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# Transitional Care Unit Implementation

New York State authorized up to 13 new transitional care units to begin operation in the near future. Hospitals chosen to develop these units can enhance patient care and improve their financial bottom line, serving both mission and margin. To make the most of this opportunity, they need to master a complicated implementation process. This brief highlights the opportunities and challenges of transitional care and offers advice for successful implementation.

IMPLEXpartners guided implementation for one of New York State's first TCU demonstrations which has grown into a very successful new program (see the list of New York's current TCUs on page four). Our consultants have developed and managed both acute and sub-acute care operations in New York State and around the country.

## The advantages of transitional care

Done well, transitional care improves the quality of life for medically complex, cardiac, pulmonary, orthopedic and other patients. It enables them to leave the hospital – mostly for home – having completed acute care treatment and regained the strength and skill to handle daily living requirements including eating, dressing and moving around the house. They leave with better nutritional health, with pain problems addressed, and with depression treatment arranged, when necessary. And they return to the hospital less often than other discharged Medicare patients.

In addition to its health care benefits, transitional care offers financial returns for hospitals through a combination of reduced acute care lengths of stay and a shift to Medicare's Part A reimbursement system which provides per diem payment for TCU stays. As a service line, transitional care unit operating expenses usually exceed revenue by approximately 20 percent, depending on the size of the unit. However, when considering hospital length-of-stay savings attributable to the TCU, a modest-sized unit can add $750,000 or more to the hospital's bottom line.

## Important distinctions

Acute care focuses on intervention, stabilization and initial recovery. Transitional care usually begins four or more days following acute care admission. It restores physical, mental and social well-being while completing acute care treatment. TCU care plans emphasize awareness, engagement, benchmark points and events that require extensive cross-disciplinary coordination among physicians, nurses, therapists, nutritionists, pharmacists, social workers and others.

Physically, the transitional care environment provides some of the comforts and conveniences of home including varied meal settings, frequent social activities and flexible visiting hours that encourage family members and friends to visit.

The revenue process differs radically from acute care billing. The Medicare Part A prospective payment system (PPS) covers transitional care treatment. (The State allows no Medicaid reimbursement.) Part A provides payment according to "resource utilization groups" (RUGS) based on the amount of nursing care, rehabilitation therapy and other services provided. TCUs collect detailed patient-level information through a "minimum data set" system (MDS) and submit this data periodically to generate payment.

Operating as Medicare skilled nursing facilities, transitional care units must conform to highly-specific New York State and federal Medicare regulations – rules that TCUs must follow to the letter or else risk Medicare exclusion. As hospital-based units, they also follow Joint Commission strictures and Medicare patient safety rules.

## Essentials for success

To succeed, transitional care must attract physicians and their patients, deliver high quality care across a range of disciplines, provide a physical environment that differs from typical acute care settings and maintain meticulous records, among myriad other requirements. Five essentials for success are summarized below.

1. **Provide high quality, comprehensive care.** New York State is serious about improving patient outcomes. Its request states up front that "improvement of quality outcomes for the TCU population through the provision of appropriate services, delivered in the most efficient manner, is the primary goal of the TCU demonstration program." Outcomes that matter include:

   - Limited length of stay,
   - ADL and nutritional improvement,
   - Limited falls and pressure ulcers and other patient safety outcomes,
   - High percent of discharge-to-home rates, and
   - Low readmissions.

   To deliver these results, TCUs provide seven-day per week care across several disciplines including medical and nursing care, pharmaceutical and nutrition services, therapies of all types, social and recreational activities and other services.

2. **Create the proper physical environment.** Transitional care units don't look like traditional med/surg units. Décor is important. They have common rooms where patients eat meals and snack, socialize with family members, friends and fellow patients. They have rooms for family conferences. Nursing stations don't dominate the unit or don't even exist. Rehabilitation facilities are either on the unit or very close at hand.

3. **Keep meticulous records.** It's hard to overestimate the importance of detailed transitional care record-keeping, including MDS information, care plans and other documentation. Proper payment and passing grades on long-term care audits depend on this. Hospitals must bring PPS expertise on-board as they begin TCU planning.

4. **Hire strong leaders.** TCUs are overseen by a licensed nursing home administrator, a part-time position. They need a full-time nursing director and a part-time medical director. Each of these leaders needs significant experience in both acute and long-term care. The medical director must be a strong physician who understands geriatrics, has a working knowledge of acute and sub-acute care regulations, and has excellent relationships with attending physicians who can refer patients to the TCU. All three leaders should be on staff when planning begins, several months before the unit opens, to guide facility design, develop policies and procedures, recruit and train staff, develop cross-disciplinary teamwork, involve and educate physicians and complete many other tasks.

5. **Enroll physicians.** Attracting sufficient numbers of patients to transitional care is the most elusive ingredient for success. TCUs must gain referrals from acute care attending physicians, including many who know nothing about transitional care and who may not be inclined to send patients there. Hospitals have to involve referring physicians – surgeons, primary care providers, hospitalists, critical care physicians, cardiologists and others – in planning the program and they need to inform and educate the physician community through the life of the program.

## Implementation challenges

Bringing a new transitional care unit online requires nine months or more of intense work, depending greatly on the construction schedule – an implementation process that presents significant challenges throughout.

The first challenge is to educate and align hospital leaders around the transitional care program – its purpose, promise and goals. Administrators, physicians and other clinicians must agree on the type of patients to serve, the intended outcomes for these patients and the financial results desired. This takes analysis and facilitated discussion and decision-making.

Design challenges come next, with significant facility changes required in most cases and brand new operational processes in all instances. Physical space must be configured to meet long-term care standards; new processes for admission, service delivery and discharge laid out in detail; budgets, staffing and training plans completed; billing systems specified; information systems selected, and performance management routines designed.

Executing these designs requires constant attention. As noted above, transitional care draws contributions from virtually every corner of the hospital – physicians, nurses, therapists, nutritionists, social workers, financial counselors, medical records staff, budget analysts, billing staff, housekeepers, building maintenance staff and others. Many of these people have never worked as closely together under tight timeframes on something as new as transitional care. Without skilled and effective project management, group facilitation and conflict resolution, the unit will open months late, if at all.

The ultimate challenge is to sell the importance of transitional care to physicians and their patients so they will use the TCU. This requires continual education and technical support by people who understand transitional care. Without this, the unit may open but no one will come.

**Five initial TCU demonstration hospitals**

- John T. Mather Memorial Hospital, Port Jefferson
- Champlain Valley Physicians Hospital Medical Center, Plattsburgh
- The Mount Vernon Hospital
- United Health Services, Binghamton General Hospital
- Medisys Health Network at Jamaica Hospital Medical Center, Queens

IMPLEX*partners* is a New York-based firm that consults with health care organizations on implementation, performance improvement and culture change. This brief draws on the firm's experience as project manager for one of New York State's first five demonstration hospitals, which helped create a highly successful transitional care unit. The firm and its clinical partners have developed and managed acute and sub-acute health care operations in New York State and elsewhere.

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