Mary Free Bed Advisory Group

CARE TRANSITIONS SERVICES

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Effective care transitions connect services across the continuum, aligning patient clinical needs and functional abilities with social determinants of health to sustain long-term outcomes. Helping patients easily 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 Mary Free Bed Advisory Group's Care Transitions Model uses patient risk stratification, predictive analytics and clinical expertise to aid your acute-care team. We can help you:

- Reduce excess days.
- Improve patient throughput.
- Prevent readmissions.
- Appropriately utilize post-acute services.
- Improve functional outcomes and patient experience.
- Enhance patient access to quality services throughout the continuum.

ACUTE TO POST-ACUTE CARE NAVIGATION

Most care transition products narrowly focus on the most cost-effective level of care without considering the associated risks, social determinants of health and/or the long-term functional outcomes necessary for patients to remain in the community.

Using our proprietary predictive tools, the Care Transition team takes these variables into account and offers a comprehensive approach to your patients' treatment, beginning in acute care and extending up to 90 days after discharge from a post-acute setting.

This all-inclusive approach provides the most efficient use of post-acute services across the continuum, ensuring your patients sustain desired outcomes over time, based on:

- Their expected recovery trajectory
- Receiving the right care at the right time in the right place.

POST-ACUTE MANAGEMENT

Our Care Transition program includes interactive touchpoints with patients and care teams from the acute-care stay continuing to a minimum of 90 days after discharge from the post-acute setting. This includes:

- Hospital readmission reduction strategies
  - Establishing procedures to reduce emergency department visits and unnecessary readmissions.
  - Implementing clinical care pathways across the continuum.
  - Enhancing collaboration between acute and post-acute care providers.
  - Navigating readmission meetings with post-acute providers.
  - Monitoring patients remotely when appropriate.
- Sub-acute length of stay and quality management
  - Identifying timely transitions to home or higher levels of care as needed.
  - Vetting continuing care network of post-acute providers for quality.
  - Supporting implementation of necessary clinical care models to meet the needs of patients in primary service areas surrounding the acute facility.
- Home and Community Support
  - Enhancing timely start of care.
  - Ensuring resources are effectively deployed.
  - Identifying potential need for change in function and associated management.

CARE TRANSITIONS REPORTING AND ANALYTICS

To provide the best service possible, we provide objective feedback to those we serve. Our Care Transitions reporting and analytics supplies vital data to improve length-of-stay management, reduce readmissions, optimize operational efficiencies and sustain patient outcomes throughout the course of their recovery.

You'll receive important details by diagnosis about patients across the care continuum for greater insight into clinical, operational and quality performance to facilitate programming that meets the changing needs of the patients you serve.