



Transitions of care: How case managers mitigate risk for clients along the care continuum

Effectively transitioning a client from one care setting or provider to the next is fundamental to client wellbeing. Given that ineffective transitions can put clients at clinical, emotional, and financial risk, board-certified case managers must be experts at adeptly facilitating transitions to optimize health outcomes.

“As any case manager knows, transitions of care across the continuum are among the most significant periods in client care,” states Teresa M. Treiger, RN, MA, CCM, CHCQM, FABQAURP, Chair of the Commission for Case Manager Certification. “Transitional care planning—the movement of clients from one level of care, care setting, or provider to another—can be complex, as clients’ needs can be diverse and complicated.”¹

The variety of providers that clients see after leaving acute care can increase the likelihood of medical errors and patient safety mishaps. If a

client is at high risk of falling after hospitalization for an injury and that risk is not conveyed to their next provider at a rehabilitation center, the client may be more likely to fall without close supervision. Suboptimal handoffs and inadequate transfers of information can increase the danger of detrimental outcomes.

The Joint Commission defines transitions of care as the movement of patients between health care practitioners, settings and home as their conditions and needs change.² Poorly executed transitions of care can cause unnecessary readmissions, and the Centers for Medicare and Medicaid Services (CMS) establishes penalties for hospitals whose readmission rates are too high. Further, CMS’ bundled payment and accountable care organization payment models make payment contingent on care provided across the continuum of care. CMS reports that \$26 billion per year is spent on poorly managed care transitions of Medicare patients.³

Dr. Toni Cesta is a key thought leader in case management. Prior to her work as an educator, she served as Senior Vice President at Lutheran Medical Center, overseeing case management, transition planning and various other

1. Cesta, Toni (PhD, RN, FAAN) “Transitions in Care and the Role of the Case Manager”; Hospital Case Management, Dec 2017

2. Transitions of Care: The need for a more effective approach to continuing patient care. Self-Insurance Programs. <https://flbog.sip.ufl.edu/risk-rx-article/transitions-of-care-the-need-for-a-more-effective-approach-to-continuing-patient-care/>

3. Evaluation of the Community-Based Care Transitions Program. Econometrica, Inc. for the Centers for Medicare & Medicaid Services. Nov. 2017. <https://downloads.cms.gov/files/cmmt/cctp-final-eval-rpt.pdf>

fundamental areas. She has seen firsthand the importance of proper transitions and emphasizes their role on the continuum of care.

“The patient might receive care from a primary care physician, a specialist in an outpatient setting, then transition to a hospital physician and nursing team during an inpatient admission,” Dr. Cesta notes. “Then, they might move on to yet another care team at a skilled nursing facility. Finally, they might return home, where care is received from a visiting nurse or support from family member or friend.”

The importance of transitions across the continuum of care

“Care continuum” refers to a client’s care journey across the delivery system in various settings spanning all types of care.⁴ For the best outcomes, clients need timely, appropriate transitions across levels of care that best meet their needs. Case managers facilitating

transitions must anticipate all possible services a client may require, as well as potential compliance issues, and know what is needed to facilitate proper transitions along the care continuum (see **Figure 1**).

Clients may transition between various touchpoints along the continuum or be supported by multiple care touchpoints at once, such as visiting a physician's office while also receiving pharmacy services and community support (see **Figure 2**).

“When you look at that robust continuum of care, you have to think, how does that all come together if it's an accountable care organization, or a bundled payment model, or if I'm trying to reduce my readmission rate?” Dr. Cesta explains. “Case management is the glue that pulls that all together.”

Case managers play a fundamental role

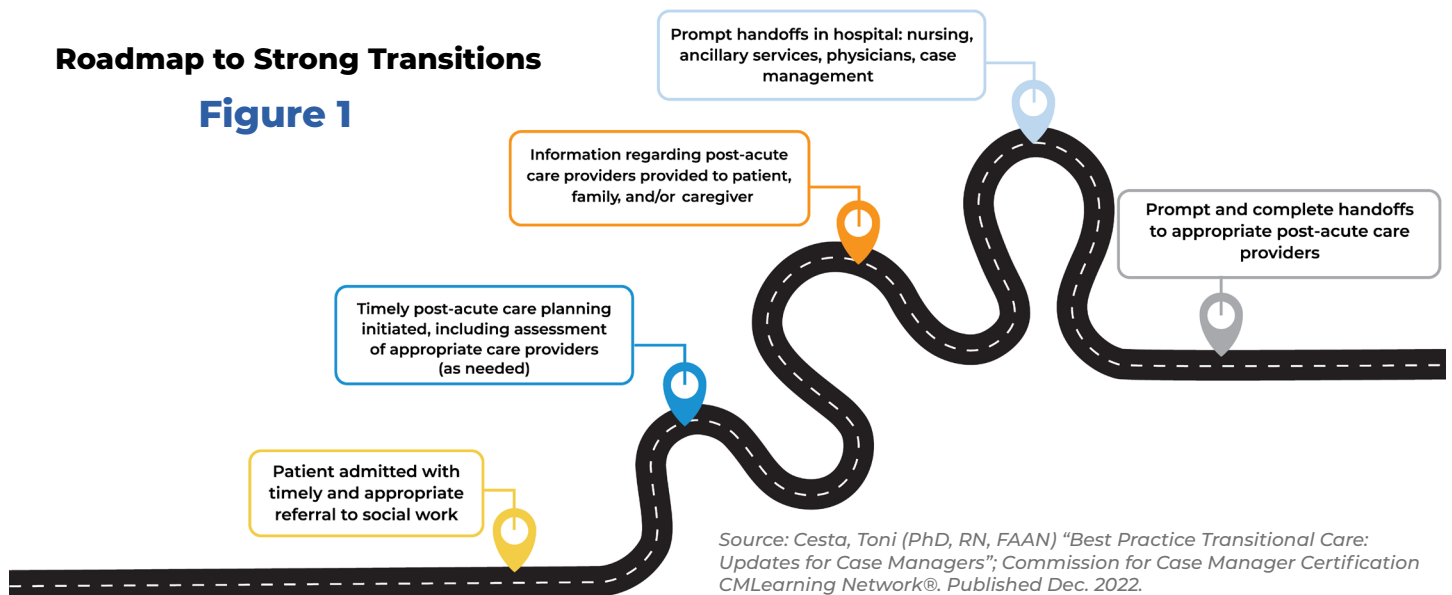
Case managers navigate smooth transitions and mitigate risk with exceptional communication, planning, and handoffs.

“At the beginning of a hospital or acute care stay, case managers need to communicate with clients, their families, support systems, and clinical team, setting goals for the acute care episode and for the eventual transition of care,” Treiger notes. “When confusion ensues, calm case managers are often the key communicators helping all to understand the acute care stay situation and goals with transition to a new setting.”

Board-certified case managers help clinical providers and insurers better understand the most appropriate settings for clients. They assess and communicate risk, scan the environment, review client needs, determine their support systems’ availability, and assess their financial situation.

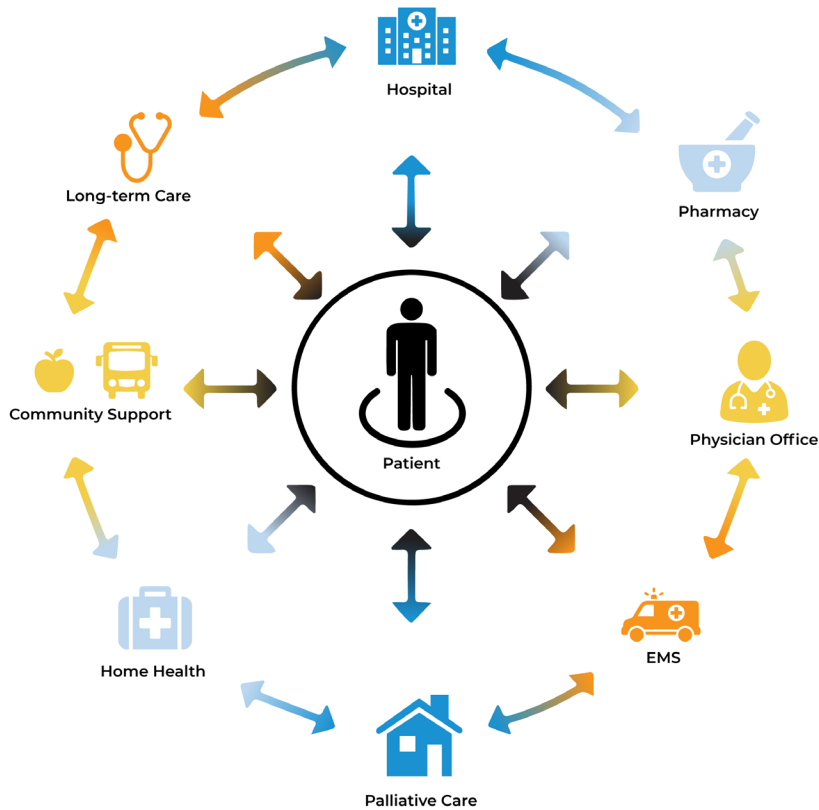
Roadmap to Strong Transitions

Figure 1



Source: Cesta, Toni (PhD, RN, FAAN) “Best Practice Transitional Care: Updates for Case Managers”; Commission for Case Manager Certification CMLearning Network®. Published Dec. 2022.

4. Evashwick C. Creating the continuum of care. Health Matrix. 1989;7(1):30-39. <https://pubmed.ncbi.nlm.nih.gov/10293297/>



Source: Cesta, Toni (PhD, RN, FAAN) "Best Practice Transitional Care: Updates for Case Managers"; Commission for Case Manager Certification CMLearning Network®. Published Dec. 2022.

Figure 2

“One patient might be fine at home after knee replacement surgery,” Treiger points out. “Another similar patient might be better served at a rehabilitation center post-surgery. One family may be anxious to have their family member come straight home after surgery. Another family may have no nearby caregivers, and as such prefer that the client go to a rehab unit until physical therapy and occupational therapy clears the patient for safe walking.”

The American Case Management Association (ACMA) outlines transition of care standards for certified case managers to follow (see **Figure 3**).

The transitional planning process can be highly involved (see **Figure 4**). It begins with assessing the client, making note of their condition, risks, and needs. Next is the discharge plan development, including the goals of treatment. Discussing a client's goals and preferences with them to inform the discharge plan can help ensure it aligns with their expectations. The plan should be flexible and under constant evaluation in case it needs to be changed as the situation evolves. Case managers should confirm that the client's transition destination is correct before final preparations are implemented. Using best practices, the case manager facilitates the client's transfer

to either another level of care or to their home. Dr. Cesta notes the final step that many fall short on is follow-up with clients after transitions.

Best practices for transitions of care

Getting clients into the right next level of care must be top of mind. Case managers must account for potential delays such as limited windows for accepting new patients. Coordinating with quality post-acute care is critical, and under evolving payment models, case managers must provide complete information about providers' quality of care and keep a client's network in mind when making a referral. Strong post-acute care transitions can reduce emergency department use, readmissions, and costs while improving quality of care and client satisfaction.

Strong foundational elements of effective transitions of care are as follows:

- A robust, coordinated interdisciplinary team
- Selecting the least restrictive next level of care that meets a client's needs
- Including the client and their family within the transition planning process and educating them about community resources for long-term health
- Establishing a safe transition plan
- Evaluating the clients' benefits to ensure they align with choices

Many interventions may improve transitions, including post-discharge follow-up calls—especially once clients have returned home—ensuring primary care access and conveying information to providers at the next level of care. Identifying end-of-life issues can be helpful to connect clients with relevant community services, as can connecting clients requiring complex care to medical programs with 24/7 support.

Effective care transitions require access to a client’s historical treatment data, often via a patient portal, as well as staffing with clearly defined roles and standardized policies. Emergency department case managers can help coordinate post-acute services and identify the appropriate next level of care. Collaboration with local providers can help to prevent avoidable readmissions and contributing factors such as poor communication and clinical complications. Timely

communication of discharge summaries including continuing care and diagnostic testing results to referring physicians should always be a priority. Standardizing the process is essential, particularly on off days, as is improving medication reconciliation and delivery of instructions to clients with communication barriers. Dr. Cesta recommends conducting medication reconciliation in both the hospital and the home, where clients are more likely to have spare medication.

Common challenges and the dangers of poor transitions

Transitions of care can be extremely complex due to the number of stakeholders involved, especially with multiple providers. Case managers are likely to encounter the following factors and challenges that can complicate transitions:

- Coordination between multiple providers
- Patient, family and/or caregiver decision making for next level of care
- Payer reimbursement variation
 - Fee for service, bundled payment, alternative payment models
 - Inadequate funding for next level of care needs: Unfunded, underfunded, lack of supplemental coverage
- Avoidable days/delays
- Readmitted patients with longer stays
- Physician practice patterns
- Communication across the continuum
- Inadequate coordination of care, planning, and goal setting
- Post-acute care providers
 - Compromised care: Readmissions, increase in costs, and length of stay
 - Delays in accepting patients

Dr. Cesta recommends that acute and post-acute committees regularly convene to review data and discuss improvement opportunities,

ACMA Transitions of Care Standards



Source: Cesta, Toni (PhD, RN, FAAN) “Best Practice Transitional Care: Updates for Case Managers”; Commission for Case Manager Certification CMLearning Network®. Published Dec. 2022.

Figure 3

Transitional Planning Process



Source: Cesta, Toni (PhD, RN, FAAN) “Best Practice Transitional Care: Updates for Case Managers”; Commission for Case Manager Certification CMLearning Network®. Published Dec. 2022.

Figure 4

especially for high-volume post-acute settings.

Managing post-operative morbidity is another challenge. Heart damage following non-cardiac major inpatient surgery occurs in an estimated 20% of patients and is often asymptomatic.⁵ Larger Medicare populations are more likely to have more clients at risk, especially in smaller hospitals. Considering these risk factors is helpful during the assessment process to inform transition plans.

Vital: Strong and effective handoffs

Efficient handoffs to the next level of care are a key determining factor of a smooth versus an ineffective transition. The Joint Commission Center for Transforming Healthcare defines handoffs as effective communication when transferring and accepting client care responsibility by conveying client-specific information between caregivers for safety and continuity.⁶ Some nursing units in acute care settings may transfer 40% to 70% of clients daily, driving high frequency of handoffs.⁷

Handoffs can be internal—to a staff nurse at the bedside, ancillary services like physical therapy, physician colleagues or others in the case management department and

post-acute care providers—or external outside the walls of the hospital to a nursing home, home care agency, or other community care setting.

With multiple specialists involved in client care, strong handoffs are essential to prevent gaps in client care or safety failures such as falls, medication errors, wrong-site surgery, and even client death. And it's all too easy for these errors to transpire. A study of incidents reported by surgeons found that communication problems contributed to 43% of incidents encountered, and 66% of those communication issues pertained to handoffs.

Communication strategies for effective handoffs must incorporate verbal and electronic communication. Verbal communication should be systematized between caregivers with an open line of communication. Electronic communication tools should include checklists, time-out forms, and transitional minimum data sets to ensure nothing slips through, and provide baseline information with a best practice framework, all preventing unnecessary readmissions. There are many tools available to improve handoff performance, such as the I-PASS mnemonic (illness severity, patient information, action list, situational awareness and contingency plans, and synthesis by receiver).⁸

The ability to identify and connect with other team members, both in the care setting one works within and outside of it in next levels of care, is a fundamental step that is often missed.

"Sometimes, case managers, nurses, and doctors have reported difficulty in contacting the correct health care provider," Dr. Cesta notes. "If you're looking at a patient who's in a bundled payment or accountable care organization (ACO) model, you need to know not only who the providers are in the hospital, but also who is going to pick that patient up in the community within that ACO."

Dr. Cesta recommends bedside walking rounds as a tool to bring the whole health care team together and minimize distractions such as machinery noises and outside conversation. In order to optimize handoffs, board-certified case managers should implement interactive communication with plenty of questions; updated client information; and develop a process for verifying information that has been received, such as repeat-backs (see **Figure 5**). It is important to ensure that handoff information includes access to clients' historical data. Finding a quiet setting can help minimize interruptions or distractions.

5. Ruetzler K, Smilowitz NR, Berger JS, et al. Diagnosis and Management of Patients With Myocardial Injury After Noncardiac Surgery: A Scientific Statement From the American Heart Association. *Circulation*. 2021;144(19). doi:10.1161/cir.0000000000001024

6. Joint Commission Sentinel Event Alert. Inadequate hand-off communication. 2017;58:2. [https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_58_hand_off_comms_9_6_17_final_1\).pdf?db=web&hash=5642D63C1A5017BD214701514DA00139&hash=5642D63C1A5017BD214701514DA00139](https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_58_hand_off_comms_9_6_17_final_1).pdf?db=web&hash=5642D63C1A5017BD214701514DA00139&hash=5642D63C1A5017BD214701514DA00139)

7. Mary Ann Friesen, White SV, Byers JF. Handoffs: Implications for Nurses. *Nih.gov*. Published April 2018. <https://www.ncbi.nlm.nih.gov/books/NBK2649/>

8. Blazin LJ, Sitthi-Amorn J, Hoffman JM, Burlison JD. Improving Patient Handoffs and Transitions through Adaptation and Implementation of I-PASS Across Multiple Handoff Settings. *Pediatric Quality & Safety*. 2020;5(4):e323. doi:10.1097/pq9.0000000000000323

Key components in developing transition strategies

It's essential for case managers to keep in mind various factors that can impact smooth transitions, including:

- The client, their family, and family caregivers
- Case management processes
- Hospital and post-acute care
- Physicians
- Alternative payment models with other case managers
- Potential staffing challenges
- Strategies in case of turnover and handoffs to limited staff during days off

Dr. Cesta summarizes the case management transition management process by describing individual components of the process: input, throughput, and output. She points out the following examples:

- **Input:** A client may transfer from another organization or may come as a direct admission from a physician's office. They may come from an ambulatory surgery, an outpatient procedure, a skilled nursing facility, a nursing home, acute rehab, or other settings.

- **Throughput:** A client may be transferred to a higher or lower level of care or to a next level of care within the organization. Case managers must facilitate proper written and verbal intra-hospital handoffs across the acute care continuum and develop a strategy to ensure clients are covered, even if or when they are not there, with proper handoffs.
- **Output:** A client may then be transferred to another acute care hospital, discharged to a next level of care facility, or discharged home where they'll then return to primary care.

Dr. Cesta emphasizes the importance of primary care as a level of care for handoffs. "Patients don't live in hospitals, they live in the community," she states. "To forget about that primary care provider does them a disservice."

Families and caregivers must be included in the process

Families can play a key role in care, so building a relationship with them early on in transition planning can establish rapport and help prevent delays. However, family dynamics and

issues such as conflict can still factor in and cause delays.

Empathy should always be a priority. Transitions can be disruptive and upsetting to families, with each new transition bringing changes in providers, rules, financial requirements and care plans. Case managers should reassure clients and their families to mitigate distress that can hinder healing, cause delays, or drive miscommunication.

Family caregivers (see **Figure 6**) are especially impacted by transitions. 1 in 5 Americans, or 53 million people, were caregivers in 2020, according to the National Alliance for Caregiving and AARP.⁹

Case managers should build strong relationships with family caregivers and collaborate with them as part of the health care team. Caregivers must understand how processes will work in a new setting, and case managers should give them the opportunity to ask questions while providing other resources. Case managers need to recognize family caregivers' important role. Case managers should empower caregivers to act on their authority as

Implementation Expectations for Effective Hand-Offs



Interactive communication allowing for the opportunity for questioning between the giver and receiver of patient information.



Up-to-date information regarding the patient's care, treatment and services, condition and any recent or anticipated changes.



A process for verification of the received information, including repeat-back or read-back, as appropriate.

Source: Cesta, Toni (PhD, RN, FAAN) "Best Practice Transitional Care: Updates for Case Managers"; Commission for Case Manager Certification CMLearning Network®. Published Dec. 2022.

Figure 5

an essential partner on the health care team who has the right to obtain information, within legal and regulatory parameters, about their family member's care and be involved in decision making.

Further influences on transitions of care

In addition to family and family caregivers, the health care system's complex nature allows many different factors to impact transitions of care outcomes. These include delays due to physicians, hospitals, payers, regulations, and even the case management department itself.

While physicians are required to document discharge destinations, they may not always have transitions at the top of mind or be strong planners. Delays can ensue if they avoid end-of-life

conversations with families or are invested in a particular post-acute care facility or provider. Case managers can help remind providers of the importance of documenting discharge destinations and keep these possible delays in mind to get ahead of them. Payer delays can influence transitions as well, especially in managed care organizations due to vendor choices, DRG-reimbursed client delays, next level of care approvals, on-site reviewers, or contractual requirements. Outside of managed care, types of reimbursements, self-pay or flat rate issues, or contractual limitations post-discharge (such as not having enough coverage for post-acute services) can affect outcomes.

Regulatory issues can also be influential. For instance, the Balanced Budget Act of 1999 allows clients and their families to choose from participating

Medicare providers and appeal their discharge. Another example of regulatory factors influencing outcomes, the Medicare Outpatient Observation Notice (MOON), requires hospitals to explain status as an outpatient rather than an inpatient to people entering outpatient care for more than 24 hours. Issues within the hospital or case management department can also cause delays. Delays in service, hospital-acquired conditions, poor communication, and lack of complete, timely documentation can all cause problems. Quality of collaboration and communication with teams and consultants, hospitalists, or physician advisors can also affect outcomes. A case management department's processes, staffing models, education, skill sets, and workload can all cause variations in transitions of

A person is a caregiver if they



Source: Cesta, Toni (PhD, RN, FAAN) "Best Practice Transitional Care: Updates for Case Managers"; Commission for Case Manager Certification CMLearning Network®. Published Dec. 2022.

Figure 6

9. Jr SM. Caregiving in the US 2020 | The National Alliance for Caregiving. www.caregiving.org. Published May 11, 2020. Accessed December 13, 2022. <https://www.caregiving.org/research/caregiving-in-the-us/caregiving-in-the-us-2020/#:~:text=This%20report%20is%20the%20most>

care outcomes. Leadership being outcomes-focused and data-driven is essential to quality transitions of care, as is integration across the care continuum, with case managers at all touchpoints. Transition case managers can be especially crucial to transitions of care for high-risk clients. This begins with

assessing risk by flagging frequent readmission or specific diagnoses, following them in care settings, and staying in touch with them for the first 30 days after discharge. Transition case managers ensure transitions go smoothly and collaborate with community case managers.

Case managers are crucial to improving transitions of care. With exceptional communication, client evaluation and coordination abilities, board-certified case managers at every touchpoint of the continuum of care can drive sustainable, superior health outcomes for all clients.

About the Experts



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Toni G. Cesta, Ph.D., RN, FAAN is Partner and Health Care Consultant in Case Management Concepts, LLC, a consulting company which assists institutions in designing, implementing and evaluating acute care and community case management models, educating case management professionals and assisting in implementation of case management departmental changes.

The author of nine books and a frequently sought after speaker, lecturer and consultant, Dr. Cesta is considered one of the primary thought leaders in the field of case management. She writes a monthly column called "Case Management Insider" in the Hospital Case Management journal.

Prior to her current work as a consultant, Dr. Cesta was Senior Vice President of Operational Efficiency and Capacity Management at Lutheran Medical Center, overseeing case management, social work, discharge planning, utilization, denial management, bed management, the patient navigator program, the clinical documentation improvement program, and systems process improvement. She designed and implemented a Master's of Nursing in Case Management and Post-Master's Certificate Program at Pace University. Dr. Cesta served for seven years as a Commissioner for the Commission for Case Manager Certification.



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Teresa Treiger, RN, MA, CCM, CHCQM, FABQAURP is a thought leader inspiring Conscious Case Management® practice across the health care continuum. She earned her undergraduate degrees in nursing and healthcare administration from Laboure and Stonehill Colleges, respectively, as well as her Masters of Organization Management at the University of Phoenix.

Teresa's nursing practice concentrated on acute care, neurosurgery, orthopedic trauma, respiratory intensive care, and urgent care before shifting to business-focused care coordination and utilization management at managed care organizations. Subsequently, she developed care management and population health programs at McKesson and oversaw the development and implementation of an uninsured care management program in collaboration with Baptist Health.

Teresa is a prolific author, editor, and featured columnist across journals and books on case management and care coordination. She is founder and principal at Ascent Care Management, providing private case management, consulting, professional education, peer mentoring, and publication services. In the past, Teresa served as a founding board member of the National Transitions of Care Coalition (NTOCC) and is a past National President of the Case Management Society of America (CMSA).



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