

## Fact Sheet: Highlights from the Post-Acute Care Transitions Position Paper

### Why Post-Acute Care Transitions are Important

The recent focus on improving post-acute care transitions (the process by which a patient moves from hospital to home or other settings) is being driven by an interest in reducing re-hospitalizations. The United States has an 18% rate of hospital readmissions within 30 days of discharge—and as many as 76% of these are preventable. According to Medicare data, over half of readmitted patients received no care or follow-up in the 30 days after hospitalization.<sup>1</sup> Patients that do receive care after being discharged from a hospital often experience care that is fragmented and uncoordinated, which results in duplication of services, inappropriate or conflicting care recommendations, medication errors, patient/caregiver distress, and higher costs of care.

Recent studies by Coleman, Naylor, and others suggest that interventions targeted toward post-acute care transitions can reduce readmission rates by one-third. These interventions focus on improving the care transitions process, providing direct patient support, improving self-management capabilities, and increasing access to needed information and tools. Four commonly care process improvement interventions that focus on post-acute care transitions are 1) the

Care Transitions Intervention, 2) the Transitional Care Model, 3) Guided Care, and 4) Geriatric Resources for Assessment and Care of Elders. The first two models emphasize hospital-to-home care transitions, while the last two models emphasize practice-based care coordination that includes care transitions elements.

### Post-Acute Care Transitions (PACT) Technologies

Post-Acute Care Transitions (PACT) Technologies can potentially lead to more effective transitions of care by improving medication adherence, medication reconciliation, patient monitoring, communications between and among clinicians, patients, and informal caregivers, risk assessment, and other important aspects of care transitions.

The table below describes possible “PACT” technologies for improving post-acute care transitions.

<sup>1</sup>

**Table 1: PACT Technologies**

<b>Technology Areas</b>	<b>Short Description</b>	<b>Examples</b>
<b>Medication Adherence</b>	Medication adherence is the degree to which patients take medication as it is prescribed by the health care provider.	Automated Medication Dispensers, Medication Reminder Technologies, Algorithms to Detect Poor Medication Adherence.
<b>Medication Reconciliation</b>	Medication reconciliation is the process of creating an accurate list of all medications a patient is taking and comparing that list against new physician orders.	Computerized Medication Lists, Algorithms to Detect Medication Prescription Problems (such as duplicate prescribing).
<b>Remote Patient Monitoring</b>	RPM technologies are used to closely monitor a patient's health condition in their home and transmit up-to-date information to family caregivers, providers, and other third parties.	Desktop devices that query patients about their health and collect and transmit data from home diagnostic devices (e.g., glucometers or blood pressure monitors).
<b>Personal Health Records(PHRs)</b>	Personal Health Records (PHRs) refer to a set of technologies that help patients track their health care services, access important health records and manage their own health information.	Personal health records that are web-based.
<b>Social Networking</b>	Web-based social networking enables communities of older adults, caregivers, and clinicians to connect, share knowledge with, and provide support to other older adults and their care providers.	Social networks created around a specific person and a specific situation (such as an individual needing support to recover from a recent hospitalization).
<b>Remote Training and Supervision(RTS)</b>	RTS technologies are systems that support the training and supervision of health care workers and patients who are not physically collocated with their educator.	Two-way videoconferencing that enables exchange of information and supported care; Just-in-time email alerts to prepare home health nurses for a patient visit.

## Center for Technology and Aging Initiatives: Background on Tech4Impact

In June 2010, AoA and CMS announced they will jointly award up to \$60 million in formula and competitive grants through the Program Announcement entitled: “Implementing the Affordable Care Act to make it easier for Individuals to Navigate their Health and Long-Term Care through Person-Centered Systems of Information, Counseling and Access.” As a complement to the AoA and CMS Program Announcement, the Center for Technology and Aging (CTA), with support from The SCAN Foundation, has created a separate funding opportunity: the **Tech4Impact Diffusion Grants Program**.

CTA announced the release of **Tech4Impact Diffusion Grants Program** with the aim to help selected states expand the use of **technologies for improving post-acute care transitions** and reduce avoidable re-hospitalizations.

The purpose of the **Tech4Impact** Diffusion Grants Program is to accelerate adoption and diffusion of technologies that better enable evidence-based care transitions models and result in improvements in health outcomes and cost of care, and an increase in the number of people that are able to safely and effectively transition from hospital to home or to long-term care community settings. CTA envisions state-led aging and disability resource centers (ADRCs) working with their community partners to expand use of patient-centered technologies that will help recently hospitalized individuals maintain their health and independence and avoid re-hospitalizations.

### References:

1. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. *N Engl J Med*. Apr 2 2009;360(14):1418-1428.