Mary Free Bed
Advisory Group

CARE TRANSITION SERVICES

Helping patients smoothly transition to the most appropriate level of care in a timely manner is vital to their well-being, but the process is becoming more complicated with health care bundling and mercurial insurance requirements. The industry expertise of the Mary Free Bed Advisory Group combined with the talents of your team members can help ease care transitions. We provide assistance in several areas, all customized to meet your unique needs.

ACUTE CARE TRANSITIONS

Are excess days, readmissions and a lack of system throughput decreasing your hospital's overall performance and causing bed shortages? We can help. Our CONNECT program provides oversight of the patient discharge process and educates your staff how to quickly identify when patients are ready to move to the next level of care. We work with your case managers to review each admission and help them understand the criteria for each post-acute setting, so patients go to the right location at the right time. Patients benefit and so does your hospital by avoiding excess days, decreasing readmissions and opening your beds for new patients.

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INPATIENT REHABILITATION FACILITY (IRF) TRANSITIONS

Admission requirements for inpatient rehabilitation programs are rigorous, but we help you implement pathways and care models to optimize access to your program. We also emphasize efficient utilization of rehabilitation days and work with your team to enhance communication with acute care case managers.

We can help you:

- Understand InterQual® Criteria
- Learn about payer-specific access navigation
- Clear hurdles for patients who are part of a bundle program
- Manage post-admission denial
- Manage length-of-stay targets
- Create network services reports (payor-level outcome and utilization data)
- Understand durability of outcomes
- Establish procedures for post-discharge calls to reduce ER visits and unnecessary readmissions
- Create processes for establishing single case agreements
- Structure case management and social work, and understand the differences in roles
- Maximize effectiveness and efficiencies of team conferences and care conferences
- Introduce case manager zoning

OUTPATIENT REHABILITATION CARE TRANSITIONS

Elevate your outpatient rehabilitation program with care transitions that create access points for your clients. Our services include:

- Surgical care transitions (prehab and post-surgical management)
- Sports injuries
  - Field to rehabilitation
  - School and semi-pro/pro transition pathways
- Pain management care transitions (inpatient to outpatient to home/self-management)
- Single case agreements
- Day rehab programs
- Post-acute huddles
  - Home and community transitions
  - Care transition hand-off communication
  - Transitions to and from residential living

SKILLED NURSING FACILITY CARE TRANSITIONS

Skilled nursing facilities are one of the most utilized post-acute settings in the United States. Our care transition services help your care management team ensure services are effectively and efficiently provided.

They include:

- Patient length-of-stay management
  - Working with transitional care coaches who follow patients in bundles
  - Managing patients who are part of a bundle
  - Identifying timely transitions to home or higher levels of care
  - Selecting short-stay admissions
    - How to evaluate the most appropriate referrals for your programs
    - Transitioning residents to your program
- Payer-specific access navigation to avoid denials
  - Initial-stay authorizations
  - Continued-stay authorizations
  - Network services reports
- Hospital readmission reduction strategies
  - Clinical care models
  - Collaboration with acute care providers
  - Navigating readmission meetings with referral sources

HOME HEALTH CARE TRANSITIONS

Patients are being discharged from acute care hospitals and referred to home health at record numbers. They have shorter hospital stays than ever before and head home with more complex and higher acuity conditions. Bundled-payment initiatives also are shortening the number of home health visits clients may receive. Our services include:

- Network services reports
- Utilization management and analysis of visits
- Transitions of care pathways to acute and other levels of care
- Pain management care transition (inpatient to self-management)

Our approach is customizable. If you have a specific need not listed here, give us a call. We are happy to create a customized solution for you.

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