this report or from other best practices resources. For example, solutions may initially focus on improving information transfer through an electronic medical record or clarifying which practitioner is accountable for the patient at different stages of the transition. Performance measurement can be an invaluable tool, particularly when opportunities arise to compare current practice with a baseline year. It also may be advantageous to "piggyback" efforts to improve care transitions with other initiatives, such as those aimed at improving patient safety, the creation of disease-specific care pathways, or other continuous quality improvement activities.

Next, the extent of the problem and the proposed improvements need to be incorporated into a business case and presented to senior leadership and other key stakeholders, including medical directors, nursing directors, discharge planners, case managers, administrators of home health agencies and skilled nursing facilities, relevant community-based agencies, and consumer representatives. This first meeting should build awareness of the problem and reduce the "silo mentality" discussed in this report. To the extent possible, the costs and adverse consequences of poor care transitions need to be articulated, such as the financial costs of recidivism; frustration and dissatisfaction for patients, caregivers, and clinicians; and potential litigation and negative publicity. ✧

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