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Care Transitions in an Academic Setting

By Aman Sabharwal, M.D., and Brian Pisarsky, RN, Managing Directors, *Kaufman Hall*

Hospitals and health systems across the country have been struggling with issues around timely care transitions. The COVID pandemic disrupted communications and relationships among care transitions teams; at many organizations, these disruptions have not yet been resolved. Bottlenecks at post-acute facilities—including skilled nursing facilities, inpatient rehabilitation, and long-term acute care hospitals—that have been struggling to meet staffing needs have been another contributing factor, as has the heightened acuity of patients who may have delayed seeking care.

While timely care transitions are an industry-wide challenge, the challenge is particularly acute for academic hospitals, driven in part by the unique tripartite academic mission of education, research, and the provision of clinical care. For example:

- Multidisciplinary rounding of care teams is a critical component of effective care transition management. Academic health systems also use teaching rounds to train new residents, and teaching rounds often become intermixed with multidisciplinary rounding, diminishing the effectiveness of the latter.
- The academic emphasis on learning, research, and experimentation is often not aligned with the timely movement of patients across the care continuum.
- Academic care delivery models do not always include a physician advisor who can escalate issues if a patient is falling behind on the estimated date of discharge.

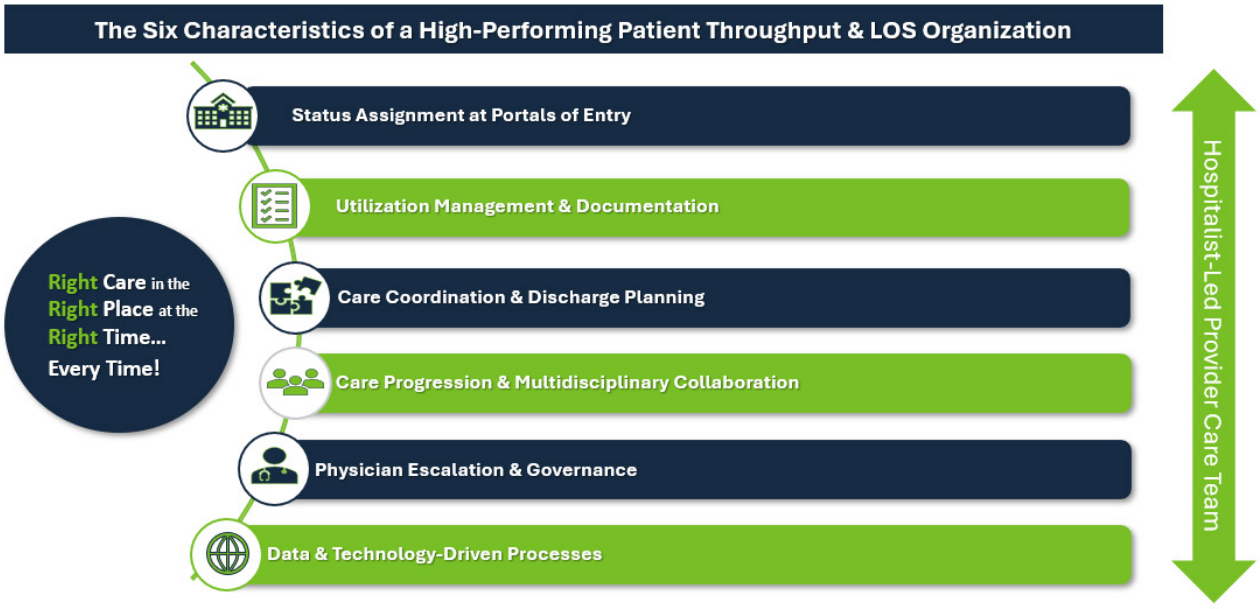
Compounding these factors is the fact that academic hospitals already have higher occupancy rates, on average, than community hospitals. This intensifies the need for timely care transitions from patient access, timely backfill, and revenue perspectives.

While board members at academic health systems do not need to immerse themselves fully in the details of care transitions and discharge planning, it is helpful for them to understand the fundamentals of patient throughput methodologies that effectively move patients through the continuum of care and result in timely patient discharges.

The Characteristics of High-Performing Hospitals

Hospitals that are particularly effective at managing care transitions and patient length of stay demonstrate six basic characteristics:

- They focus on accurately documenting the status of patients at portals of entry into the system.
- They ensure that utilization of resources is appropriate for the patient and document all resources utilized.
- They begin discharge planning as soon as a patient is admitted, and leverage coordinated care teams to help ensure that the estimated date of discharge becomes the observed date of discharge.
- They carefully manage the patient's progress through the care continuum and use multidisciplinary rounding with key members of the care team to keep that progress on track.
- They employ a physician advisor through whom members of the care team can escalate issues that might delay the patient's estimated date of discharge.
- They leverage data and technology to establish benchmarks for estimated length of stay, based on the patient's acuity, and monitor progress in adhering to these benchmarks.



Connecting all these dots is a hospitalist-led provider care team. Hospitalists are specifically trained to manage patients' inpatient stays and can be highly effectively leaders of multidisciplinary provider care teams that include nursing professionals, social workers, and case management professionals.

Managing Care Transitions in an Academic Setting

For any number of reasons, the characteristics of hospitals that exceed at managing care transitions, inpatient and ED throughput, and overall length of stay cannot be applied in cookie-cutter fashion in an academic setting. Academic hospitals admit patients of the highest acuity, for example, and accordingly have a significantly higher number of "outliers" to standard estimated discharge dates for different conditions. This does not mean, however, that academic hospitals cannot apply the characteristics of high-performing hospitals to improve their care transitions and patient length of stay.

> Care transitions are one of many issues that may be affected by the tripartite academic mission of research, teaching, and clinical care. But they are also a significant driver of financial performance and patient satisfaction.

Status assignment: Given the acuity range of patients admitted to an academic hospital, accurate status assignment is especially important. Patients with lower acuity often can be treated following a standardized care transitions protocol with a more reliable estimated date of discharge, or potentially transferred to a community hospital partner.

Resource utilization and management: The full resources of academic medicine are not required for the full range of patients. There may be exceptions—for example, the trial of a new procedure or protocol on a condition-defined patient cohort—but resource utilization should generally flex to align with patient acuity and needs.

Discharge planning and care coordination: Again, accurate status assignment should identify patients that can follow a standardized care transitions protocol that is focused on an estimated date of discharge designated upon admission. Collaboration with the case management team helps to ensure timely discharge or identification of services that can be provided at the next level of care or in an outpatient setting.

Care progression and multidisciplinary collaboration: It is important to maintain a distinction between multidisciplinary rounding, which is focused on timely care transitions for all patients, and teaching rounding, which may focus more on specific patients or acuity levels. These rounding teams have very different goals and should operate separately with different team compositions.

Physician escalation and governance: Physician faculty members are accustomed to a significant degree of independence in managing care for their patients and are not used to being questioned about care decisions or patient progress. Implementation of

hospitalist-led provider teams tasked with overseeing care transitions for all patients can be a significant cultural shift, but they can have a significant impact on improving length of stay.

Data and technology: This may be an area where academic hospitals have an advantage over other hospitals. Academic hospitals, in general, have often made significant investments in technology platforms and data analytics, and accordingly have access to more robust datasets that can help define the most effective care transition protocols.

Care transitions are one of many issues that may be affected by the tripartite academic mission of research, teaching, and clinical care. But they are also a significant driver of financial performance and patient satisfaction. By understanding the significance of timely care transitions and asking questions that can help identify opportunities for improvement, board members perform an important oversight function that can make real contributions to financial and operational performance.

Key Questions for Board Members

To better understand where there may be care transition opportunities at their academic hospital, board members should ask the following questions:

- How do our hospital's care transition, ED throughput, and length-of-stay key performance indicators compare to other academic hospitals? To general community hospitals?
- To what extent do we assign patients to a standardized care transition protocol centered on an estimated date of discharge?
- To what extent does our observed date of discharge align with the estimated date of discharge?
- Has our organization implemented hospitalist-led provider care teams?
- Do we maintain separate teams and schedules for multidisciplinary rounding and teaching rounding?
- Do we have a dedicated physician advisor program for escalation of delays and barriers?

TGI thanks Aman Sabharwal, M.D., and Brian Pisarsky, RN, Managing Directors at Kaufman Hall, for contributing this article. They can be reached at aman.sabharwal@vizientinc.com and bpisarsky@kaufmanhall.com.